# Sexual and Reproductive Health Services and Peer Education at Mnambithi TVET College:
## A Rapid Assessment


health
Department:
Health
PROVINCE OF KWAZULU-NATAL

UNFPA

## Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AYFS | Adolescent and Youth Friendly Services |
| CBD | Central Business District |
| CCG | Community Care Giver |
| CHF | Community Health Facilitators |
| CTP | Committee of Technikon Principals |
| DOE | Department of Education |
| DOH | Department of Health |
| DramAidE | Drama in AIDS Education |
| FGD | Focus Group Discussion |
| FPD | Foundation for Professional Development |
| HCT | HIV Counselling and Testing |
| HEAIDS | Higher Education and Training HIV/AIDS |
| HESA | Higher Education South Africa |
| HIV | Human Immunodeficiency Virus |
| IEC | Information Education and Communication |
| IHL | Institutions of Higher Learning |
| KAB | Knowledge Attitudes and Behaviours |
| ISHP | Integrated School Health Programme |
| KZN | KwaZulu-Natal |
| NAFCI | National Adolescent Friendly Clinic Initiative |
| NCS | National Communication Survey |
| PAR | Participatory Action Research |
| PEP | Post Exposure Prophylaxis |
| PHC | Primary Health Care |
| SAUVCA | South African Universities Vice-Chancellors Association |
| SHARP | Students HIV/AIDS Resistance Programme |
| SLO | Student Liaison Officer |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health Rights |
| STI | Sexually Transmitted Infection |
| SYP | Safeguard Young People in South Africa Programme |
| TB | Tuberculosis |
| TOP | Termination of Pregnancy |
| TUT | Tshwane University of Technology |
| TVET | Technical Vocational Education and Training institutions |
| UNFPA | United Nations Population Fund |
| UP | University of Pretoria |
| UJ | University of Johannesburg |
| UNIVEN | University of Venda |
| UNISA | University of South Africa |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organisation |

# Contents

# 1. Introduction

**The United Nations Population Fund (UNFPA) supports the South African government's implementation of interventions to address Sexual Reproductive Health and Rights (SRHR) and HIV prevention for adolescents and youth aged 10 to 24 under the banner of the "Safeguard Young People in South Africa Programme" (SYP). To promote this work, UNFPA sub-contracted DramAidE (Drama in AIDS Education), a non-profit organisation based in KwaZulu-Natal (KZN) for a period of three months to work with Mnambithi TVET College students and staff and health care workers from UThukela District Department of Health (DOH).**

DramAidE was tasked with the following:

- Facilitating the implementation of the dual protection campaign.
- Training Peer Educators to implement communication campaigns on dual protection.
- Conducting a rapid assessment of the status of the peer education programme at the college and whether the sexual and reproductive health (SRH) services provided by DOH are adolescent and youth friendly.

This study essentially aimed to establish if there is a peer education programme at Mnambithi TVET College focusing on SRH and HIV prevention and whether the services rendered are adolescent and youth friendly. It therefore investigated the status of these two factors, identified gaps and proposed solutions. The significance of such a study cannot be overstated because in developing countries there is a lack of research on what young people perceive to be important during the delivery of reproductive health services[1]. Furthermore, it is hoped that the study will help to fill the current research gap on peer education programmes, particularly those in Institutions of Higher Learning (IHLs).[2]

Peer Education can be described as a programme that uses individuals that share certain characteristics with their target audience, i.e., age, background, social orientation etc., to promote behaviour change. On the other hand, adolescent and youth friendly services (AYFS) is defined as a quality improvement system that is implemented in Primary Health Care (PHC) facilities using ten quality improvement standards to ensure that resources, capacity, and the necessary activities are put in place to improve young people's uptake of health services. It therefore promotes the delivery of services that attract adolescents and youth, respond to their needs and retain them for continued care[3]. Its implementation involves a far more technical alignment of resources and activities that are generally not in place at Mnambithi TVET College. Although the college has a class room on the Ladysmith campus that is used as a consulting room during the fortnightly clinic consultations as well as mobile clinics that provide services twice a month on Ezakheni campus and once a month on Estcourt campus, this in itself does not qualify as AYFS provision as there is no fixed clinic on any of the campuses with systems that comply with the ten national AYFS standards.

While the AYFS quality improvement system has not been implemented at Mnambithi TVET College, SRH services are provided to students at the college. The delivery of youth friendly health services that attract, retain and respond to the needs of young people therefore remains pertinent in improving student wellbeing. In light of this, this study investigated the status of adolescent and youth friendliness during the provision of SRH health services to students at Mnambithi TVET College on campus and at the clinics surrounding their campuses, namely, Ezakheni 2, St Chads, Waltons and Connor Street Clinics. The ten standards were used to understand the processes and systems expected to be present to attract and retain young people in the PHC system.

Qualitative research methods were used including focus groups and individual interviews with students, Student Liaison Officers (SLOs) at Mnambithi TVET College, the UThukela District staff implementing AYFS and staff rendering services at the college as well as those working in the aforementioned clinics. These participants were selected using purposive sampling due to the fact that the study had to be completed within a month and half.

## Report Breakdown

This report begins with a brief discussion of what the study was about, how it was conceptualised and what it aimed to achieve. It then provides a background of what AYFS and peer education are highlighting the relevance of this study. The report also presents a brief background on Mnambithi TVET College, as well as an account of the geographical distribution of IHLs in ILembe, UGu, UMkhanyakude, UThukela and Zululand districts of KZN, including the mapping of the SRHR and HIV prevention peer education programmes identified in these institutions. This is followed by an overview of the work done in UThukela district around AYFS thus far, before discussing the research methodology employed for the study and the limitations encountered. The analysis of the data is presented, followed by a summary of the findings, and recommendations on how to improve the peer education practice and delivery of SRH services at Mnambithi TVET College. The final part of this report includes a proposed action plan that aims to address the challenges identified.

## Objectives of the Study

- To understand how the peer education programme is implemented at Mnambithi TVET College.
- To assess the provision of youth friendly health services within Mnambithi TVET College in line with the DOH's 10 national AYFS standards, focusing on five mandatory standards.
- To identify the gaps in the peer education programme and AYFS at the college.
- To understand how the peer education programme and health service delivery at the college can be improved.
- To propose recommendations to UNFPA on how to standardise and improve peer education programmes and AYFS in IHLs.
- In consultation with Mnambithi TVET College and the provincial and district DOH, propose a plan to address the gaps identified in the implementation of AYFS and peer education programmes.

# 2. Background

## SRH Services for Young People

**The history of SRH programmes targeting youth in sub-Saharan South Africa is a fairly recent one that dates back to the late 1970s following the realisation that this target group did not have sufficient information and understanding of reproductive health issues. To bridge this gap, the initial programmes prioritised the provision of information on reproductive health to young people, and capacitating parents and teachers to relay this information. Programmes that promote young people's access to SRH services are not as advanced in Africa as in other parts of the world, primarily due to either political factors or socio-cultural norms that frown upon encouraging young unmarried people to access family planning services[1].**

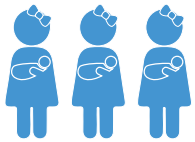
However, given the SRH challenges they face, it cannot be denied that access to such services must be improved among young people. Worldwide, more than a million young people between the ages of 15-24 are newly infected with HIV each year[4]. According to the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2012, in South Africa, more than a third of women have given birth to their first child by the age of 19. While teenage pregnancies account for only 10% of all pregnancies, women below the age of 18 account for 30% of maternal deaths[5]. In 2013, almost 60% of all new HIV infections occurred among adolescent girls and young women between the ages of 15 and 24[6]. Indeed, the HIV-incidence rate among female youth aged 15 to 24 in South Africa is more than four times higher than their male counterparts. In 2012, KZN not only had the highest HIV prevalence in the country but the highest HIV prevalence of 12.0% among young people between the ages of 15 and 24[4]. Similar to the Second National HIV Communication Survey, 2009 (NCS)[7] the survey also found that the key drivers of the HIV pandemic in South Africa include: multiple concurrent partnerships (which have increased especially among males aged 15 to 24) and intergenerational sex. Other risky behaviours are a rise in sexual debut before the age of 15 especially among males, and decreased condom use[4]. Furthermore, more than half of the estimated annual 11 million incidents of sexually transmitted infections (STIs) in the country occur among adolescents and youth. Research also shows that young people are most vulnerable to "physical and psychological trauma resulting from sexual abuse, gender based violence, physical violence and accidents"[8]. These statistics clearly indicate that young people in South Africa require more information and access to SRH services[9].

A study conducted by the South African national DOH and LoveLife in 2000 found that public health facilities delivered poor services characterised by long waiting times, lack of privacy, bad attitudes among nurses, inconvenient opening times and adolescents' lack of knowledge or awareness of health issues that affect them. This resulted in young people failing to access such services, perpetuating their health challenges[8]. According to the World Health Organisation (WHO), if the health services that are provided to young people do not appeal to them, this effectively denies them such services. For example, adolescents dislike standing in long queues because they are afraid that they might be seen by someone they know or of being asked complex questions and scolded by health care workers[10]. In a study that assessed youth friendly health services in Zimbabwe and Kenya, a list of the characteristics of such services was read out to adolescent participants. At the bottom of their list were exclusive youth only rooms or structures and the need for younger health care workers. Confidentiality, short waiting times, affordability and friendly staff proved to be far more important and appealing traits. This suggests that young people have the same health service needs as adult users as their

**SOUTH** AFRICAN

**National HIV Prevalence, Incidence, Behaviour and Communication Survey**

In South Africa, more than a third of women have given birth to their first child by the age of 19.

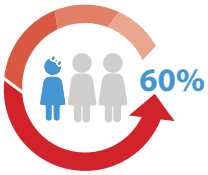


**TEENAGE** PREGNANCIES

While teenage pregnancies account for only 10% of all pregnancies, women below the age of 18 account for 30% of maternal deaths.

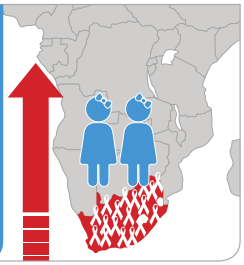
**HIV** INFECTIONS

In 2013, almost 60% of all new HIV infections occurred among adolescent girls and young women between the ages of 15 and 24.



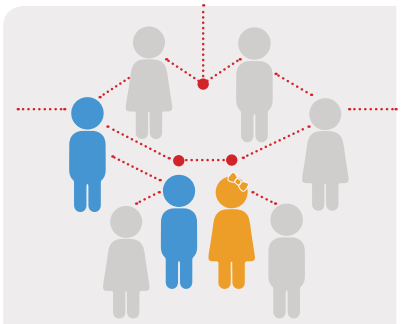

**HIV** INCIDENCE

The HIV-incidence rate among female youth aged 15 to 24 in South Africa is more than four times higher than their male counterparts. In 2012, KZN not only had the highest HIV prevalence in the country but the highest HIV prevalence of 12.0% among young people between the ages of 15 and 24.

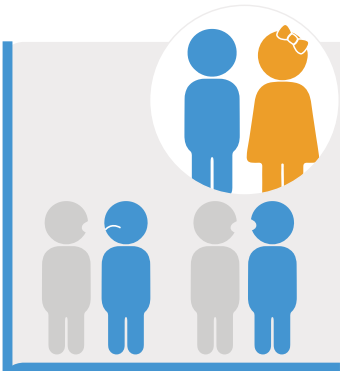


## **KEY DRIVERS** OF THE HIV PANDEMIC IN SA

Similar to the Second National HIV Communication Survey, 2009 (NCS) the survey also found that the key drivers of the HIV pandemic in South Africa include:



**Multiple concurrent partnerships** (which have increased especially among males aged 15 to 24) and intergenerational sex.



**Sexual debut:** A rise in sexual debut before the age of 15, especially among males.

**Decreased condom use.** More than half of the estimated annual 11 million incidents of sexually transmitted infections (STIs) in the country occur among adolescents and youth.

preferences were not necessarily specific to their age group[1]. Similarly, a study that evaluated young people's perceptions of youth friendly services in 15 clinics in Soweto, South Africa, found that the most important characteristics of acceptable health services among young people were positive and friendly staff attitudes and confidentiality. Here too, structural changes, i.e., youth centres were not a priority[11]. Other barriers that prevent adolescents from accessing health services include the unavailability of the services they need, i.e., emergency contraceptives or safe termination of pregnancy. Even when such services are available adolescents are sometimes unable to access them due to restrictive policies, long travelling distance to the health facilities, the high cost of health services and lack of information about how and where to access them[9].

Eliminating these barriers is therefore pivotal in ensuring that young people have access to SRH services so that they are able to live long, healthy, productive lives. International policies and support systems such as the United Nations Convention on the Rights of the Child, 2003; the African Charter on the Rights and Welfare of Children, 1990; the International Conference on Population and Development, 1994 and The Maputo Plan of Action (2006) guide and promote the up scaling of access to SRH services among young people across the world. Informed by these international guidelines South Africa has a Draft Adolescent and Youth Health Policy, 2012 which seeks to strengthen and guide health programmes targeting adolescents and youth[12].

This policy guides the up scaling of SRH services to young people through the AYFS initiative, formerly known as the National Adolescent Friendly Clinic Initiative (NAFCI), and managed by the non-profit organisation, LoveLife from 1999 to 2006[8]. AYFS is not defined as a programme but rather as a quality improvement strategy or system that is integrated into existing health facility structures and processes to deliver a specific service package

to improve the quality of adolescent and youth SRH services at PHC level. The AYFS service package includes the following[13]:

- Information, education and counselling on SRH.
- Information, counselling and appropriate referral for violence/abuse and mental health problems.
- Contraceptive information and counselling, and provision of various contraceptive methods including oral contraceptive pills, emergency contraception, the injectable contraceptive and condoms.
- Pregnancy testing and counselling, and antenatal and postnatal care.
- Pre- and post-TOP counselling and referral.
- Information on STIs and HIV, diagnosis and syndromic management of STIs, including partner notification.
- HIV information, pre- and post-test counselling, and appropriate referral for voluntary testing if services are not available.

AYFS specifically targets those between the ages of 10 and 24. This group is referred to as young people as it encompasses both adolescents and youth. The term adolescent refers to those between the ages of 10 and 19, whilst those aged 15 to 24 are called youth[12]. AYFS uses a set of 10 national standards to guide the delivery of the service package. These are as follows[8]:

- **Standard 1:** Management systems are in place to support the effective provision of health services for young people.
- **Standard 2:** The facility has policies and processes that specifically support the rights of young people.
- **Standard 3:** Appropriate health services are widely available and accessible.
- **Standard 4:** The facility has a physical environment conducive to the provision of AYFS.
- **Standard 5:** The facility has the drugs, supplies and equipment necessary to provide the AYFS service package.
- **Standard 6:** Information, educational sessions and other communication services that promote healthy behaviours among young people are provided.
- **Standard 7:** Systems are in place to train all staff to provide effective and friendly health services to young people.
- **Standard 8:** Young people receive adequate psychosocial and physical assessment.
- **Standard 9:** Young people receive individualised care based on standard case management guidelines/protocols.
- **Standard 10:** The facility has mechanisms in place that ensure continuity of care for young people.

The standards are also used by facilities to assess their own adolescent and youth friendliness and enable them to identify areas for improvement. Every PHC facility is expected to meet all ten standards in order to be certified as an accredited AYFS facility, following an assessment by an external examiner. Once a facility successfully meets the minimum five standards, 1, 3, 6, 9 and 10, they are recognised as implementers of AYFS[8].

While the process of implementing AYFS involves following 11 precise steps, in broader terms, it is first implemented through training health care workers and Peer Educators (known as Ground Breakers) on AYFS. The training is provided by district Master Trainers trained through the national DOH. Each health care facility is expected to have at least one trained AYFS champion. An AYFS Implementers' Manual developed by LoveLife and the DOH assists with this process[8].

Implementation often translates into activities like happy hour, which is a period of time in which young people who visit the clinic are fast tracked and attended to first, a suggestion box for comments from young people or structural improvement of health facilities in the form of a chill room or building dedicated to consultations with young people. These rooms aim to appeal to young people by having colourful walls with posters, couches, a television or computers. The Ground Breaker based at the facility or the AYFS champion host information sessions on SRH issues with young people as they wait for services. Furthermore, whilst AYFS implementation focuses on PHC facilities, it also relies on mass media as well as the buy-in and involvement of community based stakeholders[8]. Each PHC is expected to establish an AYFS team or committee to drive the implementation of AYFS. It should include a young person in the form of a Peer Educator or Ground Breaker, an adolescent or youth client, or any other youth stakeholder[8].
In an effort to address the barrier of negative and

judgemental attitudes from nurses, the DOH designed a Values Clarification package. This includes quality improvement training conducted by the DOH to assist health care workers to distinguish between their personal beliefs and their professional obligations.

## Overview of AYFS Implementation in uThukela District

The implementation of AYFS in UThukela District at facility level started in 2012. There are 34 PHC facilities in this district and only nine are currently providing the AYFS service package in line with the minimum five AYFS standards; 1, 3, 6, 9 and 10. However, none are accredited AYFS providers. All PHC facilities are expected to be accredited AYFS facilities by 2018. In this district the DOH works in partnership with CHIVA SA, PathFinder International, South Africa, LoveLife and the Health Systems Trust to apply AYFS in the PHCs. Of the nine implementing clinics, six were initiated and supported by CHIVA and three by PathFinder International SA[14].

District training on AYFS was held from 11th to 13th November 2014 facilitated by three District Master Trainers who were trained at the provincial training conducted by LoveLife. The health care workers included PHC Managers, PHC Supervisors, Operation Managers, School Health Teams, Community Health Facilitators (CHFs), Community Care Givers (CCGs) Supervisors, LoveLife and Ground Breakers.

Twenty-five clinics were selected by the provincial DOH as priority sites for the roll out of AYFS in 2015.

The nine clinics currently implementing AYFS in the district have undergone significant transformation in the past three years through the efforts and support of CHIVA SA and PathFinder International SA. Not only have both organisations trained health care workers to implement AYFS, but they visited the facilities on a monthly basis in order to monitor implementation. Pathfinder International SA has organised awareness events at its three facilities and provided equipment such as computers and games which are used by young people during clinic visits. They have also funded small scale structural renovations to make the facilities more appealing to young people and paid stipends to the Peer Educators[15].

CHIVA SA mainly focused on capacity building among health care workers through training on various SRH related issues. In August 2015, CHIVA SA facilitated youth afternoon sessions with the support of international volunteers who also offered guidance and clinical support to clinic staff[15].

While much has been achieved at the nine clinics since implementation, the roll out of AYFS in UThukela District is not without challenges. These include[15]:

1. The under-utilisation of the AYFS suggestion box.
2. Drug shortages.
3. Resistance to fast tracking young people during school hours at some facilities.
4. The unavailability of funds from the DOH to pay and retain Peer Educators, thereby relying on volunteers whose tenure is unpredictable and therefore unsustainable.
5. A lack of buy in from some PHC managers and supervisors, meaning that those implementing AYFS are not receiving facility level support.
6. Lack of implementation by DOH staff members who have undergone AYFS training.
7. The migration of health care workers trained in AYFS.
8. The lack of space to establish chill rooms in the facilities.
9. A lack of capacity to continuously monitor AYFS implementation in all PHCs.
10. The use of different approaches by different organisations in the implementation of AYFS.
11. AYFS champions who have many roles and are therefore unable to fulfil all the requirements of AYFS implementation.

## Background: Peer Education in Institutions of Higher Learning (IHLs)

Peer Education is regarded as an important approach to achieve the objectives of AYFS in both health facilities and within community settings. The National Adolescent and Youth Health Policy Draft, 2012 further encourages that it be integrated into IHLs[13].

Worldwide, peer education is recognised as an effective strategy to address HIV/AIDS[15]. In South Africa, the peer education programme was established on IHL campuses across the country following the recognition

that they present an environment where students are vulnerable to peer pressure. Being young, vulnerable and often away from home for the first time students are susceptible to unhealthy behaviours such as drug and alcohol abuse, and unprotected and transactional sex; increasing their vulnerability to HIV infection[16].

Peer Educators are believed to be more persuasive and effective in discouraging students from engaging in risky behaviours then adults because they are able to establish a connection with them[17]. It is also a more cost effective strategy to improve students' health and well-being than using professionals Peer education programmes in IHLs are often specific to the socio-cultural contexts in which they are implemented. This is very important as students are not a single homogeneous group even within each campus. The programme provides role models who exemplify healthy sexual behaviour on campus[15]. A baseline study exploring the perceptions, knowledge, and attitudes of students and campus radio staff at several South African universities found that whilst students already have high levels of knowledge on HIV transmission, they still engage in risky sexual behaviours. It proposed that campus radio stations focus on the factors that act as barriers to safe sex, i.e., intergenerational sex, multiple sexual partners, etc.[17]

A study in Durban found that peer education programmes in IHLs also promote Peer Educators' personal development that improved their career prospects and helped them to acquire information and experiential insights for their own studies. However, the study also noted that there was often poor attendance at some activities organised by Peer Educators as a result of poor timing, e.g., some activities were conducted in the evenings. Furthermore, some students simply didn't know about the activities or did not trust the source of information[2].

The first peer education programme at an IHL in South Africa was the University of Cape Town's Students HIV/AIDS Resistance Programme (SHARP) which was launched in 1994. A formal national programme, the Higher Education and Training HIV/AIDS (HEAIDS) programme was launched in 2000/2001. It falls under the Department of Higher Education and Training and is carried out by Higher Education South Africa (HESA). In collaboration with other stakeholders, HEAIDS trains and equips Peer Educators and their supervisors to conduct various activities around HIV/AIDS prevention, care and support.

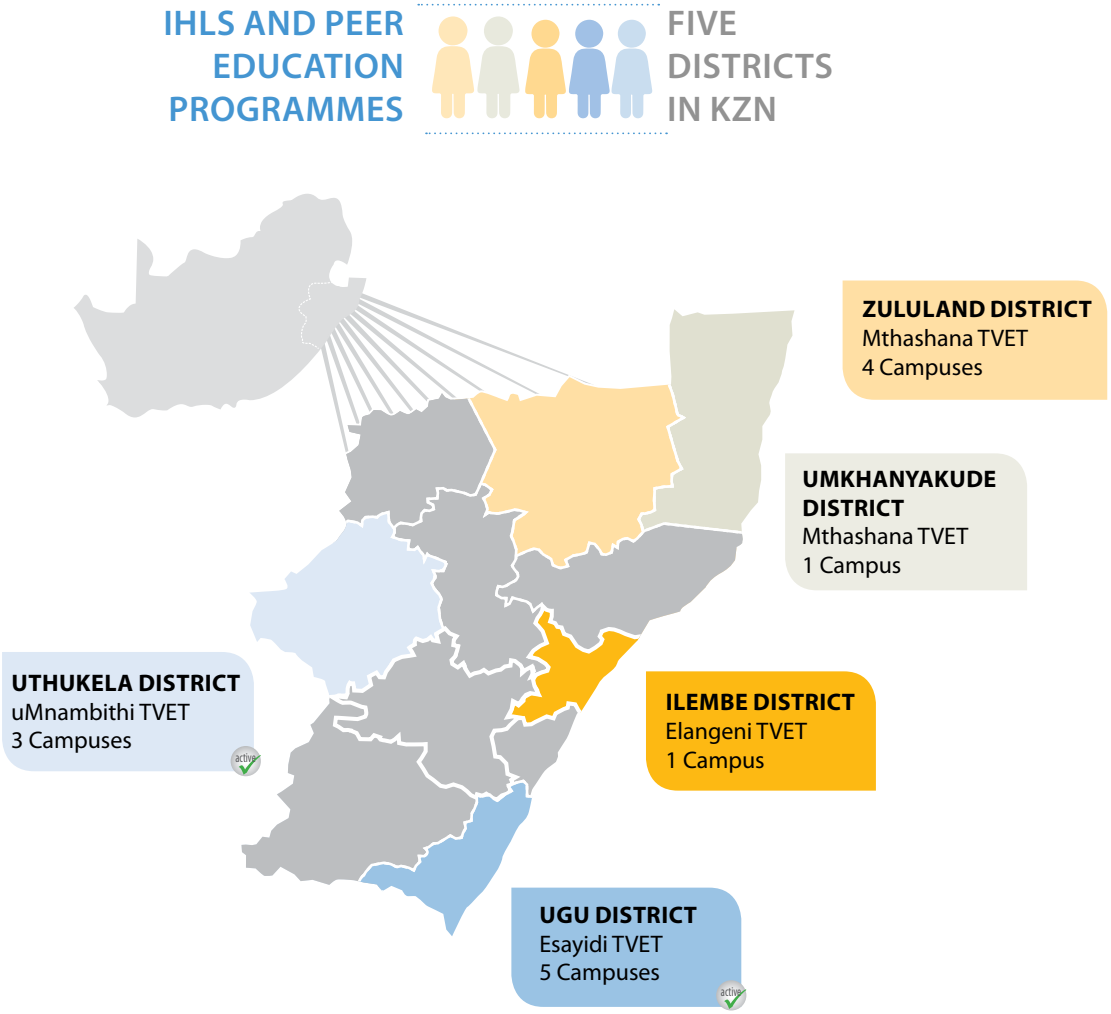
Although the HEAIDS programme initially focused on South African universities, at the South African AIDS Conference in 2015, HEAIDS announced its current focus on Technical Vocational Education and Training institutions (TVETs) as part of the national response to HIV.

There are 50 public TVETs in South Africa with an annual enrolment of about 658 000. A study conducted in 2014 by HEAIDS and the Human Sciences Research Council (HSRC) and presented at the SA AIDS Conference in 2015 investigated the knowledge, attitudes and behaviours (KAB) around HIV/AIDS among 6 654 students and staff at TVETs. It found that many of the participants possessed key information on HIV prevention, treatment and care, even though they could not remember where they had acquired this information. However, they were not well informed on the details of important services. The study also found that a significant number of first year students were either pregnant or had impregnated someone. This suggests the urgent need for contraceptives to be made more readily available at TVETs[20].

## Mapping of IHLs and Peer Education Programmes in the Five Districts: iLembe, uGu, uMkhanyakude, uThukela and Zululand

There are four TVETs in the five KZN districts of UGu, UMkhanyakude, Zululand, ILembe and UThukela. Esayidi TVET College in the UGu district has five campuses. Elangeni TVET College has one campus in Ndwedwe under ILembe district; its other campuses do not fall under the districts targeted for this study. Mthashana TVET College has four campuses in the Zululand district and one in uMkhanyakude district. Finally, uMnambithi TVET College has five campuses but only three have a peer education programme because two are skills centres based in UThukela district where most students do not attend on a daily basis.

Private colleges also operate in this district that do not offer SRH education and therefore do not have operational peer education programmes.




The most common health challenges in these TVETs range from HIV infections, to unwanted pregnancies, STIs, sexual and gender based violence cases and alcohol and drug abuse. In areas where poverty is rife, there is a high prevalence of transactional sexual relationships which increase the likelihood of unplanned or unwanted pregnancies as well as HIV infection.

While some TVETs have a peer education programme, all reported limited activities as they were not trained on peer education and are therefore uncertain of their roles and responsibilities in this programme. Only two TVETs reported an active programme: Elangeni TVET – Indwedwe and Mnambithi TVET campuses. Elangeni TVET reported that they are trained each year on peer education and they have a weekly activity plan to promote SRH and also distribute condoms in classes. On some campuses the peer education programme is supported by different partners who help to promote active SRH programs. In TVETs where students were selected as Peer Educators but not given training, they only assist when events take place. UMnambithi Ladysmith campus highlighted that they have an active programme because they have some of the required resources like an HIV policy and in-house health clinic that operates on bi-weekly basis. This onsite DOH clinic offers HIV testing and counselling and contraceptives as well as other medical services. The common challenges reported by TVETs which affect the provision of peer education activities include the lack of office space, funding and peer education training.

**Table showing mapping of IHLs and peer education programmes in the five districts**

| District | TVET College | Campuses | Enrol-ment | Classification | Type of Peer Education Programme Available | Number of Peer Educa-tors | SRHR & HIV Prevention Activities | Type of Campus Health Facilities/ Services Available |
|---|---|---|---|---|---|---|---|---|
| UGU | Esayidi | Port Shepstone Enyenyezi Gamalakhe Kokstad Umzimkhulu | 8042 | TVET | SRH & HIV Prevention Programme | 50 | They do not have set activities planned. They only assist when there are campus events (First thing first) | None Students use the local clinics/ hospitals |
| | UNISA | Wild Coast Campus | | University | None | None | None | None |
| | Coastal College | Port Shepstone | N/A | TVET | N/A | N/A | N/A | N/A |
| | PC Training and Business College | Port Shepstone | N/A | Private College | N/A | N/A | N/A | N/A |
| | Boston City Campus & Business College | Port Shepstone | N/A | Private College | N/A | N/A | N/A | N/A |
| | Computer College of SA | Port Shepstone | N/A | Private College | N/A | N/A | N/A | N/A |
| | Creston college | Port Shepstone | N/A | Private College | N/A | N/A | N/A | N/A |
| | Damelin College | Port Shepstone | N/A | Private College | N/A | N/A | N/A | N/A |
| ZULULAND | Mthashana | Vryheid | 1 202 | TVET | SRH & HIV Prevention Programme | N/A | None. Only assist when there are campaigns (First thing first) | Mobile Clinics that come once in two months |
| | | Emandleni | 576 | | | | | |
| | | Kwa Gqikazi | 1 013 | | | | | |
| | | Nongoma | 1 114 | | | | | |
| | | Nquthu | 567 | | | | | |
| | PC Training and Business College | Vryheid | N/A | Private College | N/A | N/A | N/A | N/A |
| ILEMBE | Elangeni | Ndwedwe | 844 | TVET | SRH & HIV Prevention Programme | N/A | In partnership with LoveLife, Peer Educators visit classes once a week to do presentations and distribute condoms. | No campus clinic. Students use local clinic/ hospitals |
| | Coastal College | N/A | N/A | TVET | N/A | N/A | N/A | N/A |
| | PC Training and Business College | N/A | N/A | Private College | N/A | N/A | N/A | N/A |
| | Boston City Business College | N/A | N/A | Private College | N/A | N/A | N/A | N/A |
| | Mfolozi | Mandeni | N/A | TVET | N/A | N/A | N/A | N/A |
| | | Sundumbili | N/A | TVET | N/A | N/A | N/A | N/A |
| | Damelin College | Stanger | N/A | Private College | N/A | N/A | N/A | N/A |

| District | TVET College | Campuses | Enrol-ment | Classification | Type of Peer Education Programme Available | Number of Peer Educa-tors | SRHR & HIV Prevention Activities | Type of Campus Health Facilities/ Services Available |
|---|---|---|---|---|---|---|---|---|
| UTHUKELA | Mnambithi | Ladysmith A | 1 826 | TVET | Academic Peer Tutors & SRH & HIV Prevention Programme | 10 | They mostly assist when they are planning for campaigns and they distribute condoms (First thing first). They also refer students to student support offices. | DOH mobile teams visit the three campuses. Twice a month at Ladysmith campus, Twice a month at Ezakheni campus and once a month at Estcourt. |
| | | Ladysmith B | | | | 00 | | |
| | | Ezakheni A. | 2 477 | | | 10 | | |
| | | Ezakheni B. | | | | 00 | | |
| | | Estcourt | 1 253 | | | 9 | | |
| | eThembani Community Centre | Ladysmith | 700 | Community Centre | N/A | N/A | N/A | N/A |
| | Intec College | Ladysmith | N/A | Private College | N/A | N/A | N/A | N/A |
| | Apex Academy | Ladysmith | N/A | Private College | N/A | N/A | N/A | N/A |
| | Michealmas College | Ladysmith | N/A | Private College | N/A | N/A | N/A | N/A |
| UMKHANYAKUDE | Mthashana | Maputa | 209 | TVET | SRH & HIV Prevention Programme | N/A | None. Only assist when there are campaigns (First thing first) | No campus clinic. Students use local clinic/ hospitals |

## Background: Mnambithi TVET College

Mnambithi TVET College was established in 2002 following the merger of Ladysmith Technical College, Ezakheni Technical College, Ezakheni ex-College of Education and Ezakheni Skills Centre. The college currently has campuses in Ladysmith, Ezakheni and Estcourt. A new campus is planned in Bergville. The Ladysmith campuses, together with the central office, are both located in the Ladysmith Central Business Area (CBD). The Ezakheni campuses are located in Ezakheni Township about 25km from Ladysmith CBD. With an enrolment of 5 556 the college is positioned to service those from the rural communities of Estcourt, Bergville, Pomeroy, Msinga, Mooi River and Ladysmith. Therefore the student population mainly consists of those from rural parts of the province. Nonetheless, the college no longer has boarding facilities. Many students rent apartments in nearby towns or pay to board in the homes of locals. Although the college phased out N1-N3, a new curriculum known as National Certificate Vocational (NCV) was introduced in 2007. The Nated course is also offered at the college and students who are part of this programme attend classes from 3pm[18].

# 3. Research Methodology

## Study Design

**Our approach to the study was informed by Participatory Action Research (PAR), an approach to community investigations that highlights the role of participation and action. Change agents work together with communities to bring about change through reflection and collective efficacy[19].**

**Qualitative research uses interviews, focus groups, surveys, etc. to answer questions that elicit information on the human side of a research issue, including behaviours, opinions, beliefs and relationships between people. Hence, it is useful in identifying factors that are not tangible, such as ethnicity, religion, socio-economic position and gender[20].**

Due to the limited period of a month and half in which this study had to be completed, we selected participants who were easily accessible whilst able to contribute reliable data. Purposive sampling was employed to select participants with the assistance of the DOH UThukela District office and Mnambithi TVET College. Three focus groups were held with students from Mnambithi TVET College. They were representative of the college's three campuses and consisted of students who were part of the peer education programme. Two semi-structured interviews were conducted with three Student Liaison Officers (SLOs) who coordinate the Peer Education Programme on the three campuses. Although the interviews and focus groups were initially set to take place in a single venue on the same day, staff and students from the Estcourt campus cancelled on the day due to unforeseen circumstances and were rescheduled to a much later date.

The initial round of investigations with the students and staff from the Ladysmith and Ezakheni campuses were very useful in shaping the study as it was through these discussions that we were able to learn about the type of SRH services offered on these campuses, by whom and how. It also enabled us to establish which community clinics were used by students at the college, particularly those from the two campuses that were represented. This data made it possible for us to narrow down the size of the sample. In an effort to gain insight into the status of AYFS in the clinics and the provision of services to students at Mnambithi TVET College, two semi-structured interviews were initially held with three district staff members, the District Youth Coordinator who was also the coordinator of AYFS implementation in the district and a single interview with two healthcare workers from St Chads and Ezakheni 2 clinics.

The final round of data collection included one focus group discussion with six health care workers at the Ladysmith Hospital PHC centre, three from Ladysmith Hospital and a representative from Waltons Clinic. Watersmeet, Driefontein and Steadville clinics each sent a representative to participate in the focus group. Health care workers from Connor Street Clinic were not represented due to time constraints.

All of the interviews and focus groups were recorded using a voice recorder and note taking. This data was analysed using thematic analysis. Such analysis "focuses on identifiable themes and patterns of living and/or behaviour"[21]. The researcher used transcripts of the data collected during interviews and focus groups to identify similar patterns of experiences. This was followed by a preliminary analysis of the summary of the themes to verify the validity and relevance of the quotes selected. Informed by the PAR approach, the entire research process was continuously guided by DOH officials, Mnambithi TVET College and UNFPA

through on-going communication via emails, telephone conversations and meetings. A meeting was held with all the stakeholders on 10th September 2015 at the DOH UThukela District Office to share the results of the study. The stakeholders provided recommendations on how the challenges identified could be addressed. They also committed themselves to ensuring that the plans that were discussed would materialise.

## Ethical Considerations

This study only engaged with participants of legal age. All participants completed and signed an informed consent form to indicate that they understood what the research was about, what their rights were and that they agreed to participate in the study. The form was read out and explained by the researcher where necessary in the language most appropriate for the participants. Furthermore, pseudonyms are used to protect the identities of the participants.

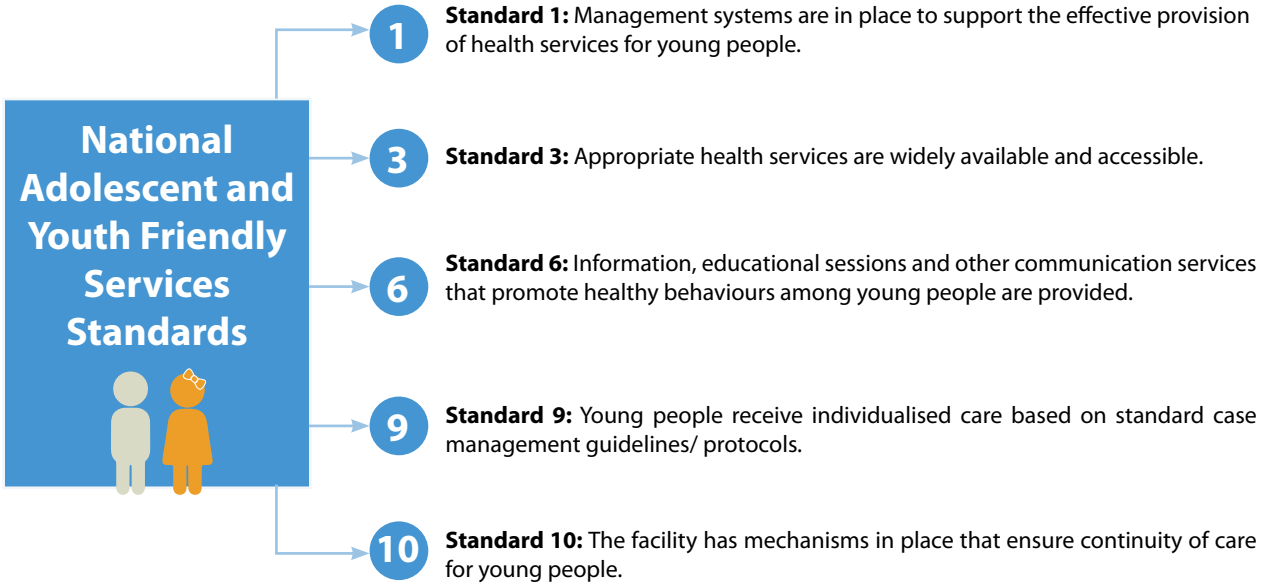
## Limitations to the Study

Due to the fact that the study was expected to be conducted within a short period of about a month and a half (from 14th July - 31st August 2015), time was the main limitation. The challenges dictated by the time factor were as follows:

- *Estcourt students and staff not represented at initial interviews:* This had significant implications for the study. It denied us an opportunity to establish the type of SRH services offered on this campus and whether students used community clinics, and if so, which ones. This made it challenging to identify and timeously secure interviews with health care workers or PHCs relevant to the study.
- *Mnambithi TVET College management not represented at initial interviews:* Although we had originally expected to interview five staff members directly involved with the peer education programme at the college, only two were available. This prevented us from gaining insight into the issues from a management or institutional perspective.
- *Connor Street health care workers not represented:* This meant that we were unable to learn about the use of this clinic by students at Estcourt early on in the study. However, students' perceptions of the services rendered at this clinic, as well as those shared by health care workers from other clinics during the focus group are noted.

# 4. Data Analysis

This section describes some of the key themes that emerged during the focus groups and interviews in relation to the study's objectives. All direct quotations are extracted from the discussions that took place during these interactions and pseudonyms are used for the participants quoted to protect their true identities. The first part is a discussion of the themes guided by the 10 national AYFS standards, focusing on standards, 1, 3, 6, 9 and 10. The second part discusses the themes that emerged in relation to the peer education programme.




## Prevailing Health Challenges in the District and Among Students at the College

The leading health challenges among young people between the ages of 10 and 24 in the district include: a high rate of HIV infection, teenage pregnancy, abortions and substance abuse. Indeed, substance abuse is believed to play a key role in fuelling young people's vulnerability to diseases, especially in more rural areas.

Another challenge is the high number of young girls who come to the clinics for termination of pregnancies. It seems that they are using this as a contraceptive method. This not only suggests that young people are not practicing safe sex, but indicates a lack of awareness of available contraceptive methods.

A respondent said,

*Yes, some of students use C-Top as a contraceptive, not because they have a challenge for this pregnancy, but they will keep on coming for C-Top, especially for those at tertiary levels. Other students come for STIs and Pap Smear.*
(DOH PHC staff, Ladysmith FGD)

The most common health challenges among students at Mnambithi TVET College ranged from minor ailments such as influenza, stomach cramps and sinus problems, to starvation, HIV infection, unplanned pregnancies, rape, transactional sex, substance abuse and STIs. STIs emerged as the leading health challenge and young people are afraid to disclose these at the clinic. Health care workers often only discover the STI upon examination. This is not only an indication that many students are engaging in unsafe sex, but suggests that there are poor levels of sex education among students particularly around safe sex practices and methods.

Although unplanned pregnancies were at the forefront of the health challenges experienced in previous years, it seems that this problem had decreased. There are perceptions that this is linked to students' increased access to contraceptives, especially Implanon via the mobile clinics that visit the college, particularly during HEAIDS campaigns. One of the SLOs said,

*It was bad in the past when we didn't have HEAIDS and clinics, it was huge. But now, students are accessing the clinics and mobile clinics that come for contraceptives. Now we see it getting low, though we cannot have the statistics exactly on how many students are pregnant, for now we haven't seen, by this time we would have seen students pushing their tummies outside. But we have actually seen that it eliminates especially with the new programme of the Implanon, they enjoy it more than the other contraceptives.*
(Thembi Mdlalose, SLO, Ladysmith Interview)

The fact that most of the students come from rural areas also means that they come from impoverished backgrounds. Most are subjected to hunger which is detrimental to their health, especially those on chronic medication. An SLO said that they are often compelled to give students money from their own pockets so they are able to take their medication.

In the face of poverty and hunger, female students are said to engage in transactional sex in order to purchase food and clothes and pay for accommodation and tuition, particularly because it takes some time for bursaries to be paid out.

Because they come from areas far from the college, students seek accommodation nearby. Ezakheni campus is currently the only campus with student residences which has led to students from other campuses seeking accommodation in the communities surrounding their campuses including renting rooms from locals. This has exposed female students to being victims of rape or in some cases transactional sex.

*It is a challenge as well…because they have to look for places to stay, we have rape cases because they have to go to a certain area and that malume (uncle) wants to rape them…the landlord, the ladies have to sleep with them to get the place to stay. So it is a very big challenge and very depressing even to us to work with students. Especially for women, they take advantage of them.*
(Thembi Mdlalose, SLO, Ladysmith Interview)

Substance abuse, especially of alcohol, and dagga surfaced as a significant challenge at the college. Although cases of students coming to campus drunk from high levels of alcohol intake are very rare, students, especially male students are said to partake in this activity off campus. However, it seems that male students engage in other forms of substance abuse on campus. A known drug dealer is selling drugs to the students on the Ladysmith campus.

The above findings suggest that there is a significant lack of awareness of SRH issues among students at the college and young people in general. This was expressed by one of the Peer Educators when she said,

*We need information about condoms…*
(Peer Educator, Ladysmith FGD)

Coupled with widespread poverty among students, this seems to be the driving force behind the health challenges experienced by students at the college and young people in general.

## The Type of Services Students or People Seek at the Clinics

In light of the health challenges discussed above, it is clear that young people visit both the community and campus mobile clinics to some extent to access STI treatment, termination of pregnancy, minor ailments (especially influenza and stomach cramps) testing for TB, contraceptives (especially Implanon), HCT, pregnancy tests, treatment of injuries, VMMC and pap smears.

Young people between the ages of 16 and 24 are the age group that mostly visits PHC facilities within the district to access these services. Patients between the ages of 10 of 15 are very rare and often only come to the clinics with their mothers for minor ailments such as influenza. Furthermore, the study established that the PHC facilities in the district are generally utilised by more females than males. This may be the result of socio-cultural norms that portray men as strong, dominant and powerful. Similarly, female students tend to use the clinics more than male students.

Although VMMC and STI treatment were the two most common services sought by males, it is mainly young boys between the ages of 12-15 that visit the clinics for VMMC. Older men are reluctant to access this service as they need to test for HIV first. Men, including male students at Mnambithi TVET College are scared of knowing their status and this prevents them from undergoing VMMC.

One of the strategies used to encourage men to take up SRH services is contact cards that are given to their female partners during their visit to the clinic for STI treatment. For example one of the health care workers said,

> *Mostly females, they drag the males to come to the clinic because of the contact card.*
> (DOH PHC Staff, Ladysmith FGD)

Overall the students' visits to the clinics are normally not preventative; rather they are seeking a cure for existing problems that could have been prevented had they exercised more vigilance.

## Student Awareness of the Mobile Health Service Provided on their Campus

Students displayed general awareness of the health services offered on their campus including the times and days of the week the clinic was open. This was primarily due to the fact that the mobile van used by health officials usually parks in a visible spot. A student from Estcourt campus said,

> *The mobile clinic has only visited this campus once and that was last week Wednesday morning. There were two vans parked in front of the campus gate. The students went to secure the services at the gate.*
> (Peer Educator, Estcourt)

The services are sometimes advertised on notice boards around the campuses and the SLOs do class visits to inform students about the health services on offer, especially when HEAIDS will be running a campaign. A student said,

> *We see notices on the notice board and there are campus ambassadors who encourage students to use the campus clinics.*
> (Student, Ladysmith FGD)

However, despite relatively high levels of awareness of the services on offer, it was found that there were students whose reality was different. These are students who by virtue of doing the Nated Course only attend their lectures from three in the afternoon. By this time the health services are no longer available. A student from the Ladysmith campus said,

> *I didn't even know there is a clinic on campus. I'm doing the second year here at Ladysmith B campus but I've never seen a clinic before. Students who attend late are referred to as R191–Nated, they don't have access to clinics.*
> (Student, Ladysmith FGD)

The exclusion of Nated students from the class announcements, awareness campaigns, and mobile


health services offered on campus, denies this group of students access to services.

## Accessibility of Clinics: Location, Time, Staff, Resources and Availability of Drugs

The standard hours of operation for community clinics in the area are 7:30am to 4pm, seven days a week, even on public holidays. Ezakheni 2 Clinic is normally open for 24 hours, but currently operates from 7:00am to 7pm. However, students reported that the clinic usually closes at 5:30pm. St Chads is open 24 hours a day. Although Ezakheni 2 and St Chads Clinics both had a happy hour to fast track students they were structured differently. At Ezakheni Clinic it is from 2pm-5pm except on weekends and St Chads used to have it every Wednesday but students were not utilising it so they stopped.

> ***At St Chads there was a happy hour, it was once a week on a Wednesday. The youth stopped coming and then the happy hour stopped.***
> (DOH PHC Staff, Ladysmith Interview)

It was not clear why this was the case as students from Ezakheni campus stated that they preferred St Chads Clinic to Ezakheni 2 because it offered better service.

However unlike Ezakheni 2 clinic that is located within walking distance of the campus, St Chads is about 4.5 kilometres from the campus and it costs about R7 to travel there by taxi. This could explain why students are not using this clinic in large numbers even though they prefer it. St Chads Clinic is also located within a more rural setting with gravel roads that make access difficult when it is raining. It also emerged that students from the Ladysmith and Estcourt campuses do not like to attend the clinics located within close proximity of their campuses (Waltons Clinic and Connors Street Clinic), because of poor quality service but go to them anyway because they are within walking distance.

All mobile teams are expected to work from 7:30am to 4pm, Monday to Friday. The health services provided at Mnambithi TVET College's three campuses are provided by roving HCT teams. Ladysmith campus has a class room that is used as a clinic, providing health services to the student community every second Wednesday of the month from around 8:00am to 2pm or 3pm and sometimes earlier. With just a bed and two tables, this clinic is serviced by a team of two. Closing times are normally dictated by the availability of medication. The DOH staff servicing this clinic complained that they usually run out of medication very quickly because

they are unable to carry enough to the college. They explained that they cannot order large volumes of medication from the pharmacy because they do not have enough space in which to store it despite demand. They currently use their filing cabinets to store medication. One of the nurses explained,

> *We pack medicine, and then come back to offload it again. Even that, we have files, and there's a small cupboard there. So there is no space to keep medication. Looking at the FET, there are many students. You cannot order a lot of treatment for the FET without a lot of storage. There are too many.*
> (DOH PHC staff, Ladysmith FGD)

They are also restricted in that they use a small car with very little storage space.

Although students from Estcourt stated that Connor Street usually has a large supply of medication, overall the shortage of drugs seems to be common at the community clinics used by students. This needs to be addressed as it clearly has a negative impact on the accessibility of SRH services.

While students who only arrive on campus at 3pm are unable to access these services, others reported that they use the campus clinic during their lunch break as they are generally unable to access it during classes. As a result, there are long queues and they sometimes return to class without having been attended to. Students are frequently turned away and it was reported that nurses leave early even when students are still waiting. Unlike the Ladysmith campus, the Ezakheni and Estcourt campuses do not have a dedicated room but rely on mobile vehicles that visit the campuses on set days. At Ezakheni the mobile team visits the campus twice a month, whilst at Estcourt it only comes once a month. Here, too, students reported that operating hours often clash with classes.

Another key finding was that both health care workers and students felt that the two to three staff members that service each campus was not sufficient and therefore contributed to the long queues. The use of a single room by clinic staff at the Ladysmith campus is also a significant barrier as only two students are attended to at a time. More staff and in this instance more consultation rooms would allow a far greater number of students to be serviced.

Despite the barriers discussed above, is it clear that short travel distances, short waiting times and access to treatment are very important to young people when they access SRH services. The lack of such factors becomes a serious barrier.

## Promoting Continuity of Care

For the most part, the health care workers on the campuses play an active role in ensuring that students' health needs are met even when those go beyond the bounds of what they are able to offer due to limited resources. They achieve this by referring students to nearby health facilities. Students are referred to nearby hospitals for CD4 counts, TB, dentistry services and VMMC. For example during one of the group discussions, a student said,

> *They offer circumcision but they sign you up for it, they don't perform it. They give you a referral to the provincial hospital. We meet at the clinic then we are transported to the hospital.*
> (Student, Ladysmith FGD)

What was also very evident was the role of the SLOs in ensuring that students' health needs are met on an on-going basis during their time at the college. Not only do they promote the health services available on campus, they also counsel students and refer them and sometimes even transport them to the relevant health facilities when necessary.
At the clinics, students are often encouraged to take up other SRH services, i.e., VMMC and HCT. For example, a student from Estcourt campus reported that,

> *…three weeks back I was sick with a tummy ache, I went to that clinic and they wanted me to test for HIV.*
> (Peer Educator, Estcourt FGD)

Students are sometimes given incentives such as USBs to encourage them to test for HIV. This strategy is reportedly very effective as they usually come in large numbers on the day to access the services. It was also found that a considerable number of students at the college are on chronic medication especially for

diabetes, asthma and HIV. However some do not take their medication consistently and others default for fear of being discriminated against by other students.

The fact that there are still incidents where students feel victimised because of their suspected HIV positive status suggests that there is a lack of awareness about HIV/AIDS among students. Health care workers further expressed that it is challenging to manage adherence to medication among the student population because they are not permanent residents.

Despite efforts to care for students' well-being, there appears to be a lack of synergy between the health care workers and student support services, even though they ultimately share the same goal. The health care workers simply render their services and leave; there seems to be no ongoing interaction between these two structures especially at ground level about what the prevailing challenges are and how service delivery can be improved so that all the students' SRH needs are met. Furthermore, there was no evidence either from the SLOs or the health care workers to show that there were any clear processes in place to follow up on students referred to other health facilities. This would assist the college to determine how many students were referred, for what services and if there was eventual uptake of that service. This data could be useful in understanding the impact of the interventions. The student support office also complained that they are unable to access statistics gathered through the health services rendered on the campuses, depriving them of an understanding of the health profile of students which could also be useful in the design and implementation of suitable interventions. A nurse illustrated the use of statistics,

> *We look at our stats and we identify teenage pregnancy then we identify the high rate areas. The clinic then arranges for nurses or school teams to have campaigns to increase awareness and have health education and leave pamphlets. We identify the areas with high rates first. We go there and conduct community dialogues; there are also war rooms where we meet with CCGs and other stakeholders.*
> (DOH PHC Staff, Ladysmith Interview)

A lack of such data hinders the college's ability to comprehensively cater for students' health needs.

> *And the problem that we had with the nurses is that sometimes they don't even leave the statistics with us so that we can be able to know the information, they just take everything when they go, and we are just like… Statistics will assist us in making more students being aware of their statuses as well as how to take care of themselves. Because if we do not know anything about them, we assume that everything is fine. And that assumption as well is a problem because we are not giving enough to students. They are not accessing what they are supposed to get…as much as it's academic, socially as well they need to get something from us.*
> (Thembi Mdlalose, SLO, Ladysmith Interview)

## The Quality and Management Systems in Place

One of the main concerns that arose during this assessment was the inconsistency in the times when mobile SRH services were offered on campus. For example,

> *They come at any time, they have no specific time. I remember one of the Doctors actually reprimanded them this other time, that they are supposed to be doing this but they are not doing it. So they come as they please. They bring one bus in a while and then they leave.*
> (Thembi Mdlalose, SLO, Interview)

As discussed above, this is caused by the rapid depletion of medication. However, we also learned that in some cases, nurses leave early without the knowledge of their supervisors. This is not permitted and the mobile staff servicing the three campuses needs to be closely supervised to ensure optimum service delivery. This would reduce the number of students who are turned away and also benefit those who are part of the Nated programme.

Although some clinics such as Ezakheni Clinic have suggestion boxes, this was not evident in the mobile clinics. As such, there are no activities or plans for quality improvement from both the social mobilisation and service delivery constituencies. Some of the community

clinics, even those implementing AYFS, i.e., Ezakheni also reported that they currently do not have an AYFS committee which means that young people are usually not involved in the design of interventions.

## Privacy and Confidentiality Promoting Individualised Care?

Similar to the discussion in the literature review, privacy and confidentiality were some of the most important characteristics for students during SRH service delivery. As noted above, a lack of privacy and confidentiality was a key barrier to young people accessing SRH services. Inability to access a service in a manner where one feels safe and cared for effectively denies one access to that service. It was noted that while most of the clinics used by the students practice some degree of privacy and confidentiality, Waltons clinic did not. An incident was reported where a lecturer from the college disclosed a student's HIV positive status on campus after having obtained the information from a Waltons Clinic staff member. Furthermore, it was reported that nurses at this clinic often shout when addressing young people, even about their HIV status, depriving them of their right to privacy and individualised care. A student who attended this clinic relayed her experience,

> *I want to add to the point that was made by an earlier respondent about the service at Waltons Clinic. There was a time where I need to use the clinic and I was waiting to be served. I was waiting behind a student who was called by a nurse who spoke loudly to the student and said she's positive in front of other patients.*
> (Peer Educator, Ladysmith, FGD)

The room used as a clinic at the Ladysmith campus was also criticised by students for depriving them of any privacy as two students consult at the same time with the two health workers who work there.

To promote more individualised care, students proposed more consultation rooms. They also suggested that nurses be trained on how to provide individualised care. The mobile bus was regarded as the most preferable service as it had two separate rooms in which students could be attended to privately.

## Student Perceptions of Community Clinics vs. On-campus SRH Services

The students preferred to use the on-campus clinics rather than the community clinics because they were more convenient. With the exception of St Chads clinic, they felt that services at the community clinic were slow and inefficient as they would sometimes be sent home after waiting an entire day in a queue and told to come back the next day. The perception among students is that this is caused by a shortage of staff, staff laziness and a lack of empathy (particularly towards young people). The issue of race was also raised by students who believed that in clinics with Indian nurses, Indian patients are fast tracked solely because of their race.

Again, students seem to have very strong negative views about Ezakheni Clinic and Waltons Clinic and even suggested that the latter should be closed due to its failure to offer friendly, efficient services.

Hence, both students and college staff proposed that in the long term, it would be more ideal if each campus had its own fully-fledged clinic. In the meantime, they expressed the need for the mobile services to be offered more frequently on campus, at least once a week.

## Students' Perceptions of Staff Attitudes

Students believe that health care workers, especially those from community clinics are judgemental and disrespectful. They sometimes fail to follow proper clinic procedures. For example,

> *When you go to the clinic to test, they ask you if you are there to check your CD4 count. The nurses assume that you are HIV positive. I went to the clinic and the male nurse just assumed that I was coming to check my CD4 count. I received no counselling.*
> (Peer Educator, Ladysmith FGD)

It was common for health care workers to assume and impose services on students. The mobile health care workers are also believed to be very judgemental; this might be caused by discomfort with discussing issues pertaining to sex with young people due to their personal beliefs. Values Clarification training is clearly

required so that they can gain much needed skills on how to communicate with young people without imposing their personal beliefs.

The health care workers on the Ladysmith campus were commended for their friendly services. For instance,

> *The service at Ladysmith Campus B is very friendly. They listen to you and they are patient. They offer good counselling for HIV testing. If they cannot assist you at the time they are able to refer you to a hospital.*
> (Peer Educator, Ladysmith FGD)

It is not clear if this difference in approach is due to the fact that these two nurses are fairly young. The question of the age of the health care worker was fiercely contested. Some students felt that older nurses were unable to understand them and were therefore rude. They felt that younger nurses are better able to relate to them and are therefore more approachable and friendly. On the other hand, some students believed the opposite. They preferred older nurses, stating that they were more compassionate (and would talk to you like a parent), whilst younger nurses were regarded as impatient and rude.

> *…the young nurses don't have time, it's better to get help from older nurses because they treat you like their child and offer you advice. They are rude.*
> (Student, Ladysmith FGD)

This suggests that the age of the health care worker is not really a factor; what is important is their approach. While insight into how students perceive the attitudes of health care workers is useful, the delivery of SRH services at the college cannot be successfully improved without the full support of the student support office. Indeed, based on the discussions above, it is reliant upon their active participation. They are the ones who advertise the services and encourage students to visit the clinics. If they do not have good rapport with students, it will be difficult for the student community to take up such services.

Although this aspect was not directly investigated, during discussions with students and SLOs, it was established that students find the SLOs approachable and friendly. They are compassionate, honest, helpful (even going the extra mile such as transporting students to hospital when ill), and a source of motivation. However this role is currently under-utilised, especially where SRH service delivery on the campuses is concerned. Through partnerships with the DOH, HEAIDS and other stakeholders, SLOs on each campus have the potential to carry out more structured, effective and sustainable health promotion interventions.

## Improving Youth Friendliness during SRH Service Delivery

Based on the discussions above, it is clear that much remains to be done to make SRH service delivery more youth friendly. These range from improving staff attitudes through training, especially in the community clinics used by students, to improving the reporting process, and putting systems in place to ensure that young people are represented in programme design. Furthermore, healthcare workers highlighted the fact that AYFS implementation is usually not included in the PHC budget. They therefore often rely on non-profit organisations for equipment, i.e., computers, TVs, DVD players etc. to make the clinics more attractive for young people.

> *...take the youth on a camp. But if you suggest that people will query the funding and budgets for such activities.*
> (DOH PHC Staff, Ladysmith Interview)

Ezakheni 2 Clinic is one of the nine AYFS implementing PHCs in the district through the support of CHIVA SA. As such,

> *We introduced the water cooler, consulting room 4 which is advertised at the gate where there is a sign…We also have a suggestion box for AYFS and for the community.*
> (DOH PHC Staff, Ladysmith Interview)

However, it was noted that despite efforts on the part of clinics like Ezakheni 2 Clinic (which scored 80% during recent AYFS assessments) to implement AYFS, students still found it relatively unfriendly. A student stated that,

*The service is very poor at Zakheni clinic, closes 17:30 instead 19:00. They give you the same medicine every time you visit Zakheni clinic.*
(Student, Ladysmith FGD)

Indeed, as noted earlier, students from Ezakheni campus explained that they preferred to go to St Chads Clinic (another AYFS implementing clinic) even though this meant that they had to pay a R7 taxi fare. Again, this is an indication that factors that students consider to be youth friendly go far beyond the structural changes that are currently present at this particular clinic. This is similar to the findings of a study in Zimbabwe and Kenya which found that youth valued confidentiality, staff friendliness and short waiting times over structural changes such as youth only rooms. Factors such as early closure and poor quality service at this clinic are driving students away and should thus be addressed.

While AYFS champions are tasked with orientating other staff members on AYFS so that the entire facility is involved in implementation, it seems that having one dedicated individual is a challenge in the district. In some cases trained AYFS champions change jobs and move to work in different areas leaving that clinic without a trained champion. During the discussions with nurses they also mentioned that for implementing clinics, this individual is sometimes advertised (through posters pinned to the front gate) to young people as the youth friendly nurse that they can consult. This could create the impression that this particular nurse is the only one that is welcoming towards young people, creating problems if that person leaves or is not present on a particular day. Internal systems for quality improvement are required and support should be mobilised within the facility for such change to take place. This is why it is crucial to have an AYFS committee that is dedicated to branding the entire clinic as an AYFS clinic. In this way, AYFS implementation can be sustained beyond the champions. This collaborative approach was evident at St Chads.

*At St Chads, when the youth come for the service they are seen by everyone but during the happy hour they are seen by nurses who are almost the same age as the youth. They usually come and sit in a group, and share everything but when they are coming for the service they are seen by everyone. Most of the nurses are orientated for the YFS service. There are three nurses who assist the Sister champion. They also have one to ones. In groups they get education from nurses and soul buddies and peer educators. When they come to the clinic one of the peer educators will teach on HIV or something because they are orientated in terms of the LO subject and the professional nurses will wrap up and fine tune . . .*
(DOH PHC, Ladysmith Interview)

However, the fact that young people no longer visit the clinic during happy hour where younger nurses are strategically placed to consult with them needs to be investigated. Another challenge that was raised is that champions are staff nurses who also take on other roles at the clinic, making it difficult for them to lead AYFS implementation effectively. It was proposed that there should be individuals who are solely focused on the advancement of the AYFS programme.

Furthermore, the college currently has a 30 minute break. It is during this short period that students are expected to use the clinic. This is clearly not sufficient to cater for all students and explains why the queues are often so long that many are forced to return to class having not been attended to. Students that visit the clinic during class are usually marked absent. Students proposed that they be allowed to visit the clinic during class time using a permission slip signed by a lecturer and produced at the clinic. The health care worker can stamp it so that the student is able to prove that he or she was at the clinic.

## Establishment of the Peer Education Programme at Mnambithi TVET College

Although the Peer Education programme was initiated at different times across the three Mnambithi TVET College campuses, its initial inception was in 2013 following the launch of the HEAIDS programme. However, implementation formally began in 2014 to address the health challenges of HIV, unplanned pregnancy, abortions and STIs among the student community.

The Peer Education programme at the college is managed through Student Support Services and coordinated by an SLO on each campus. Although their primary role involves providing academic support to students, it extends to looking after students' health and well-being. These SLOs recruited students to become Peer Educators using various strategies and criteria. At Ladysmith and Ezakheni campuses the Peer Educators are also Peer Tutors meaning that they hold classes where they assist students with subjects like Mathematics. The initial criterion for selection was therefore academic. The SLOs from these campuses conducted class visits, roped in the support of the SRC to spread the word and put up posters on the notice boards announcing that they were looking for Peer Educators who were scoring between 70% and 100% in their subjects. These had to be students in their third or fourth level of study, who were good at Maths and English.

Estcourt campus adopted a different approach as its Peer Educators are not Peer Tutors. The SLO also conducted class visits to recruit students who were interested in becoming HIV/AIDS ambassadors. The SRC and lecturers assisted with advertising and recruitment. A Peer Educator on the Estcourt campus said,

> *Their recruitment was very organised, they visited the classes. They even offered that we should be elected but it was easier for them because we volunteered.*
> (Peer Educator, Estcourt FGD)

In both instances, the selection process was based on students' willingness to participate in the programme and take on a leadership role. Most were already active in other extra-curricular activities on campus. There are currently 29 Peer Educators at Mnambithi TVET College, 10 at Ladysmith campus, 10 at Ezakheni campus and nine at Estcourt campus.

## Role of Peer Educators and SLOs

As Peer Tutors, the students teach and mentor other students on Saturdays. However in their role as health promoters they conduct class and residential visits where they publicise upcoming campaigns, put up posters, distribute condoms, T-shirts, and pamphlets, and recruit students for HCT and VMMC. They also provide lay-counselling to students and refer them to the SLOs for further assistance where necessary, and those at Ezakheni campus do door-to-door visits at student residences where they have one-on-one dialogues with students, and distribute pamphlets and condoms. On the Estcourt campus, general workers also assist with distributing condoms in the campus toilets. Female condoms are reportedly very popular, especially at this campus, more than male condoms. Even though the student community generally prefers flavoured condoms, there is a high uptake of CHOICE condoms. Describing the variety of activities they participate in, a Peer Educator said,

> *We also encourage males to go for MMC. We give them the information we have. We also interact with students who want to get tested and through this we get a rate of how students use the services. We give t-shirts and USBs. We use forms to count. We pass on the information to health workers. We mobilise students to the health workers to get tested or MMC. We also place condoms in the toilets. We only hand condoms out to lecturers. We give them a pack each of condoms.*

The SLOs therefore supervise the activities undertaken as part of the programme. They inform the Peer Educators about activities that need to be carried out.

## Training for Peer Education Practice

Peer Educators on all the campuses, as well as the SLOs have not received training on how to run an effective health promotion peer education programme. This could explain the lack of structure and uncertainty in programme design. At the time of this study, no action plan with set targets had been adopted. As noted previously, activities are usually undertaken as part of campaigns initiated by HEAIDS or other external stakeholders. Nevertheless, we were informed that each time a HEAIDS campaign is going to take place, HEAIDS staff workshop the Peer Educators on HIV/AIDS related information, i.e., condom demonstration and information and activities. However, students noted that this doesn't always happen timeously and sometimes takes place on the morning of the event, denying them an opportunity to adequately mobilise students to attend the events and access services. Nevertheless, Peer Educators participated in two recent training workshops. The first was a four day training conducted

by the Foundation for Professional Development (FPD) on the Ladysmith campus. Attended by both the Peer Educators and SLOs, it equipped them with basic HIV/AIDS information. Both groups stated that it enhanced their performance as they are now able to non-judgementally and confidently advise students on HIV related matters. The training also enabled the Peer Educators to make more informed choices in their own lives. For example,

> *The training has taught us a lot. We've also learnt more about HIV, we can help someone without criticising them. We have more knowledge about HIV. We were trained to offer assistance without judging the students.*
> (Peer Educator, Ladysmith FGD)

The second was two-day training conducted by DramAidE on the Ezakheni campus, again attended by both SLOs and Peer Educators. This training provided them with tools on how to design and implement SRH campaigns on their campuses. At the end of the training each campus was expected to establish an action plan. However, it was found that not all the Peer Educators attended both these trainings. Miscommunication between the SLOs and the organisers about the number of Peer Educators that could participate also resulted in only one Peer Educator from the Estcourt campus attending both trainings. It is not clear how this imbalance will be addressed. Prior to participating in the trainings the SLOs relied on their professional qualifications, i.e., psychology or previous exposure to HIV prevention programmes to engage students on HIV related matters. They did not have sufficient information or the skills to run an effective health promotion peer education programme; this explains the lack of structure. For instance,

> *For now it's just the class visits and the referrals. It's just a new thing to us as well. We still want to make sure…And we need more of how we are actually supposed to supervise them and inform them. We still need more.*
> (Thembi Mdlalose,SLO, Ladysmith Interview)

The two training workshops aimed to address this gap.

## Improving the Peer Education Programme at Mnambithi TVET College

The Peer Education programme at Mnambithi TVET College is still fairly new and therefore faces many challenges. The first is that it currently has no structure. There are no clearly defined goals and objectives. Not only are the roles of the Peer Educators and SLOs unclear, there is also no clarity on how the programme will be integrated into the activities of the college whose primary goal is teaching and learning. How, for instance, will the programme be incorporated into the structures of the college so that it becomes part of the curricular activities? Unless this challenge is properly addressed, it will be very difficult to sustain the programme at the college. The lack of organisation also translates into unclear channels of communication between the SLOs and Peer Educators.

Obtaining management's support would therefore be a crucial step in making the Peer Education programme at Mnambithi TVET College sustainable as its activities could then be included into the college calendar.

SLOs and Peer Educators should work together as a cohesive unit to define the programme's goals and objectives and establish an action plan with roles and responsibilities as well as timelines.

The second challenge is that the programme currently has no reporting system to track all its activities. Currently the Peer Educators report verbally to the SLOs on their activities. HEAIDS compiles its own reports on activities on each campus following a HEAIDS event. These reports are usually not shared with the college SLOs working with the Peer Educators on the ground. The nurses working in the campus clinics also do not share their statistics with the college, making it difficult for the college to measure the impact of this intervention (campus clinics). Thus, appropriate data collection tools with reporting templates need to be designed so that each campus is able to monitor the impact of activities. This would help inform the design of interventions conducted as part of the Peer Education programme. Such monitoring is important to ensure that interventions respond to the needs of the student

community. It is particularly important in this instance because the student community at the college is very fluid and constantly changing. Furthermore, it would boost the morale of all those working in the programme as they will be able to ascertain if they are meeting their targets and making an impact or not.

The third challenge is that many Peer Educators were not part of the recent training due to either miscommunication or logistical shortcomings. With only one Peer Educator having attended both trainings, Estcourt campus is currently the most disadvantaged. There is therefore an imbalance in terms of skills and knowledge among the Peer Educators across the campuses. Thus, the gap identified before the two workshops of the lack of training on HIV or SRH content as well as on peer education among the Peer Educators persists. While some of the SLOs said that they plan to request that the training be repeated for those Peer Educators who missed out, it is not clear if or when this will happen. It is also not certain how this problem will be mitigated in the meantime as one of the SLOs pointed out that she doesn't feel that she is adequately equipped to train those Peer Educators from her campus who missed out on the training. Given the fact that at the end of the second training each campus was expected to draw up an action plan detailing how they were going to implement the programme, it is unclear how those who were not part of the training will be included in formulating the plan and its implementation. Plans should thus be made to ensure that all Peer Educators are trained and adequately equipped. The most cost-effective, feasible way to address this gap would involve those who did attend training the remaining few. However, this might not be possible as even one of the SLOs stated that she did not feel confident enough to do so. Nonetheless, as the study was completed on the very first day of the second training, the confidence levels of this and other SLOs might have increased since then.

The fourth gap that was identified is that the Peer Educators are not easily identifiable on the campuses by students, which means that they as well as their role are not well known. At times, this lack of recognition or understanding of their role causes students to not take them seriously and undermine them.

Peer Educators proposed that having an identifiable room on each campus where they could meet and where students would be able to find them would make them more accessible. Other measures that were suggested were name tags and T-shirts.

> ***…Students must know the importance of a peer tutor so that we gain the respect from the students. It will help if we are more noticeable. We could use name tags and get more t-shirts because we only have one at the moment. Either or.***
> (Peer Educator, Ladysmith FGD)

The fifth shortcoming of the programme is the lack of IEC materials for Peer Educators to distribute to the student community. They also complained that the IEC materials arrive too close to the day of the event, hampering effective mobilisation.

> ***…Resources on our campus arrive late. Resources like pamphlets we use for campaigns. If we had resources arrive on time we would be able to campaign for five days on a campus…***
> (Peer Educator, Estcourt FGD)

Ensuring that Peer Educators have an adequate supply of IEC materials, not just for HEAIDS events but for regular distribution or display as part of their ongoing activities is key as it may have a direct impact on the results obtained. For example,

> ***On our campus the pregnancy rates have dropped. It may be because they have more information which they have received from their tutors. If there are campaigns we distribute condoms and provide them with information.***
> (Peer Educator, Ladysmith FGD)

While Peer Educators might not be able to guarantee that students read these IEC materials, it remains their responsibility to ensure that students have easy access to SRH information. The action plan should include a clear distribution plan for these materials as well the type of material and quantities required and timeframes for delivery.

## Strategic Communication Approaches to Public Health Implemented?

Each campus has an SLO who acts as a link between the college and various service providers. Currently the office works with HEAIDS to promote HCT through the First things First campaign. The Estcourt campus also runs a liquor awareness campaign with the KZN Liquor Authority to discourage alcohol abuse among students. Instead of relying on one approach, effective strategic public health communication uses a variety of approaches to get the message across[22].

Two approaches are currently implemented on the three campuses to reach students with SRH information. However these activities are often reactive, meaning that they are only done if there is an upcoming HEAIDS activation campaign, or to announce health services that will be rendered. There is no evidence of these activities being conducted as part of a formally structured internal programme. The first is an interpersonal communication approach, implemented through door-to-door visits at Ezakheni campus residences, class presentations or other student gatherings, mainly by SLO officers, and Peer Educators where they inform students about upcoming events or services. Peer Educators sometimes distribute condoms and pamphlets during activations and have one-on-one dialogues with students about SRH issues, i.e., HCT, dual protection etc. This has been the most effective strategy thus far as students are unable to avoid the information delivered, especially during class presentations. They all hear it, and are able to instantly ask questions of the source.

The second is a mass media approach through the use of posters on notice boards around the campuses. This was found to be the least effective approach as students reported that they rarely read them and that they are often removed. They also explained that the posters are often black and white, dull and small. A student suggested that,

> *…So long as they are attractive and we will read them. Posters should also be big and bright, that will attract students…*
> (Peer Educator, Ladysmith FGD)

Students also proposed the use of social media to convey SRH messages. The study found that Whatsapp and Facebook are widely used by students, mainly via their mobile phones. Although some students expressed concerns about data costs, the consensus was that Facebook would be a more suitable option then Whatsapp. The college currently has a Facebook page which is very popular among students. Some Peer Educators are already using this platform to disseminate information.

> *Facebook is also a good tool to reach students. Students interact on the Mnambithi FET College Facebook page. That is how we release information to the students.*
> (Peer Educator, Ladysmith)

This platform can be used to supplement the other approaches currently used. As an interactive tool, the Facebook page offers the opportunity to create ongoing conversations about SRH issues with students which would in turn stimulate them to think more critically about these issues and their choices. In this way, SRH talk would become part of their lifestyle and not something that is associated with the authorities.

While the health care workers that render regular services at the college (bi-weekly, bi-monthly and once a month) do not necessarily engage in any strategic communication activities on campus during these visits, the community clinics do. Here too, nurses rely on both approaches to alleviate the health challenges in the communities where they are located. The interpersonal approach also involves one-on-one communication with members of the community via door-to-door visits, where condoms and pamphlets are distributed. In those clinics that are implementing AYFS like Ezakheni Clinic, Ground Breakers are used to hold information sessions with students who come to the clinic in the chill room.

> *…they are working as ground-breakers at Zakheni B. They work with love-life. They work at the park home. They tell them about the AYFS, they channel the youth during happy hours and during meetings. They teach the CCGs how to deal with youth in the community. They also assist in events.*
> (DOH PHC Staff, Ladysmith Interview)

TVs and DVD players installed in the chill room are used to entertain young people whilst they wait to access services. Unlike on campus where media is mainly used to disseminate information, here, it is primarily used as a draw card to make the clinic more attractive to young people. Moreover, during the HEAIDS events that have taken place at the college, music was found to be a highly effective tool in attracting students to attend events. Peer Educators also highlighted that the use of props such as the First things First campaign hand which they wear as they mobilise students to participate in the campaign has acted as a draw card. Students that see them with the big hand become curious and approach them to find out what the hand is for; this gives the Peer Educator an opportunity to tell them about the campaign. For example,

> ***We also use notice boards and posters. We put up hands on boards and t-shirts. When students see you putting the hand up they are interested and stop to ask what the hand represents. We then explain that the hand comes from HEAIDS and we describe the campaign to them.***
> (Peer Educator, Estcourt FGD)

During the focus group discussions with students it was clear that students do value the IEC materials they obtain from the community clinics or during HEAIDS campaigns as they use them to learn more about their own SRH.

However, a concern raised was that whilst distributing pamphlets to students may be easier for the Peer Educators than talking to them about SRH issues, there is no guarantee that they read them. Ensuring that the one-on-one discussions are delivered in a manner that is respectful, brief, and friendly yet informative is very important in sustaining students' interest during the engagement. A stern, serious approach is usually perceived as boring. Students further pointed out that besides the internet; they rely on the SLOs, neighbours who are health professionals, and certain family members for information on SRH issues. Another key finding was that there is not only a shortage of IEC material in the community clinics, but insufficient material covering a wider range of SRH topics.

Nurses also said that when the department introduces a new product, e.g., Implanon, it is important that they receive sufficient IEC materials on that product. They were experiencing challenges with young women coming to the clinics to have the Implanon removed because of the myths associated with it. Because they do not have any materials on Implanon to refer to, they find it difficult to dispel myths or to answer questions about the implant. It is thus crucial that supporting material on new products is available in sufficient quantities. The mobile clinics servicing the campuses should also have an adequate supply of relevant SRH materials for students.

# 5. Summary of Findings

**This section presents a summary of the study's key findings. It begins with a discussion on the status of youth friendly services during the delivery of health care guided by the 10 national AYFS standards, focusing on the five key ones. The second part of this section highlights the key findings relating to the peer education programme at Mnambithi TVET College.**

## Youth Friendly SRH Services at Mnambithi TVET College

***Health Challenges:*** Although teenage pregnancy is a significant health challenge in the district, this was not the case at the college which has a low rate of pregnancies. STIs were the leading health challenge among students at the college (and with them young people's fear of disclosing possible infection to health care workers at the clinic). Lack of awareness or information and poverty appear to be the driving force of the health challenges experienced by students at the college and young people in general. The study also found that, poverty and hunger are so rife that they prevent treatment adherence among students on chronic medication.

Another challenge is the use of TOP by young females in the district as a contraceptive method. Since this was a perception among the health care workers that were interviewed, further investigation is required to determine the extent of this problem, how it manifests itself, and the reasons.

***Access to services:*** In light of these challenges, the college students usually use either the health services offered on campus or the nearby clinics to access services. The study further established that young females visit both the community and on campus clinics more than young males. Males' poor uptake of SRH services is associated with socio-cultural norms that are currently acting as a barrier. VMMC and STI treatment are the most common health services sought by males. However, VMMC is mainly accessed by young males between the ages of 12 and 15 in the community clinics. Men in the community, including male students are afraid of knowing their HIV status; thus, testing for HIV emerged as a significant barrier to VMMC. There has also been an increase in the uptake of contraceptives among female students, particularly Implanon. Although the levels of awareness of the services offered on the three campuses are relatively high due to either their visibility or advertisement (via posters or class presentations), students who are part of the Nated course are not aware of these services as they attend classes from three in the afternoon when such services are no longer available. Furthermore, access to SRH services for students at both the campus and community clinics was limited due to a number of factors. These include the low frequency of visits by health care workers; the fact that students are only able to use the clinic during the lunch break; health services on campus running out of drugs; too few staff members and a lack of privacy at the Ladysmith campus. To improve access, the students proposed that the frequency and opening times of services offered on campus be increased to just after 5pm. The long term solution proposed was the establishment of a fully-fledged clinic on each campus. These limitations drive students to seek SRH services at nearby community clinics.

However, here too students face a number of obstacles. These include early closure, negative and judgemental attitudes on the part of health care workers, opening times that clash with classes, inconsistent opening times, and a lack of confidentiality and privacy. It was noted that, while the Ezakheni 2 clinic is within walking distance of the Ezakheni campus, students preferred to travel to St Chads Clinic even though this

required a R7 taxi fare. Both of these clinics are AYFS implementing clinics, but St Chads Clinic was preferred primarily because of the shorter waiting time (due to fast tracking) and friendlier attitudes among nurses. Students regarded Waltons Clinic as the most unfriendly clinic because of the nurses' negative attitudes, long waiting times and lack of confidentiality and privacy.

The study also found that there is a need for values clarification training for health care workers to assist them in overcoming their personal prejudices. The fact that some of the students preferred young nurses and others the opposite is a key finding as it shows that, despite general perceptions that younger nurses are more youth friendly than older ones, this is not necessarily the case. Indeed, the study found that nurses' approach, rather than age, is the key determinant. Nurses with a welcoming, patient, and respectful attitude made the students feel safe, valued, and free.

The college SLOs embodied this attitude towards students. However their role in SRH service delivery by health care workers is currently under-utilised as it is limited to making announcements on the availability of services. Health care workers do not share statistics on the services delivered on campus, making it difficult for the student support office to construct a detailed health profile of their students to inform interventions. Regular provision of this data is particularly important in this context as the college student community is not static but always changing. Both the student support office and health care workers servicing students refer students to other health facilities or government departments for continuity of care. However, there is no clear follow up system to track the number of students referred, the services for which they were referred and the final outcome.

The study's most significant finding was that, similar to studies conducted in Soweto, Kenya and Zimbabwe, students cited staff friendliness, confidentiality, privacy and short waiting times as more important characteristics of youth friendly SRH services than structural changes such as youth rooms. This suggests that the success of AYFS implementation largely lies in capacity building among PHC staff as well as those providing services on campus to render services that embrace these characteristics. AYFS implementation in the implementing clinics used by students (Ezakheni 2 and St Chads) was further affected by the fact that PHC facilities do not have an allocated budget for AYFS implementation, making it difficult to purchase the equipment required to make the clinics more youth friendly. Retention of staff trained in AYFS is also a significant challenge in the district as people change jobs or relocate. Although establishing an AYFS committee is usually part of the process of implementing AYFS, the study found that not all implementing clinics had one. An AYFS committee with a youth representative in implementing clinics is crucial in promoting the sustainability of youth friendly services.

## The Peer Education Programme at Mnambithi TVET College

The college currently has 29 Peer Educators who volunteered to participate in the programme in response to a call by the campus SLOs. Peer Educators on the Ezakheni and Ladysmith campuses also work as Peer Tutors, offering academic support to students.

Peer Educators are supervised by SLOs who form part of student support services. There are three SLOs, one on each campus and their role in the Peer Education programme includes serving as a link between the external stakeholders i.e., HEAIDS and the DOH, mentorship and allocation of tasks to the Peer Educators, publicising health campaigns, counselling students and referring them to relevant services. Like the SLOs, the Peer Educators publicise upcoming campaigns and they also distribute condoms, T-shirts and pamphlets, and recruit students for HCT and VMMC. In their role as lay counsellors, Peer Educators are the first point of contact for students seeking advice on health and other social issues. However, they have not been adequately trained to perform this role. They recently participated in two training workshops which not only equipped them with basic SRH and HIV/AIDS information but empowered them to implement health campaigns on their respective campuses. In the one workshop, they were also orientated on AYFS so that they can promote increased uptake of SRH services among students. However, it is important to note that many Peer Educators were not part of these trainings. The Estcourt campus was least capacitated.

It further emerged that prior to an HEAIDS *First things First* event on campus, the Peer Educators attended an orientation workshop facilitated by HEAIDS staff on HIV/AIDS information and activities to be carried out in relation to the event. However, capacity building does not always take place timeously.

Having run for almost a year, the Peer Education programme at Mnambithi TVET College is fairly new and is therefore still faced with many challenges. These include the fact that the programme lacks structure, clearly defined goals and objectives, an action plan with roles and responsibilities and timelines. The channels of communication between SLOs and Peer Educators are unclear and the programme is not part of the college calendar. Resolving these issues will require the support and buy in of college management. Currently, there is no reporting system to track the impact of activities. Constant monitoring is called for in this kind of environment where the population is always changing. This would allow for the design and implementation of interventions that respond to the direct needs of the students present at the time. Another challenge was that the Peer Educators are not easily identifiable; this hampers student access and sometimes subjects the Peer Educators to derogatory treatment by students. The Peer Educators also pointed to the insufficient and untimely supply of IEC materials which negatively affects their mobilisation efforts.

The college currently employs two strategic communication approaches to disseminate information to students. The first is interpersonal communication and the second is mass media. The study found that posters was the least effective strategy as students did not read them, primarily because they are generally small and not colourful. Social media platforms such as Whatsapp and Facebook were proposed as possible avenues to reach students, with Facebook the most favoured.

The regular campus mobile clinics do not make use of any communication approaches and communicate the availability of services via the SLOs. On the other hand, the community clinics used by students utilise both approaches.

# 6. Recommendations

This section provides recommendations on how the two issues under study can be improved.

| Recommendations to Improve SRH Service Delivery Among Students | |
|---|---|
| Improve male students' uptake of SRH services | • Further investigations are required into male students' low attendance at clinics so that appropriate interventions can be crafted and implemented to encourage them to access SRH services. |
| | • Interventions need to be adopted to de-stigmatise HIV testing among male students so that more undergo HCT or VMMC. |
| Increase access to SRH services | • Clinic hours on the campuses must be extended to at least 4:30pm to accommodate students who attend classes from 3:00pm as part of the Nated programme. |
| | • Service delivery to be more frequent; at least once a week on each campus. |
| | • Staff delivering SRH services should be closely supervised to ensure that they do not leave early, especially during campaign events at the college. |
| | • In the long term, each campus should have its own permanent, fully fledged clinic where AYFS can be implemented to provide easy access to services. |
| | • Health care workers and the student support office should work more closely to plan on-going interventions in order to improve the uptake of SRH services among both male and female students. |
| | • Working together with the DOH, the college should design permission slips for students that need to visit the campus clinics during class. These can be issued and signed by the relevant lecturer and stamped by the health care worker with whom the student consulted. |
| Alleviate hunger as a barrier to students' health | • Interventions must be designed to alleviate hunger at the college to encourage adherence to chronic medication and reduce female students' vulnerability to exploitation and risky behaviours, i.e., transactional sex. |
| Improve privacy and confidentiality | • At least one more class room should be set aside for SRH service delivery on the Ladysmith campus to promote shorter waiting times and confidentiality and privacy for students. |
| Strengthen referral systems | • Systems should be put in place to track the number of students referred, the services for which they were referred and the outcomes of these referrals. This would enable the impact of existing services to be measured and assist in planning appropriate initiatives. For example, it would be useful to obtain this type of data from students who are referred for VMMC as it would be easier to track uptake and to identify and address issues relating to low uptake. Such information would also inform decisions on appropriate steps to be taken. |
| Strengthen data flow protocols | • To promote continuity of care of students, DOH staff working at the college should share statistics on the services they provide to students with the college on a regular basis. |
| | • HEAIDS staff should also share reports with the college after every event. |
| Increase the number of awareness campaigns | • More HIV/AIDS awareness campaigns should be implemented at the college to reduce victimisation of students who are HIV positive. |
| | • Safe sex/dual protection campaigns should be implemented on all campuses to encourage safe sex practices among students. |
| | • Interventions are also required to address substance abuse. |

| Recommendations to Improve SRH Service Delivery Among Students | |
|---|---|
| Integrate the AYFS quality improvement system at the college | • AYFS committees should be established at each PHC facility and young people should be represented. |
| | • College SLOs should be part of the AYFS committees in the community clinics used by students. |
| | • Measurable guidelines on how to implement AYFS outside of the health facility environment need to be put in place to improve SRH service delivery outside the PHCs. |
| | • Each campus should have a suggestion box dedicated to SRH service delivery where students can share their thoughts on how it could be improved. These should be reviewed on a regular basis by the SLOs and DOH staff on each campus. |
| Improve access to information | • DOH staff training on new products, e.g., Implanon must be accompanied by the provision of IEC materials for distribution and to empower health care workers with information. |
| | • Sufficient and relevant IEC materials, particularly on dual protection and HIV/AIDS education, should be made available during campus SRH service delivery. |
| Ensure a sufficient supply of drugs during service delivery at the college | • DOH staff providing services on campus should be allocated sufficient space to store drugs to avoid shortages. |
| Improve awareness of family planning methods | • The health care workers that were interviewed were of the view that young females in the district as well as female students use TOP as a contraceptive method. Further investigation is required into the extent of this problem, how it manifests itself, and the reasons. |
| Eradicate drug dealers | • Steps should be taken to prevent further drug dealing by the known alleged suspect on the Ladysmith campus. |

| Recommendations to Improve the Peer Education Programme at Mnambithi TVET College | |
|---|---|
| Provide more training | • Peer Educator trainings as well as regular refresher courses are highly recommended for students interested in becoming Peer Educators. This would enable them to understand the concept of peer education, and their roles and responsibilities on their respective campuses. |
| | • Peer Educators and SLOs should be equipped with counselling skills as this is a significant aspect of their work. |
| | • AYFS should be part of the curriculum for Peer Educator training. |
| | • A standardised curriculum should be developed for the Peer Education programme for all IHLs. This would promote consistency and the sustainability of the programme. |
| Increase identification and accessibility of Peer Educators | • Visibility and identification of Peer Educators is recommended to create a sense of brand identity. This could include T-shirts, name tags, banners, posters and pamphlets. |
| | • Physical space should be made available for Peer Educators to store records and promotional material and hold meetings to promote their accessibility to students. The space should be visible and be branded. |
| Improve the structure of the peer education programme | • A detailed action plan should be formulated for each campus in consultation with TVET management so that these activities are incorporated into the college calendar. |
| | • The action plan should include the identification of key stakeholders and outline how materials will be procured and distributed. |
| | • The roles and responsibilities of Peer Educators and SLOs need to be clearly set out to assist them to play their role on their respective campuses. |
| | • HIV Policies should be developed by IHLs that lack such policies. Staff and students should be orientated on the policy before it is implemented. |
| | • TVET management should assist Peer Educators to design their policies. |
| | • DOH staff rendering services on campus should work with SLOs and Peer Educators to plan mini-campus campaigns and render SRH services during such campaigns. |
| Improve support for the peer education programme | • The Student Representative Council should partner with Peer Educators to address health issues among the campus community. |
| | • Buy in from college management is required to include programme activities on the college calendar. |
| | • A budget should be allocated to assist Peer Educators to implement SRHR, and HIV prevention, treatment, care and support. |
| Improve strategic communication efforts | • Posters used to promote programme activities should be large, colourful and appealing. |
| | • Facebook should be used as an interactive platform to engage students with SRH messages. |
| | • Music and props should be used on an on-going basis to attract students to participate in campaigns. |
| | • DOH staff rendering services on campus should design a strategic communication approach in collaboration with SLOs, and Peer Educators to disseminate SRH information and services in a creative, youth friendly manner. |
| Strengthen referral systems | • Peer Educators could help to strengthen the referral system by following up on referrals made to the clinic and advocate for the provision of services to all those referred. |
| Strengthen data reporting protocols | • A comprehensive reporting system should be established that utilises standardised data collection tools, including a reporting template with relevant indicators. This would enable the impact of activities to be measured. |
| | • A data flow process including monthly timelines should be implemented to ensure that the reporting system operates in an efficient manner. |

# 7. Action Plan

**This section sets out an action plan to address the challenges confronting the delivery of health services to students and the implementation of the peer education programme at Mnambithi TVET College. In line with the PAR approach employed, the action plan is a product of continuous consultation between Mnambithi TVET College, UNFPA and the DOH.**

Due to time constraints, there was insufficient time to identify specific strategies, persons responsible and timeframes in relation to each challenge. In order to finalise this action plan, we suggest that the following process be undertaken beyond the scope of this contract:

- In order for the DOH to implement the study's recommendations, ethical approval should be obtained to enable the district to consult with the province on matters pertaining to policy issues, staff and budget allocations.
- Campus managers also need to present the report and steer it through internal processes and protocols for major recommendations such as the provision of additional space, reorganisation of the college calendar to accommodate peer education activities and the provision of mobile SRH services on all the campuses.

**Improving Adolescent and Youth Friendly services in the district and at Mnambithi TVET College**

| Challenges Identified | Recommendations |
|---|---|
| The negative attitudes of some health care workers towards young people accessing family planning services. | Train health care workers in values clarification. |
| Under-utilisation of the AYFS suggestion box in some facilities. | Ensure more visibility of AYFS suggestion boxes in all facilities. |
| Drug shortages. | Not established. |
| Resistance to fast tracking young people during school hours at some facilities. | Not established. |
| Unavailability of funds from the DOH to pay and retain its own Peer Educators, thereby relying on volunteers whose tenure is unpredictable and therefore unsustainable. | DOH to consider recruiting young CCGs as Peer Educators. |
| | DOH district team to work with the programme managers to address this issue. |
| A lack of buy in from some PHC Managers and supervisors, making it difficult for those implementing AYFS to receive facility level support. | Train them in values clarification. |
| | Ensure that facility based AYFS orientation workshops are held to introduce AYFS to all staff and obtain buy-in. |
| Lack of implementation by staff members who have undergone AYFS training. | Not established. |
| The migration of health care workers trained in AYFS. | PHC will be asked to indicate if staff trained on AYFS migrate so that that gap can be closed through the provision of training to other staff members. |
| The lack of funds to support the implementation of AYFS. | Ensure that a budget is allocated for AYFS implementation. |
| A lack of space to establish chill rooms in the facilities. | Not established. |

| Challenges Identified | Recommendations |
|---|---|
| Insufficient capacity to continuously monitor AYFS implementation in all PHCs. | AYFS staff based in the facilities to continuously monitor implementation. |
| Inability to monitor and evaluate AYFS implementation. | National and provincial DOH to finalise AYFS indicators in the DHIS. |
| | Implement the existing reporting tools. |
| | Data tools are currently being revised. This will be referred to data management in the province. |
| The use of different approaches by different organisations in the implementation of AYFS. | Standardise roll out of AYFS in all facilities. |
| AYFS champions play many roles and are therefore unable to fulfil all the requirements of AYFS implementation. | All staff must be trained on AYFS (not just one person). |
| | Dedicated service hours i.e., Happy hour, should be organised for all PHC facilities. |
| Low frequency of visits by nurses on campus. | Service delivery to be more frequent (at least once a week on each campus). |
| | In the long term each campus should have its own permanent fully fledged clinic where AYFS is implemented to provide easy access to services. |
| Insufficient supply of drugs. | DOH staff providing services on campus should be allocated sufficient space to store drugs to avoid shortages. |
| Too few staff working at the college, thus limiting the number of students that are able to access services. This also has privacy implications. | Mobile teams should alternate. At least four people should visit the college during peak hours, i.e., break time so that more students are able to access services and their privacy is protected. |
| Lack of established referral protocols. | Not established. |
| Insufficient space for consulting rooms. At least one more class room should be allocated for SRH service delivery on the Ladysmith campus to promote shorter waiting times and confidentiality and privacy for students. | Mrs Kunene to request an extra room at Ladysmith campus. Mnambithi TVET College to promote shorter waiting times and privacy for students. |
| Early closure of clinics and inconsistent opening times. | Opening hours on the campuses should be extended to at least 4:30pm to accommodate students who attend classes from 3:00pm as part of the Nated programme. |
| | Staff delivering SRH services should be closely supervised to ensure that they do not leave early, especially during campaigns. |
| Negative and judgemental attitudes of health care workers. | All PHC workers to be trained in values clarification. |
| Poor take-up of clinic services by male students. | Conduct male targeted campaigns. |
| Fear of testing for HIV among males creates a barrier to VMMC uptake. | Conduct male targeted campaigns. |
| Hunger leads to lack of adherence to chronic medication. | Not established. |
| Transactional sex & rape among female students. | Not established. |

| Challenges Identified | Recommendations |
|---|---|
| Lack of access to statistics on services used by students, preventing college SLOs from having a health profile of students that could assist in planning interventions. | DOH staff working at the college should share statistics on the services they provide to students with the college on a regular basis. This would strengthen continuity of care of students. |
| | HEAIDS staff should share reports with the college after every event. |
| Limited time for students to access the clinics as opening times clashing with classes. | Working with the DOH, the college should design permission slips to be used by students when they need to visit the campus clinics during class times. These can be issued and signed by the relevant lecturer and stamped by the health care worker. |
| Students not easily identifiable during visits to community clinics, preventing fast tracking/ individualised care. | Students to produce their student cards during visits to the clinics. |
| | All PHCs to be informed about this development. |
| The views of the students are not incorporated into SRH service delivery. | Each campus should have a suggestion box dedicated to SRH service delivery where students can share their thoughts on how the service could be improved. These should be reviewed on a regular basis by SLOs and DOH staff on each campus. |
| Female students (and young females in the district) use of TOP as a contraceptive method, indicating a lack of awareness of family planning methods. | Not established. |
| Discrimination against students who are HIV positive, indicating a lack of awareness of HIV/AIDS among students. | Not established. |
| Under-utilisation of SLOs/college in SRH service delivery on campus. | Health care workers and the student support office should collaborate more closely in planning on-going interventions seeking to improve the uptake of SRH services among both male and female students. |
| | SLOs and nurses working on campuses should be part of the AYFS committees in the local clinics used by students. |
| Lack of AYFS committees, jeopardising the sustainability of AYFS in the implementing clinics. | AYFS committees should be established at all PHC facilities and young people should be represented on these committees. |
| | College SLOs should be part of the AYFS committees in the community clinics used by students. |
| Nurses unable to dispel myths and provide accurate information to clients about new products, e.g., Implanon. | DOH staff training on new products, e.g., Implanon should be accompanied by the provision of IEC materials for distribution and to empower health care workers with information. |
| Insufficient IEC materials in the community clinics and during campus service delivery. | Sufficient and relevant IEC materials, particularly on dual protection and HIV/AIDS should be made available during campus SRH service delivery. |

| Challenges Identified | Recommendations |
|---|---|
| Known drug dealer outside the Ladysmith campus. | Steps should be taken to prevent further drug dealing by the known alleged suspect on the Ladysmith campus. |
| Substance abuse | Substance abuse campaigns should be undertaken. |
| Indian patients are fast tracked based solely on race in the clinic with Indian nurses. | This should be investigated. |
| Lack of support from Mnambithi TVET College management for SRH service delivery on the Estcourt campus. | Not established. |
| No guidelines on how to implement AYFS outside of PHC so that the SRH services delivered to young people attract, retain and respond to their needs. | Measurable guidelines on how to implement AYFS outside of the health facility environment need to be put in place to improve SRH service delivery. |
| Lack of buy in from college management, making it difficult for programme activities to be incorporated into the college calendar. | Not established. |
| Lack of Peer Educators' training. | Peer Educators training as well as refresher courses are highly recommended for students interested in becoming Peer Educators. |
| Insufficient visibility and identification of Peer Educators. | Create a sense of brand identity like T-shirts and name tags. |
| Lack of space for Peer Educators. | Physical space should be made available for Peer Educators to keep records and promotional material and conduct meetings. |
| Too few activities for Peer Educators and SLOs to promote HIV/AIDS awareness. | A detailed action plan should be formulated for each campus in consultation with TVET management |
| Lack of understanding of the peer education programme. | The roles and responsibilities of Peer Educators and SLOs need to be clearly stipulated. |
| No HIV Policies. | HIV policies should be formulated in IHLs where there are no policies and staff and students should be orientated on the policy. |
| Lack of funds for SRH & HIV prevention programmes. | A budget allocation is required to implement SRHR, and HIV prevention, treatment, care and support interventions on campus. |
| Demand for AYFS on campuses. | AYFS should be part of the curriculum for Peer Educators' training. |
| Lack of standards for peer education in IHLs. | Develop a standardised curriculum for the Peer Education programme at all IHLs. |
| Lack of strategic communication approach. | The DOH & DHET should design a strategic communication approach in collaboration with SLOs and Peer Educators to disseminate SRH information. |

# 8. Conclusion

**In conclusion, it is clear that while the AYFS quality improvement system was not implemented at Mnambithi College due to the lack of a fixed clinic on any of its campuses, the SRH services provided to students should seek to attract, retain and respond to the needs of young people. While the students use both campus and community clinics, they prefer to access SRH services on campus. However, the fact that they are only able to visit the clinics during the college's 30 minute break is a significant barrier. Furthermore, the study found that patient and friendly staff, short traveling distances, access to medication and privacy and confidentiality are far more important considerations among students accessing SRH services then any structural changes. This is not to say that young people do not appreciate the exclusive chill rooms and various other efforts made during the implementation of AYFS. However, it suggests that efforts to improve the uptake of SRH services at the college should begin by ensuring that the abovementioned issues are taken into account. This would make students feel valued, safe, and keen to use the health services on offer.**

Increased frequency of service delivery and, in the long term establishing a fully-fledged clinic on each campus, and strengthening referral and reporting systems should be at the top of the agenda. Furthermore, there are many gaps in the peer education programme at the college that need to be addressed in order for it to promote healthy behaviours among students. These range from the need to upscale capacity building of Peer Educators, to the establishment of clear objectives and action plans with defined roles and responsibilities, adequate and timely supply of IEC materials and strengthening reporting systems. STI infections headed the list of health challenges at the college, pointing to a high level of risky sexual behaviour. This underlines the need to improve access to and delivery of SRH services. For example, young male students' low uptake of SRH services is an issue for concern. Faced with these health challenges, the progressive establishment of both SRH service delivery and peer education programmes at Mnambithi TVET College is required to improve students' health and well-being. It is clear that the peer education programme is a powerful, youth friendly strategy to promote behavioural change. The college should thus utilise this resource and capitalise on the endless opportunities it presents to increase students' access to SRH services.

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# Appendix A

## Letter of Permission to Conduct Research at Mnambithi TVET College

higher education & training

Department:
Higher Education and Training
REPUBLIC OF SOUTH AFRICA

NO. 77 Murchison St. Ladysmith, 3370 | Private Bag X9903 Ladysmith, 3370 Tel: + 27 36 638 3800 | Fax: +27 36 631 4146

Enquiries: Ms RK Khumalo

02 September 2015

Dear Ms T Manana

**ACKNOWLEDGEMENT LETTER TO CONDUCT RESEARCH**

This letter serves to give your organisation permission to conduct research in our institution, Mnambithi TVET College.

The Student Support Services office will assist you in accessing the staff members you wish to interview in the College.

We are looking forward to a fruitful relationship with your organization.

Kind regards

DM Dlamini (Ms)
Acting Principal

Mnambithi TVET – Corporate Communication-Letterhead-2015 2015/06/03 Page 1 of 1

Skills and Education to build a better nation...

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www.mnambithicollege.co.za

# Appendix B

# Deliverable 3: Implementation of Dual Protection Campaign Report: Mnambithi TVET College

Ladysmith, Ezakheni and Estcourt campuses

## Introduction

This report analyses the implementation of the Peer Education programme and dual protection campaign in Mnambithi TVET as part of the DramAidE UNFPA contract. The dual protection campaign aims to encourage sexually active young women and men to use protection methods that will prevent unplanned or unwanted pregnancies, sexually transmitted infections (STIs) and HIV infection. Dual protection promotes the use of contraceptive methods and condoms at the same time. In the case of men it promotes Medical Male Circumcision and condom use. Most of the young people who are the main target for this campaign are based in Institutions of Higher Learning (IHLs).

## Objectives

Through UNFPA, DramAidE was tasked to coordinate the implementation of First things first "dual protection" campaigns working with HEAIDS, Government and other stakeholders on Mnambithi TVET's three campuses.

Mnambithi TVET has three active campuses with day students. The other two campuses are skills centres that students only attend during examination periods or if they have challenges with their studies. It was therefore suggested that we work with the three active campuses, eZakheni A, Estcourt and Ladysmith. DramAidE's role was to:

- Train Peer Educators and equip them with skills to implement dual protection campaigns on their campuses.
- Coordinate dual protection campaigns on the campuses.

## The Implementation of the Dual Protection Campaign at Mnambithi TVET

DramAidE facilitated the training of Mnambithi TVET Peer Educators and the campus mini-dual protection campaign.

## Peer Educators' Training

Peer Education programmes offer strong benefits to Peer Educators themselves. They enable direct participation of young people in programmes designed to support them, thereby promoting positive life skills such as leadership and communication and creating opportunities for mentoring and future job contacts.

Mnambithi TVET Peer Education training was organised by DramAidE with the assistance and support of College Campus Managers and Student Liaison Officers (SLOs). DramAidE facilitated two-day training for Peer Educators on Ezakheni A Campus from 19th-20th August 2015. The training was attended by Peer Educators from Ladysmith, Estcourt and Ezakheni A campuses. Peer Educators from the district Department of Health (DOH) also attended the training. They are based at Mbabazane, Loskop, Estcourt, Ladysmith, and St. Chads primary health care (PHC) facilities. Four district officials, Mnambithi TVET College SLOs and two lecturers were also present. The total number of people who attended was 44.

The programme included a brief overview of the Zazi and Brothers for Life campaigns as communication tools to address students. It also focused on peer education as an instrument to share and cascade accurate information to other students. Information was provided on sexual reproductive health (SRH), voluntary medical male

circumcision (VMMC) and adolescent and youth friendly services (AYFS). While this was a very full programme with limited time, the facilitators tried to address questions and comments that were raised during the training. The DramAidE facilitators used participatory techniques to equip Peer Educators with unique skills to address sensitive issues when engaging with their peers. These included small group discussions, poems, songs, dance, games, and presentations as well as talk-shows.

The participants were given an opportunity to appraise the training. They said that they appreciated the opportunity to learn different skills to deal with challenges that they encounter in their lives.

A female student aged 24 said,

*"Actually this training opened my mind; it also made change in my life. It will be very useful to me and of my peers".*

Another female student aged 23 said,

*"As a woman you must know that everything depends on you and I must not allow anyone to control my life but I must control it".*

This shows that Peer Educators are now seeing the need to take ownership of their lives as well as to share the information learned with their peers. (See programme attached).

During the training Peer Educators were asked to design their own action plans to promote the uptake of health care services on their respective campuses. An action plan is a document that lists the steps to be taken in order to achieve a specific goal. The purpose of the Peer Educators and SLOs designing an action plan was to clarify the resources required for each campus to achieve their goals, formulate a timeline for specific tasks and determine how they would acquire the resources required.

## Mnambithi TVET Campus Action Plans

Estcourt Campus Action Plan: Anti-Sugar daddy campaign
Ladysmith Campus Action Plan: Teenage Pregnancy
Ezakheni A Campus Action Plan: HIV Information Awareness campaign

### Estcourt Campus Strategic Implementation for Peer Education Programme

| Issues to be addressed | Objectives of the activity | Activities planned | Resources needed | Timeframes | Evaluation strategy |
|---|---|---|---|---|---|
| Anti-Sugar Daddies | To educate on transactional relationships and intergenerational relationships. To provide information so that students can make informed decisions. | Poetry Music Group discussions | Notice boards Markers Pamphlets Condoms | 31 August 2015 (3 hours) | Report Photos |

### Ezakheni Campus Strategic Implementation for Peer Education Programme

| Issues to be addressed | Objectives of the activity | Activities to be conducted | Stakeholders to work with | Timeframes for each activity | Evaluation strategy |
|---|---|---|---|---|---|
| Issue: HIV information Peer Educators will be informing students about AYFS and Zazi as well as Brothers for life. | To give information on HIV infections on campus Recruit students for VMMC | • Edutainment: Poetry, music for the day.<br>• Class presentations<br>• Distribution of condoms | DOH DramAidE | Date: 31 August 2015 3 hours | Report Pictures |

### Ladysmith Campus Dual Protection Action Plan - 2015

| Issue to be address | Activities to be conducted | Resources needed | Stakeholders to work with | Timeframes |
|---|---|---|---|---|
| Teenage pregnancy | Distribute condoms Group discussions Class presentations | Condoms, family planning information | Department of Health, and Operation Sukuma Sakhe | From 25/08/2015 |

## Community Dual Protection Billboard Launch

UNFPA through DramAidE was part of the dual protection billboard launch in Loskop at Nkomokazini Community hall on 4th August 2015. The area falls under uThukela district. The event was organised in partnership with the DOH uThukela district office in support of the main event by MEC Dr. Dhlomo who launched the dual protection billboard at Mangosuthu University of Technology. While this was not part of the scope of this contract, DramAidE was requested by the district DOH to present a forum theatre during the launch. This event was attended by learners from Nkomokazini and Bonokuhle High Schools and a few adults from the community. DramAidE presented a forum theatre promoting dual protection. The play was well received by learners as they were given a platform to challenge the actors on issues that were presented on stage. They reported that they learnt that when one is ready to be in a relationship, it is important to first test for HIV. Other learners stated that abstinence would prevent HIV infection and unwanted pregnancies.

An educator from Nkomokazini High School challenged the DOH nurses on their attitude towards learners who seek help at the clinic. She said that it is not good that they chase learners from the clinic. She called for their cooperation saying that learners should not to be judged. In closing, local mayor, Mrs Strydom pledged her support for the dual protection campaign.

## Campus Dual Protection Campaign Activities

### Mnambithi TVET – Ladysmith Campus Action Plan: Teenage Pregnancy

Ladysmith campus Peer Educators conducted a mini event on teenage pregnancy on 25th August 2015 and on dual protection on 2nd September 2015. These events aimed to provide students with information on HIV prevention and to encourage them to attend the main dual protection campaign on 3rd September 2015. Peer Educators and Mrs Kunene, the Ladysmith campus SLO conducted class presentations, face-to-face interventions, loud-hailing, group discussions and condom distribution in the build up to the main event. They also distributed pamphlets and placed posters on notice boards to invite students to attend. At least 500 students were reached with information on this campus. During the presentations they provided family planning information to reduce and prevent unwanted pregnancies and new HIV infections.

### Mnambithi TVET – Ezakheni A Campus Action Plan: HIV Information Awareness campaign

On 31st August 2015 Ezakheni A campus hosted a mini event in the form of a dialogue that aimed to provide information on HIV and promote dual protection using the Zazi and Brothers for Life campaigns. Peer Educators and Ezakheni SLO, Ms Mzelemu provided students and lecturers with information on HIV and SRH rights using poetry. Pamphlets and condoms and condom demonstrations were presented. At least 100 students attended the event and 6 000 male condoms were distributed. During the dialogue STIs, VMMC and positive living were addressed by Ms Mzelemu, assisting Peer Educators with accurate information. She reported that after demonstrating the use of the female condom, most female students wanted these condoms which unfortunately were not available.

### Mnambithi TVET – Estcourt Campus Action Plan: Anti-Sugar daddy campaign

On 27th August 2015 DOH official Mr Mbili who had attended the Peer Educators' training facilitated a refresher course for the Estcourt Peer Educators. The reason was that most of the Estcourt campus Peer Educators did not attend the training organised for all campuses. This course was attended by five Peer Educators that were provided with relevant information to assist them to mobilise for their campus mini events. They asked DramAidE to provide further training in order to catch up with trained Peer Educators on other campuses.

On 1st September 2015 the Estcourt campus Peer Educators in partnership with the DOH and Department of Social Development (DSD) hosted a mini dialogue on anti-sugar daddy. This campaign aimed to provide information on the dangers of transactional relationships. Student Liaison Officer Ms Mkhize highlighted the risk of losing power to negotiate condom use in such relationships, thereby putting young women and men at risk of contracting HIV and other STIs. Poems and songs were performed warning students about the dangers of transactional and intergenerational sex. The dialogue also touched on issues of alcohol and drug abuse as well as dual protection. At least 300 students attended the mini campaign. Three hundred female condoms and 600 male condoms were distributed. The DSD has requested another opportunity to address students on dual protection as some students did not attend these events.

### Main Mnambithi TVET Ladysmith Campus: Dual Protection Campaign

The main dual protection campaign in partnership with the DOH and UNFPA took place on 3rd September 2015 on the Ladysmith campus.

This event was attended by different stakeholders ranging from the local municipality, to the DOH, DSD, Peace Corps, the Ward Councillor, UNFPA, SFH-Choice, the LGBTI group, Duduza Health Care, Operation Sukuma Sakhe, the SRC and NGOs. The DOH and NGOs provided health screening services ranging from TB to STI and cervical cancer screening. HCT, BMI and MMC services were also provided. The DOH also provided family planning methods to female students including Depo, IUCD, Implanon, Nuristerate, oral contraceptives and condoms. More than 600 students attended the campaign. The SFH-choice team facilitated games on different options to negotiate condom use in a relationship and students were given token gifts for participating. Students who accessed health screenings and contraceptive methods received T-shirts.

Most of the guest speakers during the official programme emphasised the importance of dual protection and encouraged students to take advantage of the services provided by the government. They also encouraged them to take ownership of their sexual lives by abstaining or ensuring that they do not have unsafe sex in order to graduate alive without the challenges of unplanned pregnancies and HIV infection.

A female student said,

*"This was a great event with people motivating us and also the fact that they brought all these health services to our campus, we really appreciate that".*


stop
TB
AIDS HELPLINE
0800 012 322
SYP
Promoting safe
sexual and
reproductive health

**The number of students who received health services during the event is as follows:**

| Health service | Number of students |
|---|---|
| BP & Sugar | 343 |
| HCT | 271 |
| Non-reactive | 261 |
| Reactive | 10 |
| Depo | 10 |
| IUCD | 3 |
| Implanon | 5 |
| Nuristerate | 6 |
| Oral contraceptives | 1 |
| Cervical Screening | 26 |
| CD 4 Count | 10 |
| TB Screening | 84 |
| Sputum Collected | 5 |
| VMMC | 8 |
| Male condoms distributed | 1 280 |
| Total condoms distributed including mini campus campaigns | 8 180 |

## Lessons learnt

*Buy-in*

It is very important to obtain buy-in from local stakeholders when planning an event of this magnitude. Once stakeholders have bought into the concept, it is easier to organise different activities.

*Service delivery*

Bringing health screening services to the target audience is convenient for students as it is in their own space or campus. This motivates students as well as community members to take advantage of the services provided.

*Sharing resources*

It is important for different partners to work together as this promotes the success of the campaign.

*Peer Education*

TVET students need Peer Education programmes that will create opportunities to address HIV infection with their peers and encourage the uptake of health care services.

## Recommendations on how to improve further implementation of campaign activities relating to the uptake of health care services

- Annual or frequent peer trainings as well as refresher courses are recommended as most students in TVETs are seasonal.
- Sufficient time is required to plan for and organise campus campaigns.
- A campaign of this nature should include all Mnambithi TVET community campuses including neighbouring secondary schools and parents.
- The local municipality should assist the TVET to enable this campaign to reach the community at large.
- HEAIDS' involvement in such campaigns is highly recommended as this would promote support from IHLs' management.
- TVET management should take an active role in the implementation of campaigns as this will assist with planning and resource allocation by the institution.
- The DOH services provided during these campaigns need to be friendly and respond to the needs of students.

## Data collection tools to enable accurate reporting on the number of young people reached through AYFS, peer education programmes and outreach activities

Data collection tools were developed to strengthen the monitoring and reporting of Peer Education Programme activities relating to the uptake of health care services.

# Appendix C

## Peer Training Programme

UMNAMBITHI TVET: AYFS – DUAL PROTECTION TVET PEER TRAINING PROGRAMME
DATE: 19-20 AUGUST 2015

**Day One**

| Time | Item | Facilitator |
|---|---|---|
| 08:30 - 09:00 | Registration, opening remarks, warm up game, introductions, ground rules and expectations | |
| 09:00 - 09:30 | Overview of Adolescent and Youth Friendly Services- DOH | |
| 09:30 - 11:00 | Overview of Zazi & Brothers for Life campaigns | |
| 11:00 - 11:30 | TEA | |
| 11:30 - 12:45 | Peer education<br>• What and Why Peer Education?<br>• Qualities<br>• Do's & Don'ts<br>• Roles | Thenjiwe |
| 12:45 - 13:00 | Sexual Reproductive Health<br>Male Anatomy<br>Female Anatomy<br>Sexually transmitted infections: Types of STI's<br>Signs & Symptoms<br>Treatment of STI's | Thenjiwe & Mfanafuthi |
| 13:30 - 13:45 | LUNCH | |
| 13:45 -14:30 | Sexual Reproductive Health<br>Male Anatomy<br>Female Anatomy<br>Sexually transmitted infections:<br>Types of STI's, Signs & Symptoms<br>Treatment of STI's | Thenjiwe & Mfanafuthi |
| 14:30 - 15:45 | Dual Protection: Family Planning<br>What is Dual Protection<br>Why Dual protection?<br>Who needs/ responsible for Dual protection?<br>Methods to be used in case of emergency<br>Different Types of Contraceptives<br>Possible Side Effects | Mfanafuthi |
| 15:45 - 16:00 | Evaluation | Mfanafuthi & Thenjiwe |

**Day Two**

| Time | Item | Key Issues |
|---|---|---|
| 08:30 - 09:00 | Opening Prayer, Warm-up game and Recapping | |
| 09:00 -11:00 | VMMC<br>• What is VMMC<br>• VMMC and health screening<br>• Types of Circumcision<br>• Benefits of VMMC<br>• VMMC myths<br>• Wound Caring | Mfanafuthi |
| 11:00 -11:30 | TEA | |
| 11:30 -13:00 | AYFS<br>• What is AYFS?<br>• Norms and Standards of AYFS<br>• Provisions<br>• Policies<br>• Rights | Mr. Mkhonto Blose |
| 13:00 -13:30 | Lunch | |
| 13:45 -15:15 | Facilitation<br>• Definition of facilitation<br>• Facilitation techniques/ Methods<br>• Facilitation skills (planning and organising, facilitation of learning, evaluation of learning) | Thenjiwe |
| 15:15 - 16:00 | Action Plan<br>• List of issues to be addressed<br>• List of activities (objectives) to be conducted to addressed issues listed<br>• Goals (what we want to achieve through our objectives)<br>• Events planning<br>• Resources needed to implement activities<br>• Stakeholders to work with<br>• Timeframes of activities<br>• Programme evaluation strategy (M&E) | Mfanafuthi & Thenjiwe |
| 16:00-16:15 | Evaluation & Closure | |

**Strategic Implementation Plan for Peer Education Programme**

| Issues to be addressed on campus | Activities to be conducted to address each issue on campus | Goal intended by conducting activity per issue | Resources needed to conduct activities to address issues | Stakeholders required to work with for the success of activity on the plan | Timeframes for each activity | Evaluation strategy to see impact and progress |
|---|---|---|---|---|---|---|
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# Notes


UNFPA - because everyone counts.

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