**PROCESS AND IMPACT EVALUATION OF THE ODI YOUTH CENTER**

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**Master of Public Health**

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Submitted in partial fulfillment for the degree of Master of Public Health in the Department of Social and Behavioral Health Sciences, School of Public Health, Faculty of Health Sciences at the University of Limpopo, Medunsa Campus

Date submitted: February 2010

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January 2010

**DECLARATION**

I declare that the dissertation submitted to the School of Public Health, Medunsa Campus at the University of Limpopo, for the degree of Master of Public Health, is my own work in design and execution and has not been previously submitted by me for a degree at this or any other university. All other material contained herein has been duly acknowledged.

Mtashingwana Ellen Mokabane

SIGNATURE DATE

**ACKNOWLEDGEMENTS**

I would like to thank God with whom all things are possible

I also want to thank the following:

My grandmother whose thoughts and prayers are always with me in all I do

My mother who supported me throughout the years

My husband who has been by my side through the whole process

My daughter whose quality time was stolen

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**DEDICATION**

This work is dedicated to my grandmother whose love has seen me through difficult times. Your tenacity has taught me to never give up.

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#### ACRONYMS

YARHP – Youth Adolescent Reproductive Health Program

NPO – Non- profit organization

ARHS- Adolescent Reproductive Health Services

CBRHS- Community-based Reproductive Health Services

NAFCI – National Adolescent Friendly Initiative

HIV- Human immunodeficiency virus

STIs – Sexually Transmitted Infections

VCT – Voluntary Counseling and Testing

AIDS- Acquired Immune Deficiency Syndrome

PLWA- People Living With AIDS

SRH – Sexual reproductive Health

RHRU- Reproductive Health Research Unit

DoH – Department of Health

UNICEF – United Nations International Children’s Emergency Fund

CLO – Community Liaison Officer

WHO – World Health Organization

NWDoH- North West Department of Health

NYSP – National Youth Service Program

NYSU – National Youth Service Unit

#

# SUMMARY /ABSTRACT

The primary purpose of Youth Centers is to provide adolescent reproductive health services, which includes equipping the youth with life-skills and knowledge that has potential to prevent the spread of HIV infections. The Adolescent Reproductive Health program of the Y centers includes information on sexual health, teenage pregnancy (including CTOP) and STI’s. These Youth Centers are located in various locations in South Africa, Mabopane being one.

Y centers operates from the premise that, because information alone is not enough to make young people change behavior, young people also need the attitudes, motivation and negotiating capacity to put what they know into practice. Life Skills, a program that focuses on enabling young individuals to deal effectively with the demands and challenges of everyday life, is a key aspect of the program in youth centers. The program deals with building skills such as self-esteem, problem solving, assertiveness, and negotiation skills that are useful to young people in their everyday lives.

This study evaluated the implementation of the youth program at the Odi Youth Center, which is in Mabopane, as well as the impact of the center on the lives of young people who utilize these services. The positive findings of the study were that young people in the area value the services offered at the centre and are grateful to this facility, crediting it with having provided them with knowledge and skills that enable them to deal with sexual and other social matters. However, they stated that the impact would be greater if the centre could open for longer periods during the week and also on Saturdays.

HIV and AIDS education, which is a significant component of Youth Center programs, is provided by professional nurses who are employed by the Department of Health (North West Province). The centre also offers HIV counseling and testing, access to contraceptives including provision of condoms, diagnosis and treatment of STI’s. Young people reported that their knowledge of HIV is good because of the lessons they get from the centre.

 The study found the following areas of concerns,

1. that the program implementation and activities do not follow a specific structure and occur haphazardly
2. record keeping is poor
3. the clinic staff who have been mandated to run the program have not been trained on the loveLife principles and youth friendly clinics
4. the hours of operation for the Y center limits participation by the youth

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

HIV and AIDS and their social, political and economic impact still remain a big challenge even after two decades since its emergence. Global statistics indicate that young people are mostly affected because of their risky adolescent behaviors, including experimentation and risk taking tendencies. Young people are known to be vulnerable because they are considered to be more sexually active, still exploring the relationship between their sexuality and physical development, but with inadequate skills to protect themselves (UNICEF 2002).

HIV prevention interventions aimed at young people seem not to be as effective as expected, as demonstrated by the ever increasing incidence of the infections. National studies have repeatedly shown that the primary problem is not a lack of information, but rather a failure to personalize and internalize risk, and thus change behaviour. The HIV prevalence among young women aged 15-25 estimated to be living with HIV/AIDS in 2007 in South Africa was 12.7% while that of young men of the same age was 4.0%, thus highlighting the gender differences in the vulnerability of females to HIV infections (The Henry J Kaiser Family Foundation, 2008: The HIV/AIDS Epidemic in South Africa)

HIV prevention interventions aimed at young people do not only have a potential to protect them from being infected with the virus, but also to equip them with other life skills. Because HIV is also a social phenomenon, prevention interventions logically include motivational and skills development that equip young people with information and skills to navigate life and its challenges. The programs do not only teach them about HIV prevention but also taught social and health management skills, including how to take responsibility for their actions and the process of weighing risks and benefits of their behaviors. Young people also acquire knowledge related to family planning, sexuality, teenage pregnancy, sexually transmitted infections and other life skills.

Internationally, there is substantial evidence that suggests that the best opportunity to positively impact on adolescent sexual behavior is prior to the onset of sexual activity (Stadler & Hlongwa, 2002), hence the focus of Youth Center programs which encourages a delay in sexual debut for those that are not yet sexually active. The programs also often operate from schools, which enables them to reach many young people who may not necessarily go to the centers.

The complexity of health behavior change in general and health behaviour change among the youth in particular, has resulted in much work going into the development of interventions that will attract the interest of young people, which is built on the assumption that such interest will translate into behaviour change. This has resulted in the development and creation of Youth or Y centers, which is a concept of a center which offers a variety of services designed specifically to meet the needs of young people.

### LoveLife and Youth interventions

Lovelife, which was formally launched in South Africa in September 1999, is the national HIV prevention program for youth. It was developed by a consortium of leading public health organizations and a coalition of several community-based organizations: the South African government, media groups and private foundations. It is the highest funded HIV program in the country, and is regarded as an example of a truly integrated initiative against HIV. The philosophy of LoveLife resulted in the development of Y centers, which are visible structures for youth-aligned services in various areas of the country.

Lovelife is the most highly funded anti- AIDS communication campaign in South Africa; with an annual budget of about R200 million in 2008. Its main goal is to effect positive behavior change among young South Africans to reduce teenage pregnancy, sexually transmitted infections and HIV/AIDS (Dickson-Tetteh et al, 2001). Love life focuses on sexual behavior issues affecting the South African youth, and promotes positive sexual health. These issues include HIV/AIDS, STI’s, relationships and general educational campaigns and awareness.

The design construct of Lovelife is a view that motivating young people to change sexual behavior, requires active experience of an alternative and positive lifestyle, while also making institutions responsive to growing demands from young people for friendly and appropriate health and social services. The campaign is comprised of *thethaNathi* and S’camto print publications, television and radio programs, the Groundbreakers, Lovelife games, peer education, Y-Centers and Adolescent-friendly clinics as well as a series of billboards across the country.

LoveLife is also regarded as providing cutting edge interventions because of the approach it uses. A unique feature of this program is that, not only does it include young people to implement its programs, but these young people, who are called Groundbreakers, have their ears on the ground about behaviour trends among their peers and community. They are thus able to respond to current sexual and behavioral issues. However, it is not obvious that all LoveLife centers operate the same way in terms of resources, and this introduces variety in the impact of the centers.

###

### Components of Lovelife program in South Africa

***Thetha Nathi*** *(*Xhosa phrase which means speak to us)

Thetha Nathi is a biweekly newsletter targeting youths. It is distributed to schools nationally, as well as clinics that are part of the LoveLife program. It is often distributed as supplements in newspapers. Despite this wide distribution, the extent to which it is read by young people is not known. It is therefore difficult to measure its impact among young people.

***S’camta* (Slang for “talk about it”)**

 S’camta is a weekly television program which encourages teens to talk openly about sex and relationships, both with their peers and their parents*. S’camta* is part road movie, part documentary, and part music program with hosts traveling throughout South Africa, sharing stories about life, sex and being young,(Gale Group, 2002). S’camta is regarded as one of the programs that reach many young people, because many of them watch

 Television

 regularly. The strength of Lovelife and related youth centers is that it does not only give information, but also provides alternative activities for young people, as opposed to just negating their behavior. This seems to result in some success in achieving behavior change.

The above program components of Lovelife are expected to be integrated into youth programs and youth centers. The Lovelife program is a cornerstone of Y Centers, hence its relevance to the program of Odi Y-Center.

###  Study goal, study objectives and research questions

**Study goal**

The goal of the study was to evaluate the process and impact of the Odi Youth Centre on the youth utilizing its services

 **Research Objectives**

The objectives of the study were:

1. To evaluate the program implementation process of Odi Youth-Centre
2. To evaluate the impact of the Odi Youth-Centre on the youth of Mabopane and surrounding areas

**Research questions**Thefollowing questions were asked by the study:

1. What processes are in place for the implementation of programs at the Odi Youth Centre?
2. What are the views of young people on the services offered at the center?

###

### Significance of the study

 The Odi Youth Center is the only one in Mabopane and the Soshanguve area. It is therefore a resource center for more than a million young people who need its services. Information on how this center is run is therefore of importance to the Lovelife organization and users of the programs offered at the center. Moreover, the results of this study will assist the Odi Youth-Centre to bench-mark itself according to the purposes of its mission, thus recognize its strengths and weaknesses so that it can improve on weaknesses and utilize their strengths to achieve their objectives. The successes can then be shared with other centers and youth organizations. The results of the study will also be of interest to public health practitioners who work with young people, because they will be able to know and thus use what works.

### The objectives and activities of the Y Centers

The objectives and activities of the Y Centers are summarized as follows:

|  |  |
| --- | --- |
| **Y Center objective** | **Related Y Center activity** |
| 1. Reduce HIV among the youth
 | * Sexual health education
* Distribution of condoms and Lovelife magazines and booklets
* HIV/AIDS education
 |
| 1. Promote healthy and positive life-style
 | * Games and recreational activities
 |
| 1. Develop life skill
 | * Workshops and mentoring activities
 |

This evaluation will use the Y center objectives and activities as indicators for how the center is expected to run, as well as the impact it is expected to have on the young people who use its services.

# CHAPTER 2

# LITERATURE REVIEW

Around the world, the evidence shows that wherever the spread of HIV is slowing or even declining, it is primarily because young men and women are given the tools and the means to adopt safer sexual behaviors (UNICEF, 2000). This suggests that, with the correct information, approach and skills, young people can turn the HIV tide in their communities and among themselves. In almost every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred. According to UNICEF (2003), young people have the greatest opportunity to defeat HIV/AIDS. Epidemiological studies have shown that the peak incidence of HIV/AIDS occurs in young people aged 15-24 years (Reproductive Health Research Unit, 2004), hence the much attention given to HIV prevention efforts among the youth. Early sexual debut, low condom use and sex with multiple partners heighten the adolescents’ vulnerability to the virus (Eaton, Flisher, & Aaro, 2003). This highlights the need to strengthen HIV prevention efforts among the youth because not only will this save the individuals concerned, but it will also result in the decline of HIV infection rates. It is for this reason that evaluation of youth programs need to be conducted, to ascertain if such effectiveness exists.

The importance of targeting young people has been supported by the UNAIDS study report of June 2004, which show that when young people are provided with accurate information on sex and HIV/AIDS, they are more likely to delay sexual activity and use condoms when they finally do have sex. Furthermore it has been suggested that involving young people in prevention efforts not only educates them about HIV, but also gives them a sense of responsibility and pride as they take ownership of their lives and empowers them with the ability to give inputs on how to implement programs that suit them. Furthermore with the right skills and knowledge, young people can have an extended impact by having a positive influence on their peers. Young people are more likely to speak more freely and openly among themselves, supporting the practice of encouraging free verbal expression in discussion groups at Y centers.

In terms of gender, young women in many societies including South Africa are less able to assert themselves in sexual relations, or to make informed choices about sexual participation. For this and other related reasons, the rate of HIV infection is higher among girls and women than it is among men and young males. Moreover girls are anatomically and physiologically more vulnerable to HIV infection, and gender-based inequities compound their risk, hence the need to have gender specific approaches even among the youth (UNICEF 2002). Capitalizing on this knowledge, on Youth centers include programs that are gender specific to cater for the special needs of both girls and boys separately.

A study by UNAIDS in 2008 concluded that open communication with their parents about HIV, sex and sexuality appears to reduces risk among young people. This is because this communication enables them to consider their options and take independent responsibility for their actions, instead relying on their parents to ever telling them what to do. Parents also expressed their wish to have their children grow into a better and brighter future, without the danger of sexually transmitted diseases. Young people whose parents report open communication about dealing with the pressure to have sex and the risks of unprotected sex are more likely to say they have changed their sexual behavior as a result of HIV (UNAIDS, 2008).

## Challenges of effecting youth sexual behavior

### Globally

Evidence from various parts of the world indicates that the age of puberty has been falling for both boys and girls, due mostly to change in nutrition. On the other hand, age of marriage and premarital sex are increasing, meaning when these young people put marriage and sex on hold for later they will probably make informed choices when they finally have sex or do marry. Sexual coercion appears to play a considerable role in the sexual relations of both young men and women. The magnitude of sexual coercion varies across countries but appears to be somewhat lower in Asia compared with sub-Saharan-Africa and Latin America (National Research Council and Institute for Medicine, 2005).

### Nationally

Numerous studies highlighted the discrepancy between knowledge and behavior, indicating that although knowledge about HIV transmission was generally high, there was evidence that misconceptions about AIDS persist; particularly myths related to HIV transmission, and that youth still did not practice safe sex (Simbayi 1999). National opinion polls regularly record that crime; poverty, unemployment, women and child abuse are primary concerns to the public (Ngobo, 2004,). The result was surprising in the sense that HIV/AIDS was viewed as a major challenge by very few of the respondents. This problem impairs youth programs nationally because not enough support is given financially and otherwise.

### Regionally

In 2005, IPAS South Africa (an international organization that works around the world to increase women’s ability to exercise their sexual and reproductive rights , and to reduce abortion related deaths and injuries) and the North West Department of Health conducted a study to assess the strengths and gaps in the services of five youth centers in the region. Among the findings, the partners concluded that despite the youth center’s initial mission of being multipurpose facilities, the centers had become de facto reproductive health clinic, primarily serving the needs of sexually active young people who are typically isolated from such care (North West Department of Health, South Africa, 2007).

###

### Y–Centers and their role in combating HIV

 Youth centers provide a venue in the community where adolescents can be involved in positive recreational activities, vocational training, and access to peer education programs to promote healthier lifestyles; in addition Youth centers also provide clinical and preventive services related to reproductive health needs of adolescents including counseling and testing, access to contraceptive services including provision of condoms and diagnosis and treatment of STIs. The primary purpose of the Y-Centre is to demonstrate the effectiveness of a non-clinical environment in providing sexual health education and care for adolescents. South Africa has a fairly extensive network of Youth centers throughout the country that are being implemented by a variety of agencies. Currently, the main implementers of Youth Centers are Planned Parenthood Association of South Africa (PPSA), Lovelife program, and the Youth Adolescent Reproductive Health Program (YARHP), which has contracted PPASA to establish Youth Centers on behalf of three provincial Departments of Health, Gauteng, North West and Kwa Zulu Natal (Erulkar, Beksinska, and Cebekhulu 2001).

The North West Department of Health (NWDoH) absorbed the previously known PPASA centers in the province and ODI Y-Centre is one of those taken over by the department. The Y-Centers are usually stand-alone entities or they are incorporated in clinics. All of these centers have peer educators/groundbreakers that coordinate life skills workshops, conduct outreach activities and advertise the centers’ existence. In 2003 research showed that young people, who had been exposed to more than 3 Lovelife Programs, and specifically to Lovelife groundbreakers, were 60% less likely to be HIV positive than their peers (Buhrer, 2008). Lovelife is sub-contracted by several departments including the Department of Health to assist in improving SRH (Sexual Reproductive Health). Mabopane, which is a Black township North of Pretoria, has a number of these centers.

Information to guide program planners on the quality, functioning and impact of existing programs for young people–in South Africa and sub-Saharan Africa generally-is limited ( Erulkar , Beksinska and Cebekhulu , 2001).

### Groundbreakers

Groundbreakers are young people aged between 18 and 25 years, who have matriculated and are graduates from Lovelife’s motivations development and peer education training program. They go through a screening and interview process before they are trained and appointed as groundbreakers. They receive both leadership training and training specific to the tasks assigned to them. They are responsible for coordinating training for other volunteer peer educators and are responsible for internal workshops and activities. Part of their work is in schools and they receive a stipend.

###

### The SRH (Sexual Reproductive Health Issues) Program

This is the major program offered at the Y-centers. This program entails the running of five-day workshops for young people at the Y-Centre, and involves education about reproductive health (e.g. menstruation, masturbation, sexual intercourse, teenage pregnancies, STI’s) as well as issues such as relationships and substance abuse.

These workshops are compulsory for membership of the Centre. Through the workshops young people are identified for training as peer educators or they are recruited through schools. A young person chosen for this task is one “who can communicate with others, who’s free when communicating and is committed. ‘Commitment’ here refers to regular attendance and participation in the five day workshop. Those chosen then undergo a five-day peer-training program, held outside the centre. Content includes communication skills, handling of conflict and group dynamics. Trained peer educators then return to the centre where they begin to mentor young people (Naidoo, 2003). During center stage young people get a chance to expose their talent, be it dancing, acting, modeling or comedy.

Peer educators go to schools in the area to conduct talks, and the guidance or life orientation period is used for this purpose, they use the life orientation text book. These talks include discussion of puberty and adolescence, reproductive physiology, teenage pregnancy, choice on termination of pregnancies (CTOP), STIs, relationships, and HIV/AIDS. Grades 7-11 are targeted. The topics discussed here usually correlate with those of life orientation and affect mostly adolescents. School visits help to cover those students who never visited the Y-Centre for varying reasons. There is a separate three-day workshop that focuses specifically on HIV/AIDS, which is held at the Y-Centre on a monthly basis and is conducted by the professional nurse.

### Life skills

World Health Organization (WHO) defines “Life skills” as abilities for adaptive and positive behaviors that enable individuals to deal effectively with the demands and challenges of everyday life (WHO, 1999). This program deals with building basic skills such as self-esteem, problem solving, assertiveness, and negotiation skills useful to young learners in their everyday lives. Life skills are imparted to young people either by officers specially hired for this purpose or by trained peer educators. In this Centre, it is done by trained peer educator. The life orientation manual also has lessons on issues such as self-esteem, positive affirmations and goal setting.

### Sports and Recreation

Y-centers often offer sports and recreation activities that are practical to their surroundings and also those they have available resources for. Odi- Y-centre activities include football, basketball, aerobics, township dance, drama, indigenous games, poetry and art. All these activities are offered at the Centre by the groundbreakers and the volunteer peer educators. The Community Liaison officer and project manager liaise with other stakeholders such as the Department of Arts and Culture to assist with other skills.

### National Adolescent Friendly Clinic initiative

Lovelife has launched the National Adolescent Friendly Clinic Initiative, in an effort to ensure that youth throughout South Africa have access to comprehensive health services.

Usually, the clinics are incorporated into the Y-Centers because this makes them easily accessible to the youth. The National Adolescent Friendly Clinic Initiative (NAFCI) was developed around standards that were identified as important for a clinic to have before being called ‘adolescent friendly”. The standards were developed around the following essential elements of high quality client care: management; adolescent rights; environment of care; drug, supplies, equipment; continuity of care; information, education, and communication; trained staff; client assessment and individualized client care ( Stadler & Hlongwa , 2002). The focus of NAFCI is on improving clinic systems and process to create an environment that is friendly and accessible to youth. Extensive research has established that South African public health facilities are failing to provide adolescent-friendly health services (Dickson-Tetteh, Pettifor, Moleko, 2001).

 NAFCI in South Africa was developed to provide public health service managers and providers with a practical, achievable self audit and external assessment process to improve the quality of adolescent health services at the primary care level, and to strengthen the public sector’s ability to respond appropriately to adolescent health needs (Dickson-Tetteh, Pettifor, Moleko, 2001).

Although the principles and approaches of Lovelife and Y-Centers are well documented, the variations in program implementation depend on the resources and processes in a particular center, and the extent to which the center adheres to the principles of the parent program. It was for that reason that this study was conducted, to assess the impact of the Odi Y-Center, in the context of its resources and operations.

# CHAPTER 3

# METHODOLOGY

## Research Setting

This study was conducted at Mabopane, which is a township situated about 30 km from the city of Pretoria. The township consists of several sections, including pockets of informal settlements. It is neighboring Soshanguve, which is the largest township in Pretoria and has its fair share of informal settlements. Young people in Mabopane face challenges that are common to challenges facing other young people in South Africa, including the challenge to instill responsible sexual behaviour.

Mabopane has several recreational facilities and activities which do not necessarily share the philosophy of the Y-Center. The Odi Youth Centre is the focus of this study because it is supposed to operate according to the philosophy of Lovelife and Y-Centers and it specifically focuses on sexual behavior and HIV among the youth. It is the only one in this vicinity and serves youth from the various sections of Mabopane, including neighboring Soshanguve. Although the Y centre is the study setting, the study also included Tlamelong clinic because it is the adolescent friendly clinic supporting the Odi Y-Center, and for all practical intents and purposes, the Y-Center and the clinic are one entity because of the close working relationship between them, as well as the fact that the two refer patients between them. The study also included learners of Pelotona middle school because the school has a formal relationship with Odi Y-center, and utilizes the services of the Y Center on a regular basis, often being referred to the center by the teachers.

### Odi Youth Centre

The Odi Youth Centre is in the same premises with Tlamelong clinic in Mabopane, even though they are separate buildings. The Centre offers all the services according to the philosophy of Lovelife Y-centers, i.e. sexual health education, HIV/AIDS education, family planning, treatment of STI’s, pregnancy testing, counseling, and life skills. The Centre also offers the following recreational activities: football, basketball, aerobics, drama, township dance, indigenous games and poetry. The Centre is currently working towards being a NAFCI site. The above mentioned setting was used to interview professionals and groundbreakers because they could easily be accessed there.

###

### Pelotona Middle school

Pelotona is a middle school adjacent to Odi Y center. It serves learners from grade seven (7) to nine (9), who are mostly between the ages of 12 and 16, and thus fall within the age groups who are the interest of the Y centers. Pelotona was included for the evaluation because the school has a formal relationship with Odi Y-center. The learners of the school utilize the services of Odi Y Center. In the school premises, Groundbreakers also work with the youth for their interventions, which has resulted in the school being regarded as an integral part of the Y Center. It was thus appropriate to access the learners for their views of the Odi Youth Center, which is the second objective of the study. The school was also included because the Groundbreakers (the youth component of the Lovelife program) would participate in organizing the participant-groups ready for focus group discussion, as they already have a relationship with the learners. Lastly, the middle school was used because the learners would be readily accessible for the study.

## Study design

This was an evaluative descriptive study using a qualitative research method. For process evaluation, in-depth interviews were conducted among the staff, Groundbreakers and volunteers working in the Y-Centre. For impact evaluation, focus groups were conducted among the youth participants. Process evaluation was used to determine the implementation process followed for the programs while impact evaluation was used to determine the impact the program has on the youth utilizing the services of the center.

### Evaluation model/framework

The study used the goal-based model approach because the objectives/goals of the centre were known and used as a standard for the evaluation. Questions were structured to find out if the program implementation was done according to plan, and whether the program achieved what it set out to do.

To evaluate the impact of the centre on the youth, focus groups were conducted among the users of the services, being the youth themselves. A posttest-only design was used because the program was already running and no pre-testing was conducted The participants were the youth who have been committed to the activities of the centre for at least three months and the same participants are exposed to the school program done by the Groundbreakers. A questionnaire was used to collect demographic data among the youth and the staff.

###

### Study population

The study population consisted of service providers as well as service recipients of the Odi Youth Centre. They are the project manager, a clinical nurse, and the CLO (Community Liaison Officer). The team has added 2 HIV/AIDS counselors from lifeline trained by PPASA and 2 groundbreakers from Lovelife. Volunteers who are also called *Mpintsi’s* assist the groundbreakers with implementing the programs.

Service recipients were young people who utilized services of the center.

### Sample Size

The sample size was determined by data saturation point in the focus groups which were conducted with the youth participants. In-depth interviews were conducted with all Nine (8) service providers (1 manager, clinical nurse, CLO, lifeline councilor, 2 groundbreakers and 2 volunteers), to evaluate the implementation process of the service.

**Inclusion criteria**

* Staff and volunteers: Professional staff members of Odi Youth Centre, Groundbreakers and volunteers. Staff members and volunteers have to be working in the Odi Youth Centre for a minimum of six months to be included in the study, and all 8 staff members met this criterion.
* Young people who have been utilizing the services of the centre for at least three months prior to data collection, which include learners from Pelotona.

**Exclusion Criteria**

All new clients or visitors to the centre and youth who utilized the services for less than 3 months were excluded from the study.

###

### Participation recruitment

The researcher sent a letter of request to conduct the study at the Y-Centre manager, followed by a verbal discussion about the study.

**Recruitment of staff**

The researcher requested the centre manager to explain the study to the staff members and request their participation. Members who agreed to participate, signed consent forms and were included in the study.

**Recruitment of youth**

The researcher requested the centre manager to assemble the youth who had come for centre activities and were of consenting age, following which the researcher explained the study to the youth and requested their participation. All who consented to participate were then included in the focus group discussions.

The learners at Pelotona middle school were recruited through the principal, who sent letters to their parents. Learners whose parents consented for their children to participate were then recruited to participate in the study.

### Data collection

**Participants**

Permission to run focus group discussion on the school premises was asked and granted by the principal. Learners whose parents consented and they (learners) assented to participate in the focus group discussions were put in groups of 8 for the focus groups. The groups consisted of both males and females. The life orientation period was used for the focus group discussions and permission to release the participating learners was obtained from the concerned life orientation teachers. Groundbreakers helped in grouping the learners in groups of eight and arranging chairs in the room which was provided. The researcher facilitated the group discussion and the research assistant was responsible for tape recording and the logistics of confirming obtaining consent and assent procedures. The focus group discussions were held one at a time and a total of eight group discussions were conducted. To encourage participation, all learners were requested to respond to at least one question during the FGD. The sessions of the focus groups were about an hour each.

**Staff**

Staff members were individually interviewed at the youth centre. The interviews started with the groundbreakers, which was followed by the volunteers. Groundbreakers and volunteers were interviewed in the hall they use for activities. The professionals were interviewed in an office which was conducive for an interview.

Data was collected through audio-recorders and was later transcribed. The participants used both Sesotho and English. Field notes were taken to compliment the interviews.

###

### Data analysis

Thematic content analysis was used for both the in-depth interviews and focus group discussions. Content analysis resulted in themes which resulted in the following sub-headings: Training, support, equipment, working hours, these was used for in-depth interviews. For focus groups the following themes emerged: HIV/AIDS education, Sexual health, life skills, Physical activities and drama and dance.

### Ethical considerations

1. The proposal was approved by Research, Ethics and Publications Committee (REPC) of the National School of Public Health (Project number NSPH/ST/2006/06)
2. Permission to conduct the study was obtained from the North West Department of Health, who are the custodian of health services in the North West Province
3. Permission to conduct the study was obtained from the management of the Odi Youth center
4. Permission was also obtained from Pelotona Middle School
5. Informed consent was obtained from all staff members who participated in the study
6. Informed consent was obtained from all youth who participated in the study
7. Assent was obtained from all learners who participated in the study

# CHAPTER 4: RESULTS

**Introduction**

 The results of the study were compiled from the focus group discussions conducted with the youth who utilize the Odi Y-center and the interviews conducted with the staff (manager, professional nurses etc) of the center, as well as Groundbreakers and volunteers.

**Demographics**

The centre is more attended by males than females. The reason could be that boys are more into the activities offered at the center, which includes basketball, football, drama, centre stage and dance. These activities are not inclined towards girls. It may also be that girls have more home responsibilities and chores than boys do. The age range of young people coming to the centre is 13-20 years. Most of the youth attending the centre are from the vicinity of the Clinic/Centre and are school-going.

The Groundbreakers and the volunteers consist of both females and males who have completed matric. Matric qualification is a criterion for becoming a Groundbreaker. Their age ranges from nineteen to twenty-four years, and most live within the vicinity of the center.

The staff of the centre includes three females and a male. They are all below 40-years of age. The manager of the centre and the clinical nurse are both professional nurses, while the third member is a female trained HIV/AIDS counselor. The only male person is the community liaison officer. The two HIV counselors are female and above the age of thirty and they also live around the Clinic vicinity.

### The program implementation process of the centre

The centre was adopted from a non-profit organization called PPASA by the North West Department of Health. A professional nurse in reproductive health services was assigned to manage the program without any formal training of running a centre but was expected to perform the service. Another professional nurse was assigned to be a clinical nurse for the centre without any training in the principles of youth friendly clinics. The counselor was trained by life-line for HIV-AIDS. The CLO is the only person who was trained because he was with the PPASA before the hand-over. The professionals work together with Lovelife groundbreakers and the volunteers without any formal statement of this relationship and this often causes friction between them (e.g. the noise in the centre comes with the package of some activities). Some of the indoor activities are bound to create noise and the professionals sometimes can’t cope with the noise, making the performance of the activities somewhat difficult. They help each other whenever necessary but their relationship is not what an example of how a team should be.

###

### Groundbreakers and Volunteers

The two Groundbreakers were trained for a month by the Lovelife program, while the volunteers were trained by the CLO and the Groundbreakers (train the trainer program) for a week.

 The Groundbreakers stated that they often feel unwelcome, and they attribute that to the fact that they are not on the government’s pay roll, and that they operate from the premises of the clinic, as opposed to their preference of operating from the center. Their sense of belonging can be improved by re-locating their operations to the center, especially because they were trained and remunerated by Lovelife/Y-centers, and their positions were created to support the Lovelife program.

Operating from the clinic also places a limitation to their operations because when the clinic closes at 4 pm, they are also compelled to cease their services until the following day because the clinic doors are literally locked by the authorized personnel, and they do not have authority to stay behind and use the premises, despite the needs of the youth to use the services beyond the hours dictated by the clinic.

The same operations concerns and views were shared by the volunteers because they, like the Groundbreakers, volunteer to the Lovelife program. Actually both the Groundbreakers and volunteers serve the same clients and have no clinical focus.

The conclusion drawn from the operations is that operating from the clinic is seen as a hindrance by both the Groundbreakers and volunteers.

### Resources available to carry out responsibilities

**Groundbreakers**

 The groundbreakers are provided with facilitators’ manuals, life orientation text books and Lovelife magazines as materials to use for their different programs. They have a TV and some dance and educational visual cassettes, which they use for implementing their services. They improvise with some equipment like DVD players and music systems because there isn’t much provided by the centre. As one of them stated, “We improvise and bring things from home”. The centre does not have a computer, resulting in pieces of paper used for recording and poor record keeping.

**Staff**

The professionals use manuals and refer to policies from the national and provincial Department of Health. In most cases, they use their common sense and what they think is right. “We do not have guidelines or indicators to show us if we are headed in the right direction”. This makes it difficult to enhance their support for the Lovelife/Y-Center program. Family planning and VCT materials are provided for by the Department of Health. Medicines for treatment of STI’s are also adequately available for the conditions they frequently see. However, the discordance limits their ability to support the Y-Center to the maximum.

### Working Hours of the Centre

The centre operates from 8h00 in the morning to 16h00 in the afternoon. Most young people come to the centre after 14h00 (after completing the school sessions), thus have only a limited period to access services of the center. Moreover, the centre is closed on weekends and holidays, thus disabling their access. This is contrary to the principles of youth friendly clinics, which focuses on availing services at times that are suitable to the users. The centre manager, the clinical nurse, the CLO, the counselor, groundbreakers and volunteers expressed a need to have the center open until five to allow more time for those learners who come back later from school, especially those who go to school in town. They also wish it could be opened on Saturdays as it will allow more access for their services.

The groundbreakers also wish they had free access to the center so that they would be able to stay longer at the centre if necessary or come on Saturdays. Currently, only the clinic staff have the keys and are thus allow the privilege of opening the center. The staff at the centre is willing to work on Saturdays. This inability to operate beyond hours dictated by the clinic is one of the factors that make the groundbreakers and volunteers to feel less welcome at the center.

### Program support and support for personal and emotional needs

The support from management is minimal because they do not go out of their way to accommodate needs of the center; neither do they consult them when planning for services. The Y-center staff think that the clinic staff does not view the program as a priority. One of the Y-center staff stated that “the program does not have a budget”, thus making it difficult to plan for program implementation. Another reason could be that management does not know how to be of assistance and support to the center, since they have no direct mandate from provincial offices for this support. This implies that there is no formal communication regarding the relationship and support the Department of Health has with the center. The professionals (manager, clinical nurse and CLO) main complaint is that there is no clear directive from the North West Provincial Department of Health regarding operations standards and indicators for the center. Currently, they feel like they are just supporting a program whose goal they are not clear of. The Centre Manager, the clinical nurse and the CLO find personal and emotional support from each other and outside sources.

Among the Groundbreakers and volunteers, a relationship has been developed and thus they help each other on a personal and informal basis. Whenever one has a problem, whether work-wise or personal, they put efforts to relieve the distress. They counsel each other, especially about the difficulties at work and at home plus they lend each other motivational material/resources to stay encouraged. They seem to have built their own structure and seldom seek help from the centre manager, the clinical nurse or the CLO. “We cannot ask help from them” one groundbreaker said.

###

### Areas of the centre that need improvement

According to the participants, the centre needs to improve on its resources, e.g. obtain basics like computers and the internet, which are imperative for a center that offers services that need to be updated regularly. As the clinical nurse stated, “young people can get information they need quickly and those who are still computer illiterate can learn here”. They also need sound equipment with microphones, which can be used to enhance their poetry, drama and dance.

Groundbreakers and volunteers identified a need for an improved relationship between them and the clinic staff, which will improve the service they offer to their clients. The centre manager, clinical nurse, counselor and the CLO need clinic management to take the program more seriously so that their needs may also be budgeted for. They also feel that they need more staff. Working hours of the Centre should be adjusted to accommodate its clients.

### The impact of the centre on the youth of Mabopane

As stated, the objectives of the youth centre are the following:

1. Reduce HIV among youth
2. Promote healthy and positive lifestyles
3. Develop Life skills

The focus of the study was to assess whether these objectives were being realized at the centre and what impact the operations of the center has had in their lives.

Activities to achieve the objectives were identified as

1. Sexual health and HIV/AIDS education
2. Distribution of condoms, Lovelife magazines and booklets
3. Lovelife games, drama, dance and aerobics
4. Workshops/Life Skills

The second objective was to assess if such activities were conducted at this youth centre, and what impact the centre has on the youth.

The results showed that the centre is used for its intended purpose, which is, a resource for information about health issues and HIV/AIDS, a place for development of talents, which includes physical activities. The centre is a place where they get emotional support and help with their homework, depending on the content of the homework and the level of help needed. The youth learn about their own sexuality, their physical development, STI’s, teenage pregnancy and acquire life skills.

**HIV/AIDS and STI’s**

The youth participants reported that they learn about sexually transmitted infections. They have thus acquired knowledge on specific infections and discharges. They also reported their understanding of specific information on HIV and AIDS, including the various other ways in which it can be transmitted (e.g. from mother to child, through blood transfusion and through coming in contact with infected blood (e.g. sharing infected blades/needles/tattooing and needles/drug injections/ circumcision knives). This knowledge contributes to behaviors that help to reduce HIV infections.

The youth participants know that people who have STIs are at a higher risk of getting HIV. “Your chances of being infected with HIV are higher when you have a STI, because the sores open the way for the virus”, one participant stated. The HIV/AIDS education they get gives the tools to protect themselves and to educate others. They also know how it is not transmitted e.g. “you cannot get it from sharing a cup” and they know about how to care for those who are infected and affected. They know about the different stages of HIV-related diseases, and what is needed at each stage. They also know the different types of HIV tests and prerequisites that are needed before one go through a test “there is pre-test counseling- before the test and post-test counseling- after the results”. They have been taught on how to show compassion to PLWA (people living with AIDS) and on how to show empathy, even reciting the slogan” my friend with AIDS is still my friend”.

Participants have also learned about anti-retroviral treatment. They know about TB and the fact that even though it may be HIV related, it can infect a person who is HIV negative. Participants know that it is curable if one takes the treatment as prescribed. They encourage family and community members to test for TB whenever there are symptoms. Some have already had the opportunity of encouraging family member to take treatment.

 One of the most significant positive impacts of the Y-center is that of availing condoms to the youth, which has a potential impact of reducing HIV infections, if properly and consistently used. Condoms, as well as other materials like books and pamphlets on HIV and AIDS impact positively on users of the center.

The Y center is therefore seen as contributing to promoting healthy and positive life styles (the second objective of the Y center) which also reduces the chances of acquiring HIV, which is the first objective of the Y center. Both the knowledge and life skills that results from participating in the programs and activities of the Y center answers the second objective of this evaluation, which was to evaluate the impact of the Odi Youth-Centre on the youth.

### Sexual Reproductive Health and Sexuality

Participants clearly understand the reproductive system of both boys and girls. They know that onset of menstruation signifies that a girl is capable of falling pregnant. Learners have learned about terms such as masturbation and what they mean. They also understand what sexual intercourse is and have an understanding of what happens when this very act becomes rape. They understand what terms like homosexual and heterosexual mean, e.g. “Gay or lesbian means a guy that likes guys or a girl that likes girls”. This increase in knowledge supports the first objective of the Y-Centers, i.e. that of reducing HIV among the youth.

**Teenage pregnancy**

Participants have learned about safer sex practices, contraceptives and the consequences of teenage pregnancy. The consequences of teenage pregnancy for a girl include; disruption of education and career goal, fewer job opportunities, isolation from friends, choices in all aspects of life are restricted and you will be unprepared and immature to care for a child. The consequences for boys include; they are often blamed, seen as the guilty party and have to deal with a lot of anger from families, educational and occupational opportunities are decreased, often not included in the choice of option regarding the child, experience resentment and guilt, has no legal right regarding the mother and child, and relationship with families are often characterized by conflicts. Options available for teenage pregnant girls are abortion, marriage, adoption, single parenthood and fostering. Many of the participants communicated ambitions for education, to travel the world, get married then have children. This confirms the impact of the center in reducing teenage pregnancy.

**Life skills**

Health behaviour practitioners have agreed that information is not enough to make young people act. They also need to develop “life skills” – the attitudes and negotiating capacity to put what they know into practice and to make informed choices about sex drugs and other issues. The life skills program gives them skills to handle peer pressure and to make good decisions. Their self-esteem has gone up because they have learned through the lessons to assert themselves and to value who they are, they are unique and there is no one else like them in whole world. Affirmations (positive self-statements that are repeated several times a day to create a powerful and positive mindset) actually helped them to change the way they think about themselves. For example ‘I’m great, I’m strong and worthy of success” helps them to act that way. They are able to assert themselves and will not be talked into drinking alcohol, doing drugs or having sex when they are not ready. The results from the focus group confirmed that the Y center program does increase the skills and ability to take decisions about their behaviour, an important skill for decision making in sexual behavior.

Their communication has also improved and they are more skilled in communicating their needs to their parents. Few participants reported that they are more comfortable in talking to their parents about issues they would normally not talk about. They are no longer shy to stand in front of a crowd and they have learned debating skills and public speaking skills, “I am now able to talk in front of my classmates”.

Participants have learned more about sexual abuse. They have learned how to say “No” in a more confident way that will not send wrong signals. They know that the body, facial expression, hands and arms should support the message of “absolutely not”. The youth also use the centre as a place where they can be helped with their homework and a place where they can find a neutral person to intervene whenever there is a dispute between them and their parents.

**Drama and dance**

**Drama**

 Drama and dance give them a chance to discover and groom their talents. The centre has a professional way of taking their talent to another level. Every activity has a name and rules.

 ***Improvisation*** is acting in a pretend world, in a specific situation and reacting to the moment truthfully and imaginatively. No one tells you what to say, you just make it up on the spot. During this, they can find out whose imagination is wild and whose is fast.

**Waking up in someone else’s shoes.** Players imagine they are putting on someone else’s shoes (e.g. doctor, gangster, dancer) and walk in them. They stand like the character, walk and act like it. After this they change and put on another character. All this is evaluated to see if it is interesting, if the players work well together, if they use the space of their stage and if the scene has an important message. These things they would not learn if they were just doing dramas on their own.

**Dance**

Dance includes Kwaito and hip hop. They have dance manuals which instruct them on how to dance. They believe this has dramatically improved their dancing because it is at a level of choreography. Some of them aspire to become choreographers while others aspire to become actors.

These above activities are mostly favored because they do not require much equipment.

**Sports**

The youth enjoy the Lovelife games which give them the opportunity to compete outside their hometowns to see other places and meet new people “I have visited places I never knew through the Lovelife games”. The sport they play at the Centre is not only the normal football and netball they play at school, thus they get the opportunity to learn other games (e.g. basket ball). They particularly like basketball and football.

Others use the sports to keep physically fit while others use this opportunity to lose weight “I have lost some weight since I started playing soccer at the centre”. Some really believe that this is where their talent will be spotted and it will take them to greater heights (e.g. being part of the South African soccer team in the future). Others have mentioned that they love the sports because it is during these games that they are offered food.

Sport is another good reason that keeps young people out of the streets.

# CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

### Discussion

Youth centers have shown to be of service to the youth in a variety of ways. Because of their nature, they are expected to be multi-purposed, thus address various needs of young people in their respective areas. These centers serve as counseling unit to the youth who lack services of social workers and psychologists. The youth are more comfortable to talk to groundbreaker about their problems and challenges. In an assessment of Youth Centers in South Africa the youth found peer educators respectful, friendly and sympathetic. In order for the youth centers to function efficiently to meet these needs, they have to have adequate material and human resources for this purpose.

 The Centre serves as resource or information centre for learners who do not have help with their homework at home, even though they feel that computers and internet could be of greater help. The center is a more liberal environment where the youth feel free to learn about their sexuality, sexual health and HIV/AIDS. Again they are at a place where they explore and groom their talents. This keeps them away from the streets and hanging out at shops.

The uncoordinated collaboration of government and Lovelife to rescue the youth centers in North West province has serious managerial problems. The top management of Love life and that of the provincial government have no relationship at all. Government has no budget for the youth centers and its services thus it is hard to make improvements where they are needed. This shows that there was no planning at all in implementing the service.

The fact that the clinic staff was not specially trained to work in a youth centre, and that ergonomics were not considered and aligned to meet the functioning of the center, e.g. the noise results in performing some of the activities in the centre makes it difficult to cope and poses some challenges for implementation of the program. Special training for the staff of the centre would also help in understanding the principles behind youth centre services, keeping in mind that the professionals have no indicators to guide them but working with whatever information they come across as health professionals. The often unhealthy relationship between groundbreakers and the professionals is not helping the services. It would be easier if they had the same directive or one neutral person who was able to address their problems. Both the government employees and the groundbreakers agree that the operating hours are not convenient for their clients and Saturday should also be used to accommodate other clients. In an assessment of youth centers in South Africa a similar trend was seen, where Lovelife clinics peak attendance was between three and four o’ clock in the afternoon, which roughly coincides with after- school hours (Erulkar et al, 2001). Discussion on opening hours has been raised with the possibility of the Odi Youth center staying open later in the afternoon.

**Impact on youth**

Young people’s self esteem is affected in a positive way that one wonders where these young people would get these life skills if it was not for the centre. . “Life skills” empowers young people to practice safer sex, postpone sexual activity and limit the number of their sexual partners through the social interpersonal skills they have learned to make informed decisions (UNICEF 2002). Most participants report that they are able to assert themselves in relationships and are able to say “NO” if they do not want something.

 The centre has also given them communication skills which they would otherwise not have. Communication with parents is easier and more open. Young people have a privilege of inviting someone from the centre to intervene whenever there is a dispute between them and their parents.

Their talent is groomed more professionally because at the centre things are done according to standard guidelines. Groundbreakers get an opportunity to acquire skills in this one year contract; if it was not for this program most of them would be sitting at home because they have no funds to further their studies. It is truly much better for youth to keep busy at the centre with sports, music, drama etc. than to be gallivanting on the streets, smoking drugs, drinking and getting up to all sorts of mischief. Teenage pregnancy can really be curbed by the education they get from the centre. The knowledge they acquire about HIV/AIDS if put to practice can curb the spread of HIV/AIDS.

A similar trend that was seen in an Assessment of Youth Centers in South Africa (Erulkar et al, 2001) is seen in this study where more boys visit the centre than girls; is also identified in this study. Repeat visitors were more likely to be male, young and attending school. On average male visitors to the youth centers had paid four visits to the centre in the previous week, compared to girls’ two visits. The study also confirms the results of Erulkar et al, 2001 which showed that the repeat visitors were more likely to come to the centers for sports or recreation, compared to the other services offered at the centers. In this study a few participants mentioned that they mostly come to the centre for recreation and most of them are still attending school.

As was mentioned in an assessment of youth centers in South Africa, Centers should not lose sight of their health objectives. Programs should have ongoing monitoring of the numbers and profiles of young men and women reached with health inputs. In this study most data which was captured is that of clinical intervention; e.g. a register which includes profiles of those who attended VCT, those who came for family planning and those who came for diagnosis and treatment of STI’s. A register of Sexual Reproductive Health Education, HIV/AIDS workshops and life skills programs is not kept, thus we do not know the numbers and profiles of those who are impacted with these interventions.

Despite the shortage of equipment and other things, the centre is fully functional. The staff and groundbreakers improvise and do modest activities which require little. This is what was found when assessing other youth centers in South Africa. The centers offered somewhat modest recreational services such as board games, drama and dance (Erulkar, et al, 2001).

### Conclusions

Youth Centers have the ability to keep the youth out of the streets, to educate them about HIV/AIDS, STI’s, teenage pregnancy, sexuality and sexual health education. This is the best opportunity to inculcate in them the dream of a better future and to avert the chances of HIV infection. Lessons and behavior learned at this stage will be carried to adulthood.

 The life skills they acquire from the youth centre are invaluable. Youth have testified how it would be missed if it were taken away from them. Even though the centre is not perfect and has lack of equipment and other resources, it is still serving its purpose to a certain degree. The service definitely needs to be extended to surrounding areas to make it more accessible to most youth. Intervention is needed at operational level between government employees and NGO employees and a lot of work has to be done at national and provincial level to manage youth Centers.

### Recommendations

Based on the stated findings, the related recommendations emerge from the study:

1. Finding: Youth centre employees (Centre manager, clinical nurse and the counselor) were not specifically trained for the Y-center and are therefore not providing maximum support for the center.
	1. Recommendation: Training of Centre employees: This is in line with the suggestion made on the White Paper on National Youth Service Program (NYSP) under staff criteria, Youth Workers require specialist competencies depending on the nature of the service, and should receive appropriate training from accredited organizations. In some cases the Youth Workers will be enrolled in a skills program or learnership and undertake the management work as part of their work experience.
2. Finding: No measures are in place to monitor numbers and profiles of young people reached with non clinical health inputs (sexual health education, HIV/AIDS education and life skills). The monitoring and evaluation of the center is therefore not adequately done, making it impossible to motivate for further assistance like funds or material.
	1. Recommendation**:** Monitoring and evaluation of every activity in the centre. This is in line with the National Youth Service Implementation Plan, which states that there should be a clear monitoring and evaluation framework that focuses on the achievements of different targets (whether the targets of the national youth service program are being achieved).

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# APPENDICES

## Appendix A: Data collection tool for process Evaluation (staff and volunteers)

My name is Matshingwana Mokabane, thank you for agreeing to participate in this interview, which is aimed at finding your views about how the centre functions. Because you have been involved in implementing the services at the centre, I need your help to assess the process of the implementation of the service of the Y-Centre, and the method I am using requires that you use your own words to express your views. The information I will gather will help in improving the implementation process of services so that improvements can be made if needed and that services can yield the expected results. You are requested to respond openly without worrying about what your colleague will think about your response. Your responses will be kept confidential and your name will not be linked to any part of the report.

1. What position do you hold and what are your specific responsibilities in the Centre?
2. How much training (specific to the needs of the centre) were you exposed to, as a preparation to your role in the Centre?
3. What resources are available to support you in your responsibilities? Do you consider the resources adequate for what is expected of you?
4. What other responsibilities do you have (other than services you offer in the centre)?
5. What support is available for your personal/emotional needs? Is the support adequate?
6. In what areas do you think the centre needs to improve in order to serve the clients well?
7. What are the normal working hours of the Centre and what are the views regarding the appropriateness of these hours?
8. What measures are put in place to monitor the performance of the centre, and what are your views about those measure?
9. Do you have any other information that you want to share regarding the functioning of this Centre?

## Appendix B: Data collection tool for impact evaluation (youth participants)

My name is Matshingwana Mokabane, thank you for agreeing to participate in this discussion, which is aimed at finding your views and perceptions about the Y-Centre. Because you have used the services and activities offered at this Centre for some time, I need your help in assessing how the centre has impacted on your life. For that purpose, I am going to request you to participate in this group discussion, in which you will respond to a number of questions. The information I will gather will be used to make suggestions on how to improve the services of the Y-Centre so that it can serve the youth in this area in a better way. The questions I will be asking you are about your views regarding the Centre; therefore there is no right or wrong answer. You are therefore requested to respond in an open manner and state your views without feeling pressured to say what another person expects you to say.

1. What are your views regarding the need for a centre as this one?
2. What do young people in this area use the Centre for?
3. What other services are available for youths in this area and how different are the services that are offered in this area?
4. What are the most useful and interesting aspects of this centre?
5. How has the centre helped to address issues that are challenging to young people in this area? Give examples
6. How has the centre helped to respond to needs of young people in this area? Give examples
7. What are the most valuable lessons that you have learnt by utilizing the services of this centre?
8. How has this centre changed your life and the lives of other young people in this area?
9. If this centre was to be closed, what will be missed most about it?
10. Do you have any other information that you want to share regarding how this centre has influenced you in any way?

##

## Appendix C: Demographic Questionnaire

1. Full name
2. Age
3. Gender
4. Is your home around the vicinity of the Centre? If not How far is it?

## Appendix D: Informed consent

**Title of the study**

**Process and impact evaluation of Lovelife Y-Centre at Tlamelong Clinic in Mabopane**

This study aims to evaluate the process which was involved in implementing the ODI Youth centre and the impact it has had in the youth of Mabopane.

* I confirm that I have read and understood the study and the questions I raised have been answered
* I understand that my participation is voluntary and that I am free

To withdraw at any time without giving a reason and without my rights

Being affected in any way

* I understand that the researchers will hold all information and data

Collected securely and in confidence, and that my name will not be linked to any information related to this study

* I freely agree to take part in the study

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Name of Subject Signature Date

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Name of researcher Signature Date

## Appendix E: Letter of permission

 Ellen Mokabane

 Kgabo Clinic

 Winterveldt

To: Ms Manne

 Odi Sub- District office

 Private bag X509

 Mabopane

 0159

Dear Madam

Re: Request to conduct a study in Tlamelong Clinic

I am Matshingwana Ellen Mokabane, a dental therapist in the Odi- sub district stationed at Kgabo Clinic, studying for a Masters in Public Health.

I hereby request to conduct a study at the Odi Youth- Centre. The study will involve evaluating the impact the Centre has on the youth in this area and the process involved in the functioning of the centre. The recommendations of the study will help the Centre to review its services and make changes wherever necessary. Attached is the protocol of the study, which has been approved by the ethics committee at the University of Limpopo Medunsa Campus. The project number is NSPH/ST/2006/06.

I hope that the request will be granted.

Yours truly,

Matshingwana Mokabane

Cc. A.D. CHS. (Community Health Services)

 Y-Centre Manager