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TITLE **The Supply and Demand perspective of Barriers to and
Facilitators of Health service utilisation by young people in
Swaziland**

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MONTH **December**

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DECLARATION

I, **Lungelo Vukile Bhembe** declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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ABSTRACT

Introduction – The country’s health care response system is organised in a four-tiered level to facilitate service utilisation by all those who need health services. Despite the health services being taken to the people and implementing deliberate efforts to increase health services utilisation, the utilisation of health services by young people has remained minimal. Accompanied by the high disease burden especially sexual and reproductive health related, the young people’s poor health seeking behaviour compromise their quality of life. The multiplier effect of that is the reduced chances for the country to reap the demographic dividend implied by the high numbers of young people.

Aim – The aim of this study was to examine the factors that either prohibits or facilitates the use of health services by young people from the supply and demand perspective. This was achieved through identifying the supply and demand barriers and facilitators for young people service utilisation. Alongside, the different effects of supply and demand factors on the utilisation of health services by young people were to be studied.

Methods - Nine focus group discussions were conducted, three with Peer Educators; three with potential service users; and three with facility outreach workers. Seven key informants were interviewed and they were drawn from government, parastatals and development partners. Ten one – on – one interviews with service providers from involved health facilities were also conducted. The data was analysed through the directed content analysis approach from the constructivist paradigm.

Results – The socio-cultural beliefs, practices and norms which are facilitated through the limited community stakeholder engagement prohibits the young people from making the initial visit to the health facilities. These socio-cultural practices, beliefs and norms in the community also influence the health facility environment which in turn have a potential to exacerbate stigma and discrimination at the health facility and community level. Creating a conducive environment for stigma and discrimination at the health facility is the absence of adolescent and youth friendly health service policy and the current service delivery system employed at the health facility. The lack and presence of youth friendliness amongst service providers was identified as both a barrier and a facilitator of service utilisation by young people, respectively. Reported to be determined by age, sex and qualification of service provider, youth friendliness was also defined differently by young people and the technical and professional sector. However, distance to health facility and costs attached to service utilisation were not identified as barriers to service utilisation in this study.

Conclusion – Service utilisation by young people is an interplay of the supply and demand factors where the demand factors mainly affect the initial use of the health services whilst supply factors affect the subsequent use of health services. However, not all factors are equally influential to service utilisation, some factors are more influential compared to others.

ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
AMICAALL	:	Alliance of Mayors Initiatives to Combat AIDS at Local Level
ANC	:	Ante Natal Care
ARO	:	Africa Regional Office
ART	:	Anti-Retroviral Therapy
ASRH	:	Adolescent Sexual and Reproductive Health
AYFHS	:	Adolescent Youth Friendly Health Services
CMIS	:	Client Management Information System
CSE	:	Comprehensive Sexuality Education
CSO	:	Central Statistics Office
CSOs	:	Civil Society Organisations
CSW	:	Commercial Sex Worker
DD	:	Demographic Dividend
EFA	:	Education for All
ESA	:	East and Southern Africa
ESARO	:	East and Southern Africa Regional Office

FGDs	:	Focus Group Discussions
FLAS	:	Family Life Association of Swaziland
FP	:	Family Planning
FPE	:	Free Primary Education
GBV	:	Gender Based Violence
GNP+	:	Global Network of People Living with HIV
HIV	:	Human Immune Virus
HCW	:	Health Care Workers
HMIS	:	Health Management Information System
HTC	:	HIV Testing and Counselling
ICPD	:	International Conference on Population and Development
ICW	:	International Community of Women Living with HIV/AIDS
IPPF	:	International Planned Parenthood Federation
IUD	:	Inter Uterine Device
LLAPLA	:	Lifelong ART for Pregnant and Lactating women
LGBTI	:	Lesbian, Gay, Bisexual, Transgender, Intersex
MoH	:	Ministry of Health
MoSCYA	:	Ministry of Sports Culture and Youth Affairs

MM	:	Maternal Mortality
MC	:	Male Circumcision
NGOs	:	Non-Governmental Organisations
NGP	:	National Gender Policy
NHPP	:	National HIV Prevention Policy
NHSSP	:	National Health Sector Strategic Plan
NSRHP	:	National Sexual and Reproductive Health Plan
NYP	:	National Youth Policy
PMTCT	:	Prevention of Mother to Child Transmission
PRSAP	:	Poverty Reduction Strategy Action Plan
PNC	:	Post Natal Care
RHM	:	Rural Health Motivators
SRH	:	Sexual and Reproductive Health
SDGs	:	Sustainable Development Goals
SBC	:	Social and Behaviour Change Communication
SSA	:	Sub Saharan Africa
STIs	:	Sexually Transmitted Infections
SDPs	:	Service Delivery Points

SETSP	:	Swaziland Education and Training Sector Policy
SOPs	:	Standard Operating Procedures
TB	:	Tuberculosis
UNAIDS	:	United Nations Programme on HIV/AIDS
UNESCO	:	United Nations Education and Scientific and Cultural Organization
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Education Fund
WHO	:	World Health Organization
YFHS	:	Youth Friendly Health Services
YFRHS	:	Youth Friendly Reproductive Health Services
YP	:	Young People
YPLHIV	:	Young People Living with HIV

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CHAPTER 1: BACKGROUND

Introduction

The national health care delivery response to the general health needs of the population is through a four-level service delivery system (Ministry of Health (MoH), 2013a). This set up reflects the ambitions and goals of the national health sector which is ensuring high quality, accessible, relevant, affordable, equitable and socially accepted health services to all people in the country. The first level is community - based services which are provided by healthcare workers based in the communities and these services include rural health motivators. The second level of the national system is made up of primary health care clinics and public health units as well as outreach services. The health centers and regional referral hospitals make up the third level of the national health care delivery system; and the fourth level is made up of the national referral hospital and specialized health facilities (MoH, 2013a). By definition, health clinics are health facilities that provide both curative and preventive as well as maternal and child health services to the population whilst public health units are primary health care facilities providing mainly immunizations, management of Sexually transmitted infections and maternal and child health services (MoH, 2013a). MoH (2013a) further define public health centers as low capacity hospitals which receive clients from clinics and communities.

In 2007, about 85% of the national population was residing within an eight-kilometer (Km) radius of a health facility, which is 3km above the World Health Organization (WHO) recommended distance from a health facility (MoH, 2007). Furthermore, the MoH (2013a) reports that there are 287 health facilities in the country which, given the current national population estimates of 1.1

million people, implies less than 4000 people per health facility in the country. It is important to note that despite the documented increase in the number of the health facilities in the country from 2006 to date, the distribution has remained in favor of the urban areas yet the population distribution is skewed towards rural areas (MoH, 2013a & Ministry of Sports Culture and Youth Affairs (MoSCYA) and UNFPA, 2016). Despite the above, it is evident that services have been taken to the people. Whilst the services are to greater extent distributed across the country, they are also pitched to appeal to all people regardless of social and economic as well as demographic characteristics. This is despite the age and sex distribution of the country's population where 52% are females and 52% are aged less than 20 years.

The age distribution of the population in the country combined with the disease burden, which is largely dominated by communicable diseases, specifically Human Immune Virus (HIV) and Tuberculosis (TB), compels for reorienting the health care delivery system to focus more on young people rather than just being general as it is currently. Also underscoring the need for making health care delivery system appeal more to young people is the issue of the demographic dividend (DD) which basically can be harnessed through increased investments on health and education mainly (UNFPA, 2015). Largely, the United Nations Population Fund (UNFPA) argues that harnessing the demographic dividend depends mainly on investing in the sexual and reproductive health (SRH) and education issues of young people. According to UNFPA (2015), these will ensure that young people are empowered with the requisite tools and skills necessary to navigate their transition into adulthood whilst also empowering them to be active citizens in their country's development. Primary to harnessing the demographic dividend, therefore, is access to and the utilisation of health services by young people as well as the provision of comprehensive sexuality information to young people.

Rationale

The combination of hormonal, physical, mental and emotional changes during the adolescence stage in life has rendered it the trickiest to navigate. This stage is also a transition stage to adulthood from childhood which implies that the young person is neither here nor there (UNICEF, 2011). UNICEF (2011) further states that the transition into adulthood sets the trajectory for the quality of life that the individual is set to take. Besides attempting to adapt to their physical changes, young people have to contend with the need to be accepted by their peers, the search for their own sense of identity and the exploration of the position they will assume in society (UNFPA, 2014). It is thus imperative that this transition be as smooth as possible, especially in terms of SRH, in order to ensure that adolescents and young people have all the tools necessary in their search for themselves and their future lives.

The majority of the Swazi population is either in the adolescence stage or yet to begin the stage given that the median age of the Swazi population is 19.8 years (Central Statistics Office (CSO), 2011). This median age implies that Swaziland is one of the young population countries of the world. Due to the changes mentioned above, young people in the adolescence and youth stages face serious life-threatening challenges. Some of the challenges they face include early sexual debut, unprotected sex, inter and cross - generational sex, transactional sex, sexual and gender based violence (GBV), HIV infection, teenage pregnancies, maternal mortality, unsafe abortions and substance abuse (United Nations International Children's Emergency Fund (UNICEF), 2015). UNICEF and CSO (2014) further states that the median age for sexual debut in the country is 19 and 17 years for boys and girls, respectively. By the age of 18, about two thirds (67%) of young girls have already engaged in sexual intercourse and around half of the boys, 48%, have had the same experience (UNICEF, 2015).

Although the median age for first marriage is 24 years, 11% of females and 2% of males are married by age 18 (UNICEF & CSO, 2014). It should not go unnoticed that girls are involved earlier in sexual relationships than their male counterparts. With such high rates of sexual activity amongst them, it naturally follows that childbearing has become a common part of young girls lives. In 2010, about 25% of Swaziland's 33 000 annual deliveries were by adolescents and 27% of all Ante Natal Care (ANC) clients living with HIV were also adolescents (CSO, 2010). Due to early pregnancies which most of the time are unwanted by the young girls, the girls resort to abortion (MoH, 2013). However, given that abortion services in the country are permitted under certain circumstances and for one to utilise the service there is need for approval by a medical doctor, the available form of abortion to the young girls is unsafe abortion which also results to maternal mortality (MoH, 2013).

HIV and Acquired Immune Deficiency Syndrome (AIDS) is certainly the most notable of the SRH challenges encountered not only by young people but by all age groups in the country. Amongst other drivers is the lack of information on HIV where comprehensive HIV knowledge stands at 50.9% for males and 49.1% for females (UNICEF & CSO, 2014). In this respect, females certainly are at a disadvantage as UNICEF & CSO, (2014) states that only 54% of females reported having used condoms during their last high risk sexual encounter compared to 70% of males. Furthermore, 7% of females between the ages of 15 – 29 have readily admitted to having sexual intercourse with a man 10 years their senior (UNICEF, 2015).

With reference to education, education is a fundamental right for all school going age individuals in the country and the primary school enrolment in Swaziland is relatively high (Ministry of Education and Training (MoET), 2013). The government has thus signed the Education for All (EFA), Millennium Declaration as well as the Sustainable Development Goals (SDGs) which all

include quality education as a key element of development for Swaziland. As a result, the government has committed herself to providing Free Primary Education (FPE). However, only 47% of secondary school - aged children are enrolled in school and dropout rates are at 8% for males and 9.4% for females. These are attributed to teenage pregnancies, household chores, human trafficking, affairs and young people, particularly males, having an indifferent and unenthusiastic attitude towards educational attainment, especially in areas reportedly rife with marijuana farming (CSO, 2010). In fact, 41% of females attribute their dropping out to pregnancy and additionally, 33% of girls give birth by age 18 before they complete formal education (UNICEF, 2015)

GBV is another social - ill that plagues the lives of young people in the country (UNICEF 2015). Given the patriarchal society of the Swaziland population, women do not have control over their SRH issues (UNICEF, 2015). It is therefore evident that GBV is a common issue. Not only is it common, it is almost accepted as a social norm as further stated by UNICEF (2015). Evident to these assertions is that almost two fifths of women believe that GBV is justifiable if the man in question is provoked and a quarter of all females have experienced some form of violence in their lifetime (UNICEF, 2015). Furthermore, 28% of girls aged 13 – 18 years have experienced sexual violence (UNICEF, 2015).

In addition to these and other socio-economic challenges, young people face a variety of SRH issues that pose a threat to their smooth transition into adulthood. Young people need access to information that will aid them in making informed decisions about their lives as well as access to comprehensive services. In Swaziland, to a certain extent, youth friendly health services (YFHS) have been provided to young people. One can certainly state that the need to provide such has been recognized by the national government but the efforts to do so have not been seamless and without challenges. Even in instances where YFHS are provided, young people are still reluctant to utilize

the services and this is evinced by the rise in teenage pregnancies, adolescent fertility and HIV infection rates, among others. Further evidence of the limited use of health services by young people in Swaziland is revealed by the MoH (2014) through one of the strategic objectives of the national sexual and reproductive health strategic plan of 2014 to 2018 which is to increase the demand and utilisation of SRH services by young people.

Given the significant contribution of SRH challenges to the burden of disease in the country, there is more need to ensure universal utilisation of SRH services by the general population, but more specifically young people. This is not merely because of their numbers, of which they represent more than a third of the global population and more than half of the Swaziland population, but mainly because young people are the most vulnerable population group to SRH problems and that there is a strong link between SRH problems and poverty as argued by UNFPA (2011). In fact, young women and girls are the face of poverty and HIV, nationally and globally. Despite the need for increased SRH service uptake, there is still a limited comprehensive understanding of the supply and demand framework approach with regards to increasing the utilisation of SRH services by young people.

Numerous studies that seek to understand the barriers to and facilitators of the utilisation and provision of SRH services to young people have been undertaken. However, most of the literature is biased towards one side of the factors yet it is conventionally known that service utilisation is an outcome of the interplay of service supply and demand factors (Measure Evaluation, 2013).

It was evidenced from the literature reviewed for this study mainly, Mbeba, Mkuya, Magembe, Yotham, Mellah, Mkuwa, (2012); Newton – Levinson, Leichliter, Chandra – Mouli, (2016); Geary, Gomez – Olive, Kahn, Tollman, Norris, (2014); Mbeba, Mkuya, Magembe, Yotham, Mellah,

Mkuwa, (2012); Akinyi (2009); Ayehu, Kassaw, Hailu, (2016); Ministry of Sports Culture and Youth Affairs UNFPA (2016); Bayissa, (2017); Sulemana, Mumuni & Badasu (2015); Restless Development, (2012), that most of the research on young people's utilisation of health services focus on either supply or demand of the health services. A limited number of studies focus on both aspects simultaneously and analyse both aspects in the context of the other. Some studies are titled as though both supply and demand factors are addressed yet being biased towards one aspect, either supply or demand of the services. This has resulted in misplaced conclusions which does not necessarily result to the increased utilisation of health services by young people.

The most preferred and studied aspect of young people's utilisation of health services is the supply side which, based on the above listed literature reviewed for this study, focus on access and provision of services. MEASURE Evaluation (2013) argues that they are both, access and provision, associated with the supply side of the framework of health service utilisation. In some instances, despite the studies being titled utilisation, the analysis and conclusion are mainly focused on access and provision and very weak on demand side of the framework.

This study, therefore, seeks to facilitate the adoption of the supply and demand framework approach towards increasing the utilisation of SRH services by young people in the country. This is achieved through ensuring that the barriers to and facilitators of the utilisation of health services by young people are analysed from the supply and demand framework and in the context of both supply and demand of the service utilisation framework. This angle of analysis addresses the shortcoming of Social and behavior change (SBC) frameworks and the socio ecological models which fall short of facilitating and ensuring that certain human behaviors, in relation to service utilisation, and the reasons behind them are understood from the supply and demand framework of service utilisation (MEASURE Evaluation, 2013). Therefore, SBC theoretical models and the

socio ecological models do not contribute much towards comprehensively embracing and implementing the supply and demand framework approach for increasing health service utilisation by young people but mainly focus on social explanations of human behavior. Furthermore, it is worth noting that the use of the SBC frameworks and socio ecological models in studying issues of service utilisation results to focusing more on the demand side and ignores the supply aspect and the influence of economic factors in service utilisation.

Conceptual Framework

Different authors have suggested different frameworks for understanding the utilization of health services by young people. These authors include Engender Health through the supply - demand framework for Health services; Measure Evaluation through the conceptual framework on the pathways through which SRH programs achieve their objectives and conceptual framework on supply and demand as well as utilization of health services; and the World Health Organization (WHO) on the Socio Ecological model. Below, the summary of all the above mentioned four conceptual frameworks are presented. The summaries are then followed by the conceptual framework selected for this particular research study.

Supply - demand framework for Health services by Engender Health

In this framework Engender Health (2014) highlights that supply and demand factors as well as enabling environment factors, in no particular order, act together to ensure the utilization of health services. In fact, this framework postulates that the chronology of demand and supply factors as well as enabling factors is not a factor in ensuring the use of services by the population. Making up the demand factors in this framework are; the individual and family level factors which include knowledge and skill levels and the supply side factors that include the service providers at the

health facility; accountability structures and systems between the health facility and the community and the health facility service delivery systems. Finally, the enabling factors are comprised of policies as well as social and gender norms (Engender Health, 2014).

Pathways through which SRH programs achieve their objectives by Measure Evaluation

This framework draws a clear line between demand and supply factors. It stipulates that social and cultural factors mainly affect demand for health services whilst systems at health facilities mainly affect the supply of health services. This framework clearly stipulates that service utilization is a function of both supply and demand. However, supply issues also influence the demand factors, that is, the supply factors create an enabling environment for people to demand the available health services (MEASURE Evaluation, 2013).

Supply and demand as well as utilization of health services by Measure Evaluation

In this framework Measure evaluation postulates that supply and demand factors are not necessarily linked at the input level, however, the input and process level of the supply side link with the process of demand creation from the demand side. In this case, the argument implied is that demand creation cannot precede supply, supply factors have to be prioritized compared to demand factors. The demand for services is also stated as resulting in the use of services given the availability and accessibility of services (MEASURE Evaluation, 2014).

Socio - Ecological model by WHO

This framework underscores the interplay of factors at the different levels to influence service utilization. These levels are; Individual, relationship, community and societal. The factors and influences from each level are reported not to be functioning in any particular order hence highlighting the importance of addressing issues at all levels simultaneously or concurrently.

However, the framework does not highlight and categorize where the supply and demand factors lie within the levels presented in the model (WHO, 2012).

Evidently, different frameworks present different arguments on the supply and demand of health services. However, based on the original concept of the supply demand framework, from the economics point of view, which states that before a commodity or service can be demanded it should be produced or supplied and subsequent to the production/provision the service should be promoted amongst the consumers. Based on these arguments the conceptual framework adopted for this research study combines the two Measure Evaluation frameworks into one simplified framework presented in figure 1 below.

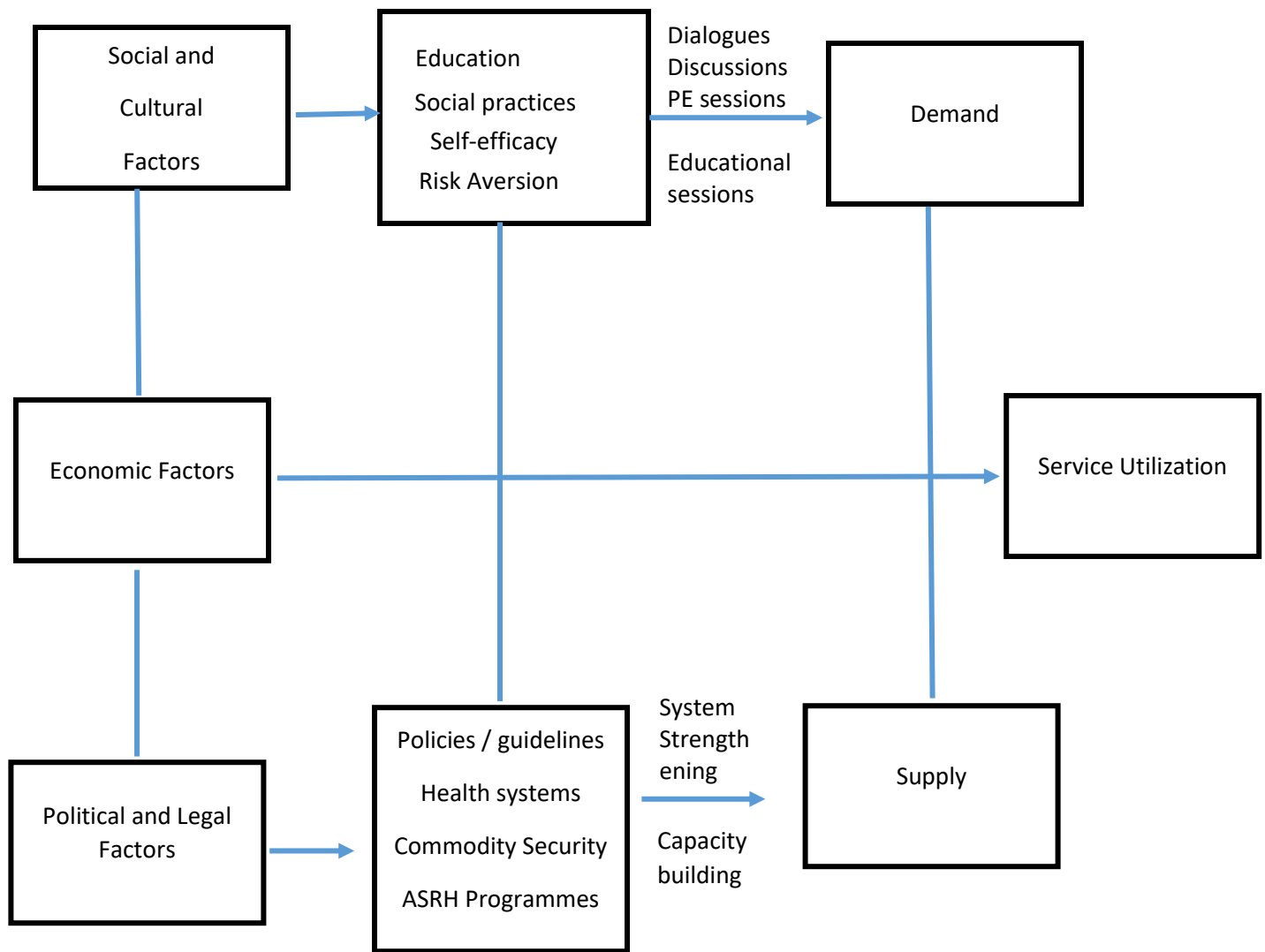


Figure 1: Health Service Supply and Demand Framework (Measure Evaluation, 2013)

The utilization of health services based on the above reviewed frameworks is a function of supply and demand for the services which can also be categorized into three themes, namely, the social and cultural factors; economic factors; and the political and legal factors. The paragraphs below present further insights on the above framework which the research study is based on. This is achieved through unpacking the themes and explaining the different steps in each theme to the service utilization step. Given the cross cutting nature of the economic factors, the relevant economic issues as aligned to each of the two themes will be discussed in each of the themes, that

is, economic issues aligned with social and cultural factors are highlighted and discussed simultaneously with all other factors categorized under the social and cultural factors, similarly for the discussion of political and legal factors.

The social and cultural factors mentioned by Measure Evaluation are; education, poverty, self-efficacy, risk aversion, gender equity, the status and empowerment of women and girls in the society and individual wellness. Policy environment, human and financial resources, interventions being implemented, Quality of Care and gender sensitivity of the programs being implemented are factors mentioned by Measure Evaluation under the political and legal issues affecting or influencing service utilization.

Scope of the Study

The aim of the study is to examine the barriers and facilitators to health service utilisation by young people from the supply and demand framework perspective.

Objectives of the Study

The objectives of the study are the following:

- To identify the supply and demand factors that facilitate the utilisation of health services by young people in the country
- To identify the supply and demand factors that prohibits service utilisation by young people in Swaziland
- To explore how differently supply factors, compared to demand factors, affect health service utilisation by young people in Swaziland.

Expected Outcomes

- A national report outlining the barriers and facilitators to health service utilisation by young people in the country from the supply and demand framework perspective

Research Questions

The principal research question to be addressed by this study is “what are the factors that either positively or negatively affect the utilization of health services by young people in the country?”

To attempt to answer this question, the question has been sub divided into the following sub questions:

- Why do some young people utilize health services whilst other young people do not use the services?
- Do young people appreciate the importance of utilizing health services?
- How differently do supply and demand factors affect the utilisation of Health services by young people?

Structure of the Report

This report is presented in six chapters of which this first chapter is followed by the review of the literature on the barriers and facilitators to health service utilisation by young people aged 10 – 24.

The literature presented in chapter two was drawn from studies in sub Saharan countries and focus is mainly on the critical appraisal of the methodologies utilised by the studies and the conclusions drawn from the findings of the studies. Furthermore, Chapter two of the report presents a critical analysis of the Swaziland Adolescent Sexual and Reproductive Health (ASRH) guidelines from the supply and demand perspective. The third chapter of the report presents the methodology utilised by the study which includes study design and steps employed for analysing the data utilised

in the study. The fourth chapter presents the findings of the study based on the conceptual framework adopted by the study from previous interventions aimed at increasing health service utilisation by young people. The fifth chapter focus on discussing the findings of the study and their implications on health service utilisation by young people in Swaziland. This chapter is concluded by providing recommendations for the health sector in Swaziland to increase the utilisation of health services by young people in the country. Finally, the report, in the sixth chapter, presents the conclusions drawn from the findings of the study.

CHAPTER 2: LITERATURE REVIEW

Introduction

The literature review focused on research methods used in conducting studies similar to the one being conducted; the research outcomes of the studies on barriers and facilitators to SRH service utilization by young people; and the guidelines of Adolescent and Youth Friendly health services (AYFHS). The literature was drawn from sources which include studies on barriers and facilitators to the utilization of youth friendly health services in different countries within the East and southern Africa sub region where Swaziland is located and studies conducted in Asia and Oceania. These studies were supported by organizations known to be leaders in AYFHS, globally. The countries from which the studies were drawn from are; Kenya, South Africa, Tanzania, Ethiopia, Sierra Leone and Swaziland as well as Malaysia and Vanuatu, whilst the institutions which supported the studies involved in the literature are; WHO, Sexual and Reproductive Health Alliance (SRHRA) and UNFPA.

The internet search engines, Google Scholar to be specific, as well as websites of journals and electronic publication databases specifically pub Med and JSTOR were used to source the literature. The search terms that were used when searching for the barriers and facilitators to health service utilization by young people were; barriers for young people's utilization of health services; facilitators for the utilization of health services by young people; barriers and facilitators to the utilization of SRH services by young people in Sub Saharan Africa (SSA). In terms of the studies related to the supply and demand of SRH services, the search terms used were; the supply and

demand framework for health services; the supply and demand for health services in developing countries; and the factors that affect the supply and demand of health care services.

The study's inclusion and exclusion criteria for the literature review was then applied to all the articles that were sourced and those that satisfied the inclusion criteria were reviewed. The inclusion criteria were made up by the following themes; Location; Target Population; Time frame and Focus. In terms of the Location, studies that were included in this literature review were mainly those undertaken in SSA countries. However, one study conducted in Asia and one conducted in Oceania were also included. In terms of the target population, only studies that focused on either males or females or both sexes aged 10 – 24 were included. The criterion on time frame ensured that only studies conducted between 2008 and 2017 were included in the literature whilst the criterion of study focus ensured that only studies that focused on either the barriers or facilitators or both to the utilization of or access to or provision of adolescent and youth friendly health services were included. Furthermore, the literature included in this study had to also have detailed information on methodology and findings.

The criteria outlined above ensured that only the relevant research studies are included in the literature. SSA countries are part of developing countries, however, the population dynamics, social systems and structures, health and economic systems of developing countries are not identical across all developing countries. Young people are mentioned in numerous strategic documents as one of the vulnerable or most at-risk populations given their characteristics which are different from the general population, focusing on studies which targeted mainly young people ensured that only the issues applicable to young people are discussed rather than a broad discussion of all barriers and facilitators which some would not necessarily be relevant to young people. Given that the focus of this literature review includes the research methodology of the different

studies, the outcomes as well as practices in the field of AYFHS, selecting studies with details in the methodology section was imperative.

From the literature search, it was evident that research that seeks to simultaneously understand the barriers to and facilitators of the use of SRH services by young people are not as prevalent as studies that seek to understand either of the two issues separately. In most studies, barriers, and more often specific barriers, to the use of SRH services by young people are studied in isolation, similarly to the facilitators of the utilization of SRH services by young people. It was also evident that some of the studies conducted are not clear whether they are focusing on barriers and or facilitators to SRH access/use/provision whilst some focus on the barriers and facilitators to overall adolescent health program which include information dissemination, service provision and monitoring and evaluation, among others. The studies which focused on access and provision were mainly included because the utilization of SRH services is influenced both by the supply (access and provision) and demand issues, highlighted in the above supply and demand framework by Measure Evaluation (2013).

Another observation drawn from the review of the literature is that a significant proportion of studies are on barriers whilst studies focusing on the facilitators are not as prevalent. There were very limited studies which address both the barriers and the facilitators simultaneously in relation to access, utilization and provision of health services to and by young people. The implication here is that AYFHS are mainly studied from the health service provider and health system point of view, including policies and supply chain issues compared to being studied from all perspectives, including the youth perspective and the end user point of view. As a result, health care systems including commodity security as well as service provision guidelines and health policy documents

are of high quality whilst service utilization by young people has remained at unacceptably low levels.

Key terms in Adolescent and Youth Friendly Health services

The field of AYFHS is dominated by numerous terms, however, the focus for this research is on the most common terms as drawn from the reviewed literature. This section of this chapter focusses on defining these terms and concepts. These terms are access and utilisation, adolescent and youth friendly health services; Integrated SRH services; Sexuality and sexuality education.

Service Access and Utilisation

Service access and service utilisation are two different terms which however are mostly used interchangeably as noted by WHO (2008). WHO further states that in as much as access, utilization, availability and coverage are used to determine whether people are receiving the services they need, access is a much broader term which requires a systematic multi-dimensional approach to understand. Aligned to the WHO observations is the argument of Penchansky and Thomas (1981) that states that in some cases access is defined as the utilization of health services whilst in some other cases access refers to the factors that facilitate utilization. Concurring with Penchansky and Thomas, Barroy, Cortez, Le jean and Wang (2016) present access and utilization in terms of access being the facilitator of utilization and utilization being the product of access, implying that first services should be accessible before they can be utilized.

WHO (2008) further states that service availability, affordability and acceptability are the key terms associated with access. Further considerations of these terms reflect the absence of utilization and confirms the position of Barroy *et al* (2016) that access facilitates utilization and that utilization is the end product of making services accessible. Gulliford, Figueroa-Munoz,

Hughes, Gibson and Hudson (2002) states that one of the key indicators or measuring access is the utilization of the health services. Through carefully studying these concepts, access and utilization, Mooney (1983) concluded that access mainly refers to supply of health services to the populace by the health facilities whilst utilization mainly refers to the demand of the health services from the health facilities by the population. With reference to Mooney's definition, access entails putting in place the systems and structures as well as other equally important resources for ensuring that services are available and affordable to the targeted population whilst utilization is more concerned on whether people demand the service from the health facilities where the services are available and affordable.

Based on Mooney's definition and the literature reviewed for this study, most of the studies refer mainly to the supply aspect of services to young people yet studies on the demand aspect of health services by young people have not been as extensively studied as compared to the former. This conclusion is drawn from the fact that studies which seek to identify and better understand the barriers to access or provision of services dominate the available literature. Despite the supply and demand barriers being equally important for the increased utilization of health services by individuals, there is a dearth of evidence with regards to how demand barriers can be addressed (Ensor and Cooper, 2004). Evidently, access and utilization are two different concepts despite being often used interchangeably. The conclusion that is drawn from the above literature is that despite these two terms being different their interchangeable use has been accepted in the health sector. This is mainly because utilization is one of the indicators in which access is measured given that service availability and affordability does not translate to the use of services but the use of services is facilitated by available and affordable as well as acceptable services.

Critical to note from the main terms of access as mentioned by WHO (2008), availability, affordability and acceptability, the existence of the above does not necessarily result to the definite use of the services. In some cases, services can be available, affordable and acceptable but still, the utilization of the health services be low. This implies that one can achieve access and fail to achieve utilization which further emphasize the difference of access and utilization of health services.

Integrated SRH services

Integrated SRH services are SRH services that are planned and provided jointly with HIV services and programs to ensure increased utilization of both SRH and HIV and AIDS services by those who need them (International Planned Parenthood Federation (IPPF), UNFPA, WHO, United Nations Programme on HIV and AIDS (UNAIDS), Global Network of People Living with HIV (GNP+), International Community of Women Living with HIV/AIDS (ICW), Young Positives, 2009). This strategy is one of the outcomes of the International Conference on Population and Development (ICPD) where, according to Singh (1998) the consensus of linking family planning (FP) services with the promotion and reduction of maternal mortality (MM), the treatment and prevention of sexually transmitted infections (STIs), including HIV, the promotion of SRH for both men and women as well as young people was reached. As a strategy, integrating Reproductive Health (RH) services is based on the following principles: a focus on the structural determinants of SRH and HIV/AIDS; a right based approach including gender; strengthening of coordination and coherent response; effective involvement and participation of all stake holders including People Living with HIV (PLHIV) and young people; addressing issues of stigma and discrimination; and recognizing the fundamental role played by human sexuality (WHO *et al*, 2005 and IPPF *et al*, 2009).

Sexuality and Sexuality Education

The focus of ASRH programs post ICPD has been to address sexuality issues through strengthening and improving coverage of sexuality education and SRH services. IPPF defines sexuality as a core of human life and sexuality education as the fundamental process through which individuals acquire information about their bodies and environments, which then facilitate the formulation of attitudes and practices as well as value systems in all aspects of life (IPPF, 2009; United Nations Educational, Scientific and Cultural Organisation (UNESCO), 2009). Embedded in this definition is that sexuality is the totality of a human being and sexuality education covers beyond information dissemination but include empowerment on life skills. Furthermore, the definition also underscores that sexuality is not only about sexual and reproductive health issues rather, sexual and reproductive health issues are central to the improvement of the quality of life for all human beings and also facilitates human development.

UNESCO (2009) highlights that sexuality includes the physical, psychological, spiritual, economic, political and cultural aspects of human life. As such, UNESCO then outlines that the topics included in comprehensive sexuality education (CSE) are; relationships; values, attitudes and skills; culture, society and human rights; human development; sexual behavior; and SRH.

Adolescent and Youth Friendly Health services

The argument behind the concept of AYFHS has been that these services are different from generic health services. By definition, AYFHS are the services that attract and appeal to young people whilst also responding to their needs and being effective in addressing the issues young people present with at the health facilities (IPPF 2008). Similar to IPPF, WHO (2015) underscores that AYFHS should be accessible, acceptable, and appropriate to the needs of the young people and be

provided in a non-judgmental way based on respect for human rights as well as being all inclusive or rights based to ensure that all adolescents and young people are welcome. Additionally, availability of the services has been identified as another critical characteristic of AYPHS. This according to WHO (2015), implies that the services should always be available to young people upon request at their convenience. The MoH (2010) defines youth friendly health services as services that are provided in a setting and manner that is attractive to young people. To note here is that youth friendly health services have been used to also imply adolescent and youth friendly health services and that the setting and the manner refers to both the environment of the health facility and the act of service provision by the service providers. According to the MoH, both the environment and the act of service provision should be attractive to young people. According to WHO (2015), the eight standards of AYPHS are; adolescent literacy; community support; appropriate package; provider competencies; facility characteristics; equity and none discrimination; data quality improvement; and adolescent participation.

Despite having global standards on adolescent and youth friendly health services, AYPHS stakeholders are yet to agree on the definitions of adolescents, youth and young people whose definition has been mainly influenced by differences in geographic location and level of development.

Methodologies and Findings Utilized by Studies reviewed in this Study

Introduction

This section of the chapter focuses on critically appraising the methodologies of the nine studies reviewed as part of literature review for the current study. The studies are grouped and critically appraised according to the different methodologies utilised.

Methodologies

Four of the nine studies reviewed utilised the mixed method design methodology, two utilised the quantitative methodology and three studies utilised the qualitative design. One of the mixed method studies and one of the qualitative studies utilised secondary data where already published studies were utilised as the source of information for the studies. The remaining mixed method studies utilised primary data which was collected from young people, health officers, school principals and traditional leaders. The data was collected through interviews with both in and out of school young people, self-administered questionnaires, Focus Group Discussions (FGDs) as well as through interviewing of KIs.

The two studies that employed quantitative methodology also used primary data. Young people were reached at their homes to collect data through one on one interviews. Other stakeholders interviewed include the public and private health facilities. The questionnaire was characterized by close - ended questions. The two qualitative studies that utilised primary data, collected their data from service providers, young girls in and out of school, community leaders and also through health facility assessments. Semi - structured questionnaires were utilised. The questionnaires were translated on site in one of the studies. The section below presents the critical review of the different methodologies used in the literature reviewed.

Qualitative studies

Three studies made this category; a study conducted on the barriers to SRH service utilisation by young people conducted in Tanzania (Mbeba, Mkuya, Magembe, Yotham, Mellah, Mkuwa, 2012); a study on perceived and experienced barriers to accessing STI services for adolescents and youth in low and middle-income countries (Newton – Levinson, Leichliter, Chandra – Mouli, 2016); and

a study on the barriers to and facilitators of the provision of a youth friendly health service programme in rural South Africa (Geary, Gomez – Olive, Kahn, Tollman, Norris, 2014).

Three main weaknesses were identified from the above studies. These weaknesses are: limited stakeholder involvement as for the Geary *et al* (2014) and Mbeba *et al* (2012), implying that critical sources of comprehensive data were omitted; the use of finalised reports as data sources rather than use of the primary data; and data collection strategies as observed from the Newton – Levinson *et al* (2016) study. In terms of the sources of data, some of the studies in this category did not involve young people whilst some involved certain groups and not others. Specifically, young males were not part of the respondents in the studies done by Mbeba *et al* (2012) and Geary *et al* (2014), whilst all studies (Geary *et al*, 2014; Mbeba *et al*, 2012; & Newton – Levinson *et al*, 2016) did not involve young people who are currently not utilizing services.

In as much as young males do not use health services as much as females, involving them in studies of this nature facilitates understanding why the young males do not use the services. Given the need for the study to understand barriers, not involving males limits the study to barriers for females rather than young people. Only the Geary *et al* (2014) study involved service providers as the only data source which ensures that mainly the supply issues of service utilisation are identified excluding the demand issues. The very same study also utilised an on-site translator during data collection thus compromising data quality.

In the study conducted by Mbeba *et al* (2012), one on one interviews with young people were not utilised but only FGDs with the young people were conducted. This has a negative effect on the factualness of the data given the consideration of SRH issues in the African context, which is mainly taboo (Griffin, 2006). Therefore, not using the one on one interviews with young people

eliminates the platform where young people, individually, with an interviewer, would provide responses to survey questions. In fact, the methodologies need to complement each other to ensure data validity (Golafshani, 2003). Finally, the inclination of all the studies was on identifying barriers rather than both the barriers and facilitators which will jointly enhance the utilisation of health services by young people.

As a result of the methodology utilised by the studies, there were no facilitators of service utilisation identified. Despite the findings not classified according to supply and demand factors, this research paper goes a step further in categorizing the main findings of the three studies that utilised qualitative methodology according to the supply and demand factors. The main findings from the Geary *et al* (2014); Mbeba *et al* (2012); and Newton – Levinson *et al* (2016) on the supply side were that human resource and infrastructural issues are the main barriers to the use of health services by young people. Availability and acceptability of services; the absence of designated areas for providing youth friendly health services and for young girls to discuss SRH related topics in the community were also some of the barriers to SRH service utilisation by young people. Stigma and shame, provider attitudes, confidentiality related issues, provider perspectives on delivering services and provider behavior, were stated as the main issues affecting the acceptability of services (Geary *et al*, 2014; Mbeba *et al*, 2012; and Newton – Levinson *et al*, 2016). The main findings of Geary *et al* (2014); Mbeba *et al* (2012); and Newton – Levinson *et al* (2016) on the demand side of service utilisation were; risky sexual behaviors; community socio - cultural practices; and levels of knowledge of young people on health issues.

Quantitative Studies

Two of the nine reviewed studies utilised quantitative methodology. These studies are; The determinants of utilisation of YFHS among school and college youth in Thika west district, Kiambu county, Kenya (Akinyi, 2009); and The Level of Young People SRH service utilization and its associated factors among young people in Awabel district, north - west Ethiopia (Ayehu, Kassaw, Hailu, 2016).

These studies were pitched and framed to enable the identification of both the barriers and facilitators of service utilisation, simultaneously. However, given that the studies are quantitative, they missed the flexibility of being guided by the responses of the young people but relied mainly on existing literature and utilized the literature to guide the young people's responses. By virtue of the studies being quantitative, the richness of the data was not achieved which would have facilitated a deeper understanding of the determinants (Castellan, 2010).

The involvement of young people and KIs from government and private owned health facilities by Akinyi (2009) and Ayehu *et al* (2016) provided a platform to capture more robust data for the study. However, given that the questions were mainly closed - ended for both studies and that most of the young people interviewed, 30% and 41% for Akinyi (2009) and Ayehu *et al* (2016), respectively, did not use the SRH services, the contributions of the respondents remained minimal. In the study conducted by Ayehu *et al* (2016), the young people were interviewed at their homes and this has high potential to yield to incorrect data due to the environment at which the young people were interviewed. This is based on the documented and prevailing attitudes of parents and other adults in the African societies towards health-related issues, especially ASRH (Muhwezi, Katahoire, Banura, Mugooda, Kwesiga, Bastien and Klepp, 2015).

The study by Akinyi (2009) concludes by stating that demographic factors, especially age and sex; socio - economic factors including level of education; socio - cultural factors; health knowledge and awareness; and the organization of the health facility have an influence on the utilization of SRH services by young people. The studies also conclude that young people residing with only their mothers were most likely to utilize SRH services compared to those living with only their fathers (Ayehu *et al*, 2016). Furthermore, Ayehu *et al* (2016) concluded that young people from a family with higher income and engaged in SRH discussions with their parents were most likely to use SRH services than their counterparts. However, the reasons resulting to the effectiveness of these remain a speculation given that they were not explored in the above-mentioned studies.

Mixed Method (Qualitative and Quantitative) studies

Four of the reviewed studies had mixed methodological designs. These studies are; Socio – Cultural factors influencing utilization of SRH services among youth in Swaziland (Ministry of Sports Culture and Youth Affairs & UNFPA, 2016); Young female’s perception of SRH services and factors affecting utilization of services in high schools of Ambo town Oromia region, Ethiopia (Bayissa, 2017); Young people’s experiences in accessing SRH services in SSA; a content analysis (Sulemana, Mumuni & Badasu, 2015); and understanding the barriers to young people’s access to SRH services in Sierra Leone (Restless Development, 2012).

The studies mainly focused on in and out of school young people and disregarded the use and none use or potential use of services by the young people as the other main characteristics of young people for the studies yet service utilisation was the main issue. Some of the studies did not involve other critical stakeholders in the utilisation of SRH services by young people whilst some did not conduct any interviews with young clients. Despite that the focus was on factors influencing the

use of services by young people. By ignoring the use and non - use of services by young people, the study missed out on the lived experiences and on data that is aligned with the current behavior of young people. In as much as gatekeeper involvement is critical, they, however, provide perceived perspectives on the factors influencing the utilization and can mainly address supply related factors and to a lesser extent the demand related issues. However, given the use of triangulation by the studies this weakness was addressed to some extent.

The studies conclude by stating that reshaping social attitudes towards the use of SRH services by young people was the main solution given that social attitudes are the main barriers (Ministry of Sports, Culture and Youth Affairs & UNFPA, 2016; Sulemana *et al*, 2015; & Restless Development, 2012). However, in all the studies (Ministry of Sports Culture and Youth Affairs & UNFPA, 2016; Bayissa, 2017; Sulemana *et al*, 2015; and Restless Development, 2012), the facilitators are not adequately addressed as only the barriers were highlighted. On the supply side barriers, the studies identified quality and accessibility of health services whilst on the demand side, the studies identified community and social practices as the main barriers to service utilisation. In terms of quality and access to services, young people highlighted barriers related to their efficacy levels and negative attitude towards the use of SRH services by their parents. Being ashamed of meeting people they know at the health facility when they had come for services was also stated by young people as one of the reasons they do not use services whilst others also stated that the inability of service providers to ensure confidentiality was the main deterrent. The studies did not, however, all have similar conclusions on economic issues and knowledge levels. Sulemana *et al* (2015); Bayissa (2017); and Ministry of Sports Culture and Youth Affairs & UNFPA (2016) conclude that the economic factors do not have a significant influence on service

utilisation whilst Restless Development (2012) conclude that the level of knowledge is not an effective barrier to service utilisation.

Other studies reviewed

The studies included in this category include a study conducted by Kalo (2006) in Vanuatu; a study conducted by Ghafari, Shamsuddin & Amiri (2014) in Malaysia; a study conducted by Nalwada (2012) in Uganda; a study conducted by Evelia, Ndayala, Njue, Wanjiru, Baumgartner & Westeneng (2016) in Kenya; a study conducted by Manoti (2015) in Kenya; and a study conducted in Australia by Colucci, Minas, Szwarc, Paxton and Guerra (2012). Unlike in the other studies, the focus of the literature review on these studies were the findings.

According to Kalo (2006), Eveila *et al* (2016) and Manoti (2015), the main barriers to service utilisation by young people are the unavailability of services and commodities in health facilities, the lack of youth friendly service providers in the health facilities, the service provision methodology where young people and adults receive services together, having young people and adults in the same waiting areas and the costs of utilising the health services. The above factors by Kalo (2006) mainly focus on the supply side of health service utilisation by young people. The focus of the study is also on the barriers, of which the facilitators can be assumed to be the opposite of the barriers. However, there could have been some other facilitators which are independent from the mentioned barriers.

In a study conducted in Malaysia, Ghafari *et al* (2014) presents the barriers in three different levels, which are patient level, service provider level and service provision system level. Ghafari's argument in this study is that the issues they identified as barriers can also be categorized as facilitators given that their state determine whether young people utilise services. At the patient

level, age and sex of an individual, beliefs and attitudes of a person, community resources and environment, individual's personal health practices and the fear of being seen at the health facility were mainly presented as the main barriers or facilitators to the use of health services by young people. The age and sex of the service provider, youth friendliness skills as well as attitude of service provider were the main barriers and facilitators to service use by young people. Key from the above findings is the role played by the community environment at the patient and service provider level to determine service utilisation by young people.

In terms of the service delivery system, Ghafari *et al* (2014) states that the organization of the health care system, lack of service linkages and confidentiality, lack of youth friendliness and privacy, inconvenient working hours of the health facility and judgmental attitude from service providers are the make or break of service utilisation by young people in a health facility. Critical to note from Ghafari *et al* (2014) is that issues of service costs are not mentioned as critical whilst confidentiality, youth friendliness and lack of privacy as well as judgmental service providers are categorized as systematic issues.

Directly underscoring cultural and religious issues as having an influence on service utilisation by young people is Nalwada (2012) and Eveila *et al* (2016). Nalwada (2012) and Manoti (2015) argues that the different interpretations of service use in communities determine whether young people will use services. In some cases, health service use, especially, SRH services, is interpreted as someone is promiscuous or engaged in prostitution. Furthermore, Nalwada (2012) identifies the existence of preferences in communities which affect the use of services. Similarly, to other studies mentioned above, Nalwada (2012) and Eveila *et al* (2016) further identify stock outs, poor service organization, non-friendly service providers, costs of utilising health services and incompetent service providers as the main barriers of service use by young people. Furthermore, gender

relations and power dynamics in community also creates a barrier to service utilisation by young people especially due to pronatalist values (Eveila *et al* 2016 and Nalwada 2012)

Eveila *et al* (2016) and Manoti (2015) identify self-stigma, especially amongst the minority or key population groups as well as limited support from authorities in the form of restrictive laws and policies on the use of health services by young people. Other barriers to service utilisation by young people are the provision of services without counselling the young people, the long queues and long waiting times in health facilities as well as the asking of too many questions by service providers (Eveila *et al* 2016). Facilitators of service use by young people include affordable and accessible services, high quality of services and the characteristics of the service providers (Eveila *et al* 2016). With regards to the accessibility of the services, Eveila *et al* (2016) states that services need to be integrated and also have a good health facility environment, that is, health facility surroundings, be clean and tidy whilst young and competent service providers also facilitate the young people to use the services being provided by a health facility. Colucci *et al* (2012) further states that the facilitators of health service utilisation by young people are mainly family involvement and community involvement as well as partnership. Implication here is that there is need to partner with the community and ensure the effective involvement of parents in youth related health programmes to ensure an increased health service use by young people.

Conclusion

The studies are biased towards the barriers rather than the facilitators of service utilisation by young people. Some studies claim to be studying utilization yet they only focus on one side of the factors facilitating service utilisation, either the supply or the demand factors. Whilst some studies do focus on both the supply and demand, they, however, do not adequately involve all

stakeholders, which then result in factors not adequately addressed. The limited involvement of all stakeholders was also noted in other studies which out rightly pointed out that their focus was either on the barriers or facilitators of service utilisation by young people. From the reviewed literature, in some studies either service providers only or young people only were involved in some studies or the other stakeholders like the government officials or the community leaders were not involved. This creates a limited understanding of the supply and demand related factors because all implicated stakeholders are equally important in understanding the barriers and facilitators as well as the supply and the demand factors of service utilization.

In terms of the factors associated with the use of SRH services, the studies highlight that the age of a young person, with older young people most likely to use services, discussion of SRH issues with family, exposure to sexual intercourse and having SRH problems, are the factors associated with the use of SRH services. A closer analysis of these factors show that they are more on the demand aspects of service utilisation, hence ignoring the supply side factors. Considering these factors in Swaziland implies that majority of young people need services given that the age at sexual debut is before 18 years yet the discussion of SRH issues at home is still considered a taboo (UNICEF and CSO 2014)

Review of ASRH guidelines in Swaziland

The review of the guidelines and policy was mainly based on the premise of assessing the key issues addressed by the guidelines as relevant to the supply and demand factors facilitating and prohibiting the use of SRH services by young people. Hence, this section mainly focusses on how the factors outlined from the supply and demand framework as well as the factors identified from the literature are addressed in the national ASRH guidelines.

ASRH guidelines review

The guiding principles of the document are; SRHR including privacy and confidentiality; Gender and culture dimensions; Universal access to services; Social participation; and communication (MoH, 2013b). These principles reflect that the guidelines seek to address both the supply and demand aspects of service utilisation. Specific issues outlined under the demand aspect include; parenting, gender dimensions and community mobilisation whilst service provision, coordination and linkages are the specific issues addressed under the supply category.

Issues on the Supply side

The document highlighted, among other issues, that health worker's capacity is one of the critical elements of the supply or provision of ASRH services; the critical skills that should be possessed by the health care worker providing services to adolescents should include ability to: ensure confidentiality and privacy; respect young people; and communicate effectively with young people (MoH, 2013b). In terms of the health facilities, the guidelines outline that the health facilities should be well branded and have adequate information education and communication materials. The guidelines further outline some of the key issues that a service provider needs to undertake when providing services to young people. According to the MoH (2013b), these issues are: dissemination of information at health facilities; ensuring privacy and confidentiality for all young people utilizing services at health facilities; offering other services despite that young client has not asked for the service, these services include routine HIV testing whenever a young client present at the health facility seeking services; linking the young person with other service providers for services that are not otherwise provided in each health facility; ensure the collection of personal

information amongst young people whenever they present at the health facility; and that services should be provided in an integrated manner.

Issues on the Demand side

On the demand side, the ASRH guidelines highlight that information should be disseminated to community members through dialogues and discussions with parents and other members of the community; young people be linked with support groups in communities or other support structures in the community; psychosocial support be provided for the adolescents and their families; advocacy for adolescent needs should be undertaken at all levels. The guidelines further note that there should be counselling provided to parents in the community on ASRH issues; community mapping studies need to be implemented to determine the SRH needs of adolescents in communities; community leaders need to be engaged on ASRH issues; and finally, that health facilities need to work with peer educators (MoH, 2013b).

Discussion of ASRH guidelines from supply - demand framework

The ASRH guidelines address both the supply and demand aspects of service utilisation by young people. It is, however, not clear on the economic aspect of service utilisation. The issues of clinic routines and service delivery approach as well as socio cultural issues as emanating from the community are addressed in the guidelines. The guidelines, however, do not also undertake the initiative to comprehensively discuss ASRH programme in communities, save for highlighting the need for health facilities to work with peer educators. What is glaring here is the absence of how facilities can work with peer educators and how these peer educators can be involved to ensure increased demand for services. The guidelines, like other literature reviewed, are more biased

towards the supply side of service utilisation by young people rather than striking a balance between the supply and demand of services by young people.

CHAPTER 3: METHODOLOGY

Introduction

The study utilised already existing data which was initially collected for the assessment of YFHS in the country which was part of the East and Southern Africa sub regional initiative of ensuring that young people have access to health services as per their needs. This study was jointly commissioned by the UNFPA East and Southern African Regional Office and the IPPF Africa Regional Office (ARO). The national assessment was part of a regional assessment which involved fourteen countries of the East and Southern Africa sub region. The national assessment of AYFHS employed mixed method design and focused on Swaziland's national policies, standards and guidelines on AYFHS against the latest WHO Global Standards released in 2015.

The AYFHS assessment was aimed at providing evidence for strengthening AYFHS provision to adolescents and young people in the country and sub region at three levels which are: service delivery points (SDPs); national or country level; and at the regional level across countries in Sub Saharan Africa. It was conducted largely in clinical settings and to a lesser extent in community settings in all the regions of Swaziland involving both public and private facilities; facilities in all levels of service provision as well as geographic areas.

Proportional sampling methodology was employed to determine the national contribution to the regional sample size of health facilities (HFs), service providers (SPs), key informants (KIs) and focus groups discussions (FGDs); as well as client exit interviews. A total of ten HFs; 55 young exit clients seven key informants; nine FGDs were conducted of which three were conducted with

potential service users (PSUs); three with peer educators(PEs); and three with health facility outreach workers. Ten one – on – one interviews with SPs were also conducted.

However, for the purposes of this study, the data from FGDs, KI interviews and one – on – one interviews with service providers were utilised. The KI interviewed for the assessment were the: UNFPA Swaziland Assistant Representative; Swaziland National Youth Council (SNYC) Chief Executive Officer; adolescent and youth SRH focal person at the MoH; Director of the guidance and counselling department at the MoET; regional SRH programme mentor; Director of Youth Affairs from the MoSCYA; and national SRH programme manager.

The PSUs were selected through the snowball approach, where the first PSU was identified by the local PEs and in turn, the potential user also identified other young people in the community who did not use the services at the local health facility. This process was repeated until the number of PSUs reached ten. PEs were identified by the service providers in three of the health facilities involved in the assessment. The service providers who responded to the one – on – one questionnaire and those that participated in the FGDs were purposively selected by the health facilities involved in the assessment. The table below presents the key informants interviewed for the study.

Table 1: Characteristics of Key Informants interviewed and their Respective Institutions

Position	Institution	Sex
Assistant Representative	UNFPA, Swaziland Country Office	Female
Director, Guidance and Counselling Department	Ministry of Education and Training	Female
Chief Executive Officer	Swaziland National Youth Council	Male
Director, Youth Affairs	Ministry of Sports Culture and Youth Affairs	Male
Adolescent Sexual and Reproductive Health Focal person	Ministry of Health, Sexual and Reproductive Health Unit	Female
Sexual and Reproductive Health Programme Manager	Ministry of Health, Sexual and Reproductive Health Unit	Female
Sexual and Reproductive Health Regional Mentor	Ministry of Health, Sexual and Reproductive Health Unit	Female

Table 2: Number of FGD participants by Population group and health facility

FGD #	# of FGD participants	Date of FGD	Health Facility
Population Group: Adult outreach Worker			
FGD 1	2	29 December 2015	Siphiwo Clinic
FGD 2	8	05 th January 2016	Sithobela Health Centre
FGD 3	5	06 th January 2016	Mbabane Government Hospital
Total	15		
Peer educators			
FGD 1	6	04 th January 2016	Family Life Association of Swaziland Mbabane Clinic
FGD 2	10	19 th January 2016	Hlatikhulu Government Hospital
FGD3	8	20 th January 2016	Piggs Peak Government Hospital
Total	24		
Potential Service Users			
FGD 1	8	30 th December 2015	King Sobhuza Public Health Unit
FGD 2	8	04 th January 2016	Matsanjeni Health Centre
FGD 3	8	06 th January 2016	KaMfishane Clinic
Total	24		

Table 3: Characteristics of Service providers who responded to Survey Questionnaire

Age Group	Sex	Qualification	Health Facility
25 – 34	Female	Midwife	KaMfishane Clinic
35 +	Female	Professional Nurse	King Sobhuza Public Health Unit
35+	Female	Nurse and Midwife	Mbabane Government Hospital
20 – 24	Female	Midwife	Family Life Association of Swaziland Mbabane Clinic
35+	Male	Doctor	Hlatikhulu Government Hospital
25 – 34	Female	Nurse and Midwife	Piggs Peak Government Hospital
20 – 24	Male	Nurse and Midwife	Sithobela Health Centre
25 – 34	Female	Midwife	Matsanjeni Health Centre
35+	Female	Nurse and Midwife	Siphiwo Clinic
25 – 34	Female	Nurse and Midwife	Tikhuba Clinic

Data to respond to the current survey objectives was obtained from the responses of all the FGDs; the service provider completed questionnaires; and the key informants completed questionnaires. The health service supply facilitators and barriers were addressed mainly through the Key informants completed interviews; the health facility outreach workers FGDs; and service provider completed questionnaires whilst the service demand facilitators and barriers were addressed through the PEs and PSUs FGD responses. The completed questionnaires from the other categories of respondents were also reviewed to ascertain commonalities of issues from different population groups.

As a student, my involvement in the original research was being the national consultant who was involved in the training of the research assistants, contextualizing of survey instruments for Swaziland, the sampling of health facilities in the country to be involved in the assessment, analysing the data and compiling the national report of the assessment.

Study Design

The current study is an exploratory qualitative study which is based on the philosophical hermeneutics. The exploratory research design was utilised for this study given that exploratory studies are appropriate to study subject matters that have high uncertainty and when the problem is not well understood (Babbie and Mouton, 2003). Given that the study aimed to deepen the understanding of barriers and facilitators of health service utilisation by young people, through providing deeper explanations of some of the known barriers and facilitators whilst also identifying additional barriers and facilitators, it employed the interpretive/constructivist paradigm.

Data collection and management

The FGDs and interviews were conducted in both English and local language by the research assistants. For each FGD and key informant interview, one research assistant was the facilitator and the other a note taker. All of the interviews and FGDs began by introducing the research to the potential participant or participants, and after obtaining informed consent, the data collection proceeded. The audio files, which were recorded through research assistants' (RAs) mobile phones were used by the RAs to add detail to the transcriptions. Copies of the transcripts were kept in a secure place by the local organization involved in the assessment.

Data analysis

From the constructivist paradigm, the directed content analysis approach was utilised to establish further understanding of previously known barriers and facilitators. The same analysis approach was also used to identify themes from the data; new barriers; and facilitators within the data as obtained from the respondents of the initial AYPHS assessment. The first step for undertaking data analysis was the familiarization with all of the FGD transcriptions and the in-depth interviews through a thorough reading. Subsequently, the transcriptions were analysed through using the content analysis approach steps outlined by Wynaden *et al* (2005). These steps are coding, categorising the data, clustering the data and development of themes. Hence, the second step was developing a coding scheme to systematically code all of the data. This was done through identifying analytical axes according to their respective codes, which, in turn, were grouped into key themes as presented in the findings of the research. These themes were then compared to the themes which were identified in the literature, as stipulated in the conceptual framework. This process of developing themes from data and comparing the themes with those from literature ensured the trustworthiness and credibility of findings. It also allowed for an assessment of transferability of the findings.

Thereafter, the data sources were then triangulated to obtain the different views of the different respondents on the same issue. Of particular importance in this regard was the responses of peer educators to those of potential service users and respondents drawn from government departments and respondents drawn from non-government institutions. These responses are presented in the findings chapter with clear demarcations of which respondent group stated the different responses. The final step was drawing conclusions from the coded data.

Trustworthiness

Validation and triangulation strategies were used to ensure the trustworthiness of the AYPHS assessment done in Swaziland. These main strategies may be divided into 10 sub strategies identified by Bashir, Afzal, Azeem (2008). For the assessment, 6 of the 10 sub strategies were utilised and these strategies are:

1. **Extended period of fieldwork or data collection** – the data collection of the initial assessment was extended through setting data collection dates in different HF apart from each other. This facilitated the match between findings and reality as well as the collection of data over time for comparison.
2. **Triangulation** – the data that was asked from the different data sources were to some extent similar but asked in different ways. KIs were asked about the level of youth friendliness as well as the capacity of service providers. The same questions were asked from the other study respondents. This ensured the comparison of data between the different data sources.
3. **Capturing of verbatim quotes from the research respondents** – this was ensured during the survey through having two people per interview and FGD. One person facilitated the discussions whilst the other compiled notes. Furthermore, some RAs utilised their phones to record FGDs and KI interviews sessions. The captured quotes are used in this study to substantiate arguments.
4. **Engagement of multiple researchers** – the initial assessment was a regional venture where 14 countries located in the East and Southern Africa sub region were involved. One researcher was based in Swaziland, a team of researchers in Kenya and in South Africa. Before data collection, the Swaziland based researcher was workshopped on the research

and data collection tools were finalised. After data collection, the data was shared with the team of researchers for their review of data quality.

5. **Validation of assessment findings** – the validation process took place at two different levels. At the regional level, all 14 countries involved in the assessment participated, and at the national level, all national sexual and reproductive health stakeholders in Swaziland and HFs involved in the assessment participated. The validations confirmed the findings of the assessment with the two alterations suggested being the review of the national statistics on youth SRH issues and aligning the categorisation of service providers in the report with the categories outlined in the national health service policy and standards.
6. **Inclusion of data that did not conform with the research conceptual framework** – the data that did not conform to the research conceptual framework was however included in the report. This was facilitated by categorising the data through themes aligned to the conceptual framework.

CHAPTER 4: FINDINGS

Introduction

This chapter presents the factors that facilitate and or hinder the use of the SRH services by young people from both the demand and supply sides. The issues presented are those obtained from the data used for this study. The chapter is organized according to the supply and demand framework.

Supply Factors

The barriers and facilitators

This section presents the findings on the supply side barriers and facilitators to health service utilisation by young people. The barriers to service utilisation by young people presented are; the national AYFHS delivery approach; capacity and attitude of health service providers; stigma and discrimination; limited dissemination of AYFHS related policies and guidelines. The facilitators are; the health facility characteristics; and young and friendly service providers.

AYFHS National Delivery Approach in The Health Sector

Absence of AYFHS specific policy and guidelines

A critical caveat in the national AYFHS dispensation is that currently, there is no national policy on AYFHS neither are there any guidelines. Instead, ASRH guidelines are used as a guide for AYFHS related activities. As noted by key informants: *“There are pockets of AYFHS that exist in the country and issues of human resource, work- life balance for the nurses,*

infrastructure development, security and training of service providers at nursing school level has to be done” (Government KI).

“Yes, we have ASRH guidelines on the ground which are currently implemented at the facility level. There is also the SRH policy which guides the implementation of all SRH programmes but there is no special ASRH policy as it is incorporated in the SRH policy” (United Nations (UN) KI).

Evidently, AYFHS has not been integrated into the national health system from the onset and from the most basic levels (i.e. in training health care workers at university/college level, developing relevant infrastructure and training support staff) but has instead been integrated almost as an afterthought and in specific health issues.

The afterthought aspect of the AYFHS integration in the health sector is evidenced from the responses of HCW when they were asked about providing services to young people. One Health Care Workers (HCWs) stated that; *“...The young people need a specific nurse who can attend to them”*; whilst another HCW stated that; *“...If the package {AYFHS package} came from the MoH we would know that it is a requirement”*; and another HCW stated that; *“...It will be difficult to improve yet I have never gained any training on AYFHS”*.

From the above responses from HCWs, it is evident that the available guidelines and policies on AYFHS are only focused on ASRH and that HCWs have not been trained on AYFHS hence they view AYFHS as additional work for them. As a result, some health facilities provide youth friendly services and others do not, due to different capacity levels at health facilities. In relation to the latter, one government KI stated that; *“...The service providers need to be trained on youth friendly services”*. Furthermore, another government KI stated that; *“...To*

a certain extent, there are a number of programmes that still need to be implemented and include a number of people. We still need to create awareness to health workers on youth friendly services, everyone, parents, have to be aware of what is happening”.

Health Facility Characteristics

The cleanliness of the health facility and its location as well as client waiting times were mentioned by young people as some of the critical factors for them to utilise health services. When some of the PSUs were asked about where they utilise health facilities, the young people stated that they use them in places where:

“The health facility is quiet and secluded and private, it is not busy and the services are fast and the structures and the premises are beautiful.” (PSU FGD participant)

Capacity and attitude of Healthcare workers

The capacity and attitude of healthcare workers represent a theme that was echoed by all groups of respondents. Reference here was made not only to the service providers but also to the support staff. Aligned with this theme, young people were asked if they had ever visited their local clinic and what is the reasons they stopped to visit the health facility. One PSU stated that; *“I used to visit the health facility but not anymore because the treatment I received {from health facility staff} was not good”*

Another PSU stated an experience from someone she knew who once utilised the health services in a local health facility. The PSU stated that *“.... the nurse treated her unfairly and she never came back for other services”*. According to the PSUs, the attitude was not only displayed through words but was also actioned by the service providers through physically assaulting some of the service users during their visits to the health facility. A PE concurred with this statement by the

PSUs through stating that; *“Yes, others {young clients} have been assaulted at the maternity ward and Anti-Retroviral Treatment (ART) section for drinking timbita (traditional medicine provided by a traditional healer)”*.

When PEs were asked about the nature of the feedback they get from the young people they refer to the local health facilities. The PEs stated that; *“The feedback is mostly negative and the security and non-medical staff also mistreat the young people when they come for services”*. When requested to describe their experiences and those of other young people they know at the hands of HCWs, PSUs and PEs used the following phrases; *“bad treatment”, “shouting at clients”, “unfair treatment”, “abused/assaulted” and “mistreatment”, “treatment not good”, “raising their voices”, and “not friendly enough”*.

The lack of youth friendliness from the HCW was echoed by the different KIs involved in the survey where one of KI noted that; *“...Health workers are not adequately trained to embrace the youth; the youth are ridiculed before getting assistance in the facilities” (UN KI)*. Furthermore, KIs also viewed the attitude of service providers as the main challenge to be faced during the scaling- up of AYPHS in the country.

The attitude of SPs was highlighted by FGD participants as an issue, especially for locally recruited SPs. As such they, young people, reported not to have an issue of utilising health services in a facility where none locals were hired or in a health facility distant from their home areas. To this effect, PSUs noted that; *“...We only prefer peer educators and nurses from outside or someone from a different clinic or place to avoid him or her from gossiping {about us}”*. Another PSU emphasized on the above statement by stating that; *“I access them {health services} in another clinic because the nurses don't know me and also my health status is confidential”*.

The young people's preference for being treated by strangers was mentioned by PEs as well during one of their FGDs by stating that “... *young people want to be treated by strangers so they rather walk for long distances away from the local facility*”.

Characteristics of health service providers

According to young people a youth friendly service provider is someone who is often kind, compassionate; non-judgmental; and asks fewer questions. These characteristics were observed by the young people from the younger nurses; doctors; and male nurses. The opposite is reported to be true for older nurses and female nurses. When asked about their experiences at the health facilities where they utilise services, one PSU stated that; “*The young nurses are friendly*”. Another PSU stated that: “*They (male nurses) take good care of clients*”. PEs echoed what the PSUs mentioned through stating that “...*Young people prefer male service providers because female service providers use abusive language and are not youth friendly*”.

During one of the PEs FGDs, one PE implied that the youth friendliness of HCWs also varies with the qualification of the HCW. The PE stated that; “*The doctors are able to understand us as young people but the nurses are judgmental and bias*”.

Through the one – on - one interviews with the HCWs it was evident why the young people view the younger nurses as friendlier compared to the older nurses given that the older nurses stated that it was difficult for them to divorce their personal feelings from their work as they often imagined their adolescent clients as their own children and this prevents them from keeping quiet about their feelings with the client. One of the HCWs stated that;

“At times, I don't like providing FP services to young people at times I would chase them away. But I am happy that the facility is providing the service. I think we better focus on educating them,

the behavior won't change (if we continue providing the services), this is especially true in cases where the client is sexually active or involved in practices that are harmful to their general and sexual health."

Stigma and discrimination of key populations

The dimension of the stigma and discrimination factor regards to key populations amongst young people. These key populations include Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI), YPLHIV and Commercial Sex Workers (CSWs). However, given that young people do not disclose their HIV status and sexual orientation to service providers, it is difficult to spell out the treatment they receive from HCWs but one can suppose that their non-disclosure results from the fear of discrimination. PEs did, however, mention that: *"Everyone can get services whether they are married or not but not lesbians because Swaziland does not accept them"*. Another PE stated that *"LGBTs are afraid to access clinics because they will be judged, shouted at and rejected even before accessing services"*. PSUs further noted that *"...the desire to conceal the sex status of CSWs and LGBTIs makes it impossible to know whether they are affected by discrimination and stigmatization"*.

The above reflects that even though young people do not disclose their sexual orientation; HIV status and sexual practices to service providers, it is a common practice to discriminate individuals based on the above-mentioned characteristics at the health facility.

Limited distribution and dissemination of AYFHS related policies and guidelines

Despite not having a comprehensive policy in AYFHS, Swaziland has different policies that have implications on AYFHS. These national policies include; Swaziland Education and Training Sector Policy of 2011 (SETSP); National Sexual & Reproductive Health Policy (NSRHP) of 2013;

Poverty Reduction Strategy and Action Plan (PRSAP) of 2006; National HIV Prevention Policy (NHPP) of 2012. Other national policies with implications on AYFHS are; National Gender Policy of 2010 (NGP); and the National Youth Policy of 2009 (NYP). The country also has specific health national documents which have significant implications on AYFHS, these documents include; National Health Sector Strategic Policy of 2011 (NHSSP); National Sexual & Reproductive Health and Rights Strategic Plan 2014-2018; and the National ASRH Health Sector Guidelines of 2013.

However, these national policies, strategic plans and guidelines are not adequately distributed to all stakeholders at all levels. Hence, there is limited knowledge of these documents at all levels. Confirming the limited dissemination of AYFHS related documents was a government KI through stating that; “...*It is like Swaziland doesn't have or maybe I haven't familiarised myself with the policies. I am not sure about these policies*”. Another government KI stated that; “...*I know they (policies and guidelines) are there, but I have not read them*”. One government KI highlighted the need to disseminate the AYFHS related policies through stating that; “...*There is need for guidelines to be disseminated and used properly by service providers*”.

Clinic routines, systems and structures

The clinic routine systems and structures were mentioned by PSUs as one of the main barriers to using health facilities. One of these routines mentioned by young people was the mandatory testing for HIV and AIDS in health facilities for all clients despite the services sought. On this, a PSU stated that, “*the mandatory HIV testing pushes young people away from health facilities*”, “*HIV testing is done forcefully and not voluntarily and we youth can't test if we are not ready to test but end up doing it because we need the service at times*”

Concurring with the PSUs, PEs stated that; *“The mandatory HIV test demanded at health facilities discourages the youth from seeking services. HIV testing is not voluntary. We end up screening for HIV reluctantly because we need medical services”*.

Another issue related to the routines and systems were the processes and pathways followed by young people when utilising health services in health facilities. This is attributed to the model of service provision adopted by the health facility. To this effect, a PSU noted that; *“...We prefer separate facilities to avoid sharing services with adults. Stand-alone health facilities for the youth are friendlier and confidentiality is maintained”*. Echoing what the PSU mentioned, a PE stated that; *“The youth want privacy and to be separate from adults. It becomes obvious who has come for ART, especially at the pharmacy since the boxes of ART are too big. Some people prefer their drugs to be hidden”*

Standard operating hours are part of clinic routines and procedures. However, some health facilities have different operating hours on paper and in practice. Most clients, particularly women and children, were reported to arrive at the facility in the early hours of the morning in order to secure a consultation as early as possible and thus, health facilities are busiest in the mornings. As a result, most young people prefer to arrive in the late morning or even in the afternoon, when the facility is the least busy.

Demand Side

Barriers and Facilitators

The barriers and facilitators discussed in this section are; the socio-cultural factors which include parental support, social beliefs, stigma and discrimination; stakeholder involvement at all levels; availability of other service provider options apart from the government and

modern health facilities and modern options; peer influence; and the limited AYFHS programmes at community level.

Socio - cultural Factors

Social beliefs and Parental Support

The issue of social beliefs was noted as a barrier mainly from the key informants. When asked what they foresee as the main challenge for scaling up AYFHS in the country a government key informant stated that; “...*The beliefs of the society, churches and traditional leaders have been a challenge because they cannot address SRH issues*”. Another government key informant stated that:

“The challenges would be attitude because they think we are talking sex education...Resistance due to lack of understanding. Sexuality issues not talked about and the prevailing family structures are destroying the base or foundation”.

A UN KI stated that, “*The programmes are not accepted because the guardians and the policy makers don’t agree on Comprehensive Sexuality Education (CSE)*”.

The social beliefs were associated with the lack of support that young people receive from parents to utilise health services. A UN KI noted that:

“Parents have problems with the nurse because at times the parents don’t agree with the teachings and services provided e.g. condom usage. Parents think the health providers teach their children to engage in sexual activities yet they fail to abstain. The health care providers try to bring the balance by preaching abstinence and condom usage then parents think they are contradicting themselves by talking about condom usage, especially in the chiefdoms. E.g.

if the contraceptive is to be introduced, I have a feeling that the school committee will rubbish the implementation.”

Concurring with the above statement was another key informant from the government who stated that; *“We still need to target the parents so that they can know and identify their role as well {in AYFHS}.”* The parental stigmatising of service utilisation by young people was thought to be related to the negative attitude of influential people at community level towards AYFHS since the opinions and practices of other community members and leaders carries a lot of weight in tight - knit communities. Specifically, the key informants stated that;

“The attitude of people is bad because they associate AYFHS with sex education. There is resistance due to lack of understanding of the programme given that sexual issues are not discussed in public culturally”. (UN KI)

Another key informant noted that; *“.... No, the society does not embrace SRH issues. e.g. the youth can't even buy condoms at shops because they are afraid”* (Government KI).

The issue of social belief does not only affect individuals in the community but also affect operations of institutions within the same community; institutions such as health facilities and traditional leadership, religious leaders and churches as well as families and social groups within the community.

Availability of other health service provider options in the communities

A further factor that has an impact on the demand for health service utilization among young people is the availability of alternatives to the modern clinical services from hospitals and health centres or clinics. It has already been well established that young people are likely to shun services

if they are in any way discriminatory, violate their sense of confidentiality and anonymity or if they are inconvenient for them to use.

When asked about their use of services young people stated that

“When I go to the local traditional healer he doesn’t ask me a lot of questions {like the nurses}, I just give him the money and he gives me the [medicine]” (PSU GFD). PEs noted that “...Young people are willing to pay higher costs to access services where their anonymity and confidentiality are guaranteed. This might also include pharmacies.”

This reflects that young people, to some extent, are not willing to answer some of the questions asked at health facilities before they are provided with the service they are seeking. The “answering of numerous questions” and navigating the different stages and processes in a health facility forces the young people to seek services elsewhere, even from illegal service providers. Critical to note is that during some FGDs young people stated that they would rather pay ten times more than what they have to pay in health facilities to access the services of a “hassle-free” traditional healer.

Limited Health programs targeting young people in the communities

The PEs involved in the FGDs stated that there are no structures and platforms for them to work in the community and they are also not introduced to the community leaders to ensure effective implementation of ASRH related programs. One PE stated that:

“there are rarely any social or youth centers that serve as the base for our community education efforts and thus we rely on informal settings like sports grounds or schools and even rivers, forests and shops to disseminate health - related information to other young people”, and another PE also stated that “...We are never formally introduced to the leadership of the community and this limit our activities in communities”.

The PEs also stated that *“It is challenging to gather young people for health talks or outreach programs because they expect refreshments”*, and *“We should introduce outreach events and road shows for [promotion of] medical circumcision and HIV testing”*. The implication of the latter is that outreach events and roadshows are not utilised as strategies for reaching out to young people on health information. Furthermore, one KI noted that CSE is not yet scaled up to majority of the schools in the country but the country is yet developing plans to scale up CSE in schools. When asked whether or not CSE was incorporated in the school curriculum, a government KI stated that; *“The CSE programme was piloted and still waits for approval of the cabinet prior to its roll-out countrywide. It focuses on higher levels of learning but not the primary level. Preparation for the scale-up of CSE is going on. There is an online training of teachers on CSE, development of resource centers as well as M&E tools.”*

Another key informant added that: *“Yes, we started the implementation process last year, 2015. We are rolling out [the programme] in 25 schools. It is because the Minister made a commitment of East and Southern Africa which demands schools to be youth friendly”* (Government KI)

CHAPTER 5: DISCUSSION

Introduction

This chapter discusses the findings of the study and is organized according to the study objectives, that is, it first identifies and discusses the barriers of service utilisation by young people according to the supply and demand framework. Secondly, the facilitators of service utilisation by young people are identified and presented according to the supply and demand framework. Lastly, the chapter focuses on establishing the effects of supply and demand factors on health service utilisation by young people based on the findings from the data.

Barriers

The findings suggest that human resource and health care delivery system related issues are the main supply - side barriers whilst stigma and discrimination; competition for providing health services to young people; and the limited health interventions targeting young people are the main demand - side barriers to service utilisation.

Human Resource issues

The findings highlight that youth friendliness varies according to three main characteristics which are age, sex and qualification of the service provider. Younger SPs are reported to be more youth friendlier compared to older SPs whilst male SPs are reported to be youth friendlier compared to female SPs and lastly, doctors are reported to be youth friendlier compared to nurses. With reference to WHO (2015) on the standards for youth friendly health services, the above issues are not mentioned. Justifiable so, given that further analysis of the differences between the younger

and older SPs; male and female SPs; and the doctors and nurses the apparent issue is the lack of youth friendliness. Focusing on the barrier based on qualification and the MoH (2013a) report on the service availability mapping is considered, where there were only 241 doctors and 1911 nurses in the country, one would conclude, based on the reports by the respondents, that youth friendliness is not as widespread in health facilities in the country.

This finding, as much as it fundamentally links with limited youth friendly SPs in HFs, provides a much specific and different insight on youth friendliness compared to the three studies mentioned above, one conducted in Ethiopia by Ayehu *et al* (2016); one conducted in South Africa by Geary *et al* (2014) and one conducted by MoH (2015) in Swaziland. Two of these studies only stated that SPs need to be trained on youth friendliness without unearthing the variations on friendliness based on age, sex and qualifications which can inform youth friendliness training interventions. The study conducted in Swaziland by MoH (2015) did however highlight variations of youth friendliness but according to HF characteristics rather than SP characteristics. The HF characteristics that affect the level of youth friendliness mentioned by MoH (2015) include the geographic location of the health facility and ownership of the health facility. Geary *et al* (2014) in a study conducted in South Africa do highlight human resource as one of the barriers to service utilisation by young people but specifically mentions the limited youth friendliness as a human resource element.

However, the results present almost similar findings with Newton- Levenson *et al* (2016) and Jana, Mafa, Limwame and Shabalala (2012) on studies of the barriers of sexually transmitted infections (STIs) service utilisation amongst adolescents and youth in low and middle-income countries and challenges to youth accessing sexual and reproductive health information and services in Southern Africa, respectively. Newton- Levenson *et al* (2016) stated that HCW demographics, age and sex

were the key determinants of the HCW's level of youth friendliness. In a similar study, Newton-Levenson *et al* (2016) argue that the older the HCW the lower the level of youth friendliness and females had the lowest levels of youth friendliness. Jana *et al* (2012) also underscore the issue of low levels of youth friendliness amongst female service providers. However, Newton-Levenson *et al* (2016) and Jana *et al* (2012) did not mention of HCW qualification as having an effect on the levels of youth friendliness which was identified in this study.

Health care delivery system

The main issue reflected by the data in this theme is that the absence of an AYFHS specific policy is a barrier to health service utilisation by young people. This is mainly because policies and guidelines, in as much as they are part of the healthcare delivery system components (WHO 2010), they influence the other components of the health care delivery system. Other critical elements of the health care delivery system outlined by the findings are; client triage within a health facility; and service provision approach. Weeks (2005) and the East, Central and Southern African Health Community Secretariat (ECSA-HC) (2002) concurs with the findings of the study through defining a policy as; a set of decisions and actions designed to guide human behaviour and intentioned to facilitate the achievement of set goals and objectives; and one of the major strategies of translating commitments into plans and also being a platform for integrating human rights into the commitments made by governments, respectively. The ECSA-HC (2002) further states that a health policy is a platform for integrating interventions that stimulate positive behaviours in the health sector through facilitating; a conducive and supportive environment; provision of health education and services; expanding opportunities. By having a goal and being characterized by different steps, which include adoption, implementation and evaluation, a policy is timebound (Anderson, 2006). The common objectives of a health-related policy are to standardize actions and

ensure consistency amongst actors which ultimately result in improved health of the population, further states Anderson (2006).

The influence of policies and guidelines on the other health care delivery system components is also highlighted by UNESCO, UNFPA and UNAIDS (2016) by stating that in countries where policy level issues on providing service to young people were identified the provision and utilisation of the health services by young people was compromised. It is upon the basis of a policy where all the components of the health care delivery system are designed and implemented and where all role players are held accountable. The conceptual framework by Measure Evaluation (2013) presents policies and guidelines as separate from health systems yet WHO (2010) present policies and guidelines as components of a health care delivery system. It is contradictory to a greater extent however, the Measure Evaluation (2013) perspective based on the above definitions of a policy, is found relevant.

Taking into cognizance the shift of health services from privilege to rights and the rights based approaches to health programming since ICPD (UNFPA, 2014) and that policies facilitate intersectoral coordination; and adolescent and young people's access to health services (Kenya Ministry of Health, 2015). The Kenya Ministry of Health (2015) further states that policies promote an enabling socio-cultural environment for providing services to adolescents and young people; and strengthen the collection and utilisation of data on adolescents and young people, health policies become very critical in shaping the health care delivery system nationally and internationally.

The implications of the above definition are three folds; first, without a comprehensive policy, role players cannot be held accountable; similar actions of different role players will not be

standardized; and without a comprehensive policy on AYFHS the service utilisation by young people in the country will remain elusive. Gamm (1996) underscores the importance of accountability in the health sector for ensuring that health service needs of the public are met. Despite most of the literature reviewed for this study not mentioning the absence of a policy as a barrier to health service utilisation by young people, the recommendations do include policy development/strengthening. In a study conducted in Ethiopia by Sulemana *et al* (2015), one of the recommendations is to advocate for policy change to facilitate access to services. The conclusion of this study is therefore that the absence of an AYFHS policy results to majority of the other barriers identified by other studies and this study.

The standardization of similar actions by different stakeholders is also a key objective of a policy. The study mainly refers to the issue of youth friendliness, which due to the lack of an AYFHS specific policy different programmes can interpret it differently. Youth friendly health services are defined by UNESCO, UNFPA and UNAIDS (2016) as acceptable, equitable, effective and accessible. According to young people involved in the study, youth friendly services are services that will be offered to them; anonymously and in a respectable manner whilst also ensuring confidentiality and where they are treated with dignity. Respect, confidentiality and dignity are the common features of youth friendly services; however, anonymity is not as common yet it was mentioned by the young people as one of the key youth friendliness components. Their desire for anonymity is reflected by the young people opting to walk or travel long distances and their eagerness to utilise health services through mobile clinics compared to static clinics in their local communities. The quest for anonymity, therefore is a result of compromised confidentiality and fear of being seen by adults who know their parents. The high preference of anonymously utilising health services overshadows the costs attached to the use of health services, as stated by young

people. This implies that the barriers of health service utilisation are not equally effective in prohibiting young people to use health services. As such, issues of health facility location and costs attached to the utilisation of health services are reflected as less influential compared to attitude and capacity of HCW among other barriers.

Evidently, the prime location of a health facility is negated by the negative attitudes displayed by the HCW at facilities. This is confirmed by WHO (2015) through stating that skills, attitude and knowledge of service providers are at the core of AYFHS provision. Furthermore, Population Council (2015) also concurs with this conclusion through stating that no matter how close a health facility is located to young clients, young people will remain reluctant to utilize services if they fear that they will be discriminated against or mistreated by the HCWs. With regards categorizing the effect of the different barriers to health service utilisation, AYA/Pathfinder (2003) states that the most significant barriers for utilisation of health services by young people are service provider attitudes and biases. This is mainly because health facility characteristics which include cleanliness and attractive buildings aid in enticing young people to visit the health facility and the attitude of HCW help in ensuring that the young people have a good service utilisation experience (WHO, 1999).

Finally, the choice of words used by PSUs and PEs on their experiences or of people they know during service utilisation in the health facilities reveal that they do not necessarily have many issues with the service package offered to them but instead have issues with the delivery approach of the service package. There seem to be a focus on service package on the national documents like the SRH policy whilst the young people on the ground are placing much focus on the service package delivery approach. This kind of framing by young people mainly relates to the attitude and actions of the service providers rather than the package of the services, thus making the

delivery of the services more of a determinant of whether young people will use the services. The implication is that unless health care workers are capacitated to treat the youth and adolescents with respect and dignity and support staffs are equally capacitated to maintain the standards of anonymity and confidentiality preferred by young people, service utilization amongst young people will not see any remarkable increase.

Swaziland has a good record of locating health facilities in close proximity to areas with a high volume of young people and according to the MoH (2013a), 85% of the national population is within a 10km radius of a health facility. Health facilities in the county are often located near transport hubs, schools, residential zones and educational and business centers. Besides this, transport to health facilities in the country is rarely a challenge, particularly in urban areas, as public transportation often caters for the transport needs of those seeking to utilize health facilities in their areas of abode. As a result of this and other factors, the costs associated with service utilization are not elevated for young people as they do not have to travel long distances to access services.

Influenced by the policy provisions, the client triage in the health facility and service delivery approach are equally important factors for service utilisation by young people. This is because the process of accessing services within a health facility can be frustrating to young people (WHO, 2015). Service delivery approach also includes the service integration which according to the Rivero-Fuentes *et al* (2008) facilitates the delivery and provision of health services through availing the continuum of both preventive and curative services. Rivero-Fuentes *et al* (2008) further state that integrating services help reduce costs of service provision and reduce stigma and discrimination associated with certain health services. The integration mentioned above relates to services which also have an implication on the integration of the clients themselves, meaning

young people and adults will queue in the same place for the same service provider. Geary *et al* (2014) in a study conducted in South Africa highlights the significance of a youth standalone HF where young people need their own space to access health services. This is also echoed by Ayehu *et al* (2016) in a study conducted in Ethiopia through stating that the absence of adolescent specific service areas or spaces within health facilities is one of the reasons why young people are not utilising health services. Further confirmation of the need to youth only clinics is confirmed by Kalo (2007) in a study conducted in Vanuatu where young people also stated that one of the factors that encourage them to utilise health services was having a youth separate clinic rather than young people having the same clinic with adults. The use of a Youth Center programme approach in Cape Town resulted to increased utilisation of HIV testing services by young males who are traditionally known to under utilise health services and HIV testing services in particular (Black, Wallace, Middelkoop, Robbertze, Bennie Wood and Bekker, 2014)

The findings above imply the need to ensure that in as much as the health services are integrated, the clients (young people and adults) should be separated. The inability to integrate the services results to stigmatization based on the type of service utilised (UNFPA, 2013) whilst the integration of clients, young people and adults in the same waiting area, results to young people being afraid of being seen by their parents' friends. In Swaziland, there are three main service integration approaches which namely are: same room same service provider; same building different rooms; and same facility different buildings (MoH, 2012). The latter two approaches are the common service integration approaches employed in Swaziland and given that only 21.1% of health facilities in the country (MoH, 2013a) provide youth friendly health services, majority of the health facilities in the country have both young people and adults queue in the same waiting area for health services, implying high prevalence of stigma due to type of service utilised (UNFPA and

IPPF, 2016 & UNFPA, 2013). The stigma experienced by young people is in two folds internal and external, with the former being more prevalent (Population Council, 2015). Regardless of the type of stigma, young people end up not utilising the health services which compromise their quality of life (WHO, 2015). The setting also implies high waiting times for young people which is one of their main deterrents for service utilisation given that youth friendly health facility procedures include easy registration short waiting times and affordable service costs among others (WHO, 1999).

The implication of this finding is that in as much as service providers might be reported to be unable to ensure confidentiality, the service delivery approach of health facilities also compromise client confidentiality. This is due to the use of the same waiting areas and consultation rooms marked with service being offered.

Stigma and discrimination

Stigma and discrimination happen both at community and health facility levels. There is observed linkage between what happens at the community and what happens in the facility. What happens in the community influences what happens in the health facility in terms of stigma and discrimination and what happens in the health facility influence stigma and discrimination in the community. Rumun (2013) states that culture and belief system in a community are some of the key determinants of health service utilisation for the general community members, including young people. This implies the influence of community culture and belief system on both service provision and demand. At the community level, stigma and discrimination is a result of limited knowledge on specific health issues and existing social and cultural beliefs and practices whilst at

the health facility is it due to either the transferred social and cultural practices and beliefs or the prevailing service delivery approach.

In a study conducted by Biddlecom, Munthali, Singh and Woog (2007) in Burkina Faso, Malawi, Uganda and Ghana, the common barriers to service utilisation by young people identified included stigma and discrimination related issues and costs attached to services, limited knowledge of the available services, social and psychological, among others. Echoing Biddlecom *et al* (2007) on the barriers is Turan, Nyblade and Monfiston (2012) reporting stigma and discrimination as some of the main barriers to PMTCT service utilisation. Additional evidence of stigma and discrimination being a barrier to service use is drawn from a study conducted in South Africa by Population Council (2002) which reveals that due to stigma and discrimination in the workplace, VCT services were underutilized. This under utilisation of VCT services, according to Population Council (2002), was associated with HIV being a result of engaging in bad behaviour which is aligned with the findings of Nyblade (2008) that stigma and discrimination are mainly caused by a variety of things including the association of health issues with a negative attribute as per the society norms and expectations.

Additional to the under utilisation of health services, stigma and discrimination also results to psychological and behavioral challenges which in turn promote the spread of disease (Turan *et al*, 2012). To address the issues of stigma, Population Council (2002) outlines the compilation of effective policies whilst Nyblade (2008) states that stigma and discrimination are better addressed through increasing people capacity and knowledge on HIV related matters and implementing these interventions at multiple levels.

A study conducted by Sulemana *et al* (2015) in SSA, reflects a transfer of community beliefs on specific health issue to the health facility by the service providers through stating that the beliefs on the effects of contraceptives on the fertility levels of young girls were similar amongst young people, community members and HCWs. The move of information from health facility to community is facilitated either through service providers or the other clients visiting the health facility. In a study conducted by Newton – Levinson (2016), young people were afraid to use services because they were afraid of being seen by people they know who might as well tell their parents. When the transfer of information from HF to the community is done by service providers, it qualifies to be categorized as lack of confidentiality. According to WHO (2012), despite the heterogeneity of adolescents and young people globally, the two common characteristics of friendly services are; treating young people with respect; and keeping their information confidential.

In relation to the absence of confidentiality amongst service providers, young people felt the service providers can then inform their parents or guardians on the service that they had come to utilise in the health facility which will result to them being judged by their parents (Sulemana *et al*, 2015). In a study conducted in Sierra Leon by Restless development (2012), young people were not willing to utilise health services because they did not trust HCW to keep their information confidential and the lack of confidentiality resulted to fear of being known to use services that were associated with unacceptable behaviours in the community. However, the stigma and discrimination in the country does not equally affect all young people, the main population group affected are the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI), Young People Living with HIV (YPLHIV) and Commercial Sex Workers (CSW). This is to a lesser extent different from a study conducted by Newton – Levinson *et al* (2016) where females were reported to be

more subjected to stigma compared males. This is, to a certain extent true, because nationally, the HIV prevalence rate is high amongst females and CSWs are mainly female in the country (CSO and UNICEF, 2014). The implication of the above is that young people either experience or perceive or are informed of the existing stigma and discrimination in the health facilities. In terms of being informed about the existing stigma and discrimination, the experiences of young people being shared from one young person to the other facilitate this. Therefore, interventions that are designed to address issues of service utilisation stigma and discrimination need to effectively address the HCWs and the clients. The interventions need to also be designed to address stigma and discrimination amongst young people who experienced stigma and discrimination; who perceive stigma and discrimination; and those who were informed about stigma and discrimination at the health facilities.

With reference to the study conceptual framework and the study findings, the stigma and discrimination barrier can be linked both with the demand and supply side of the framework. This can be done through the social practices and health systems. However, the framework does not provide a clear pathway of how the supply and demand aspects interact to facilitate the stigma and discrimination in both the supply and demand side of the framework.

Competition to provide services to young people at community level

The findings of the study reflect that young people prefer to utilise services from alternative (pharmacies and traditional healers) service providers, not the primary health care facilities. There seems to be a competition in what the national government describes as complementary structures. According to the MoH (2013a), the health system of the country is organized in a four-tiered structure with the first level being inclusive of the traditional healers, the second level made up of

primary health care facilities and community based clinics. The reasons young people stated for not utilising services in primary health care facilities at communities is mainly because of the existence of barriers in the primary health care facilities which include high waiting times, too many questions asked by HCWs and the health care delivery approach. The literature reviewed for this study did high light similar barriers to health service utilisation by young people but did not take a step further to understand what young people do in response to these barriers. The data reflect that young people then look for alternative service providers that can provide the services to them in an acceptable manner and approach.

The absence of the competition as one of the factors that influence supply or demand for health services is also noted in the study conceptual framework. Hence, it is thus not feasible to elucidate the origins of the competition, whether it is from the supply or demand side, nor is it possible to categorise competition within the supply and demand framework. The available data of this study and the literature utilised in this study portrays the competition as emanating from the weaknesses of the supply side of the primary health care facilities. However, given that the study did not explore what is happening on the demand side that is facilitating the use of pharmacies and traditional healers instead of primary health care facilities, a conclusion cannot be reached. Young people also stated that they would rather pay more money to utilise the alternative health services than to use primary health care services. This underscores the issue of service cost not being much of a barrier to young people in terms of the utilisation of health services and also portrays the cost attached to service utilisation as not one of the major barriers of health service utilisation by young people in the country.

Limited health Interventions at community level

The data reflects that there is little happening outside of the health facility that seeks to promote health service utilisation by young people. Two critical aspects were pointed out in this barrier which are; peer influence and limited parent involvement. In terms of peer influence, young people were aware of other young people's experiences during the utilisation of health services in their local HFs. This was mainly due to discussions. The discussions either shared a negative or a positive experience of service utilisation at a local health facility. According to Ajike and Mbegbu (2016) in a study conducted in Nigeria, peer influence emerged to be the main source of information on health-related issues. Ajike and Mbegbu (2016) further argue that peer influence facilitates knowledge which in turn facilitates the use of health services. The same findings were confirmed in Swaziland by Dlamini, Mabuza, Thwala-Tembe, Masangane, Dlamini and Simelane (2017) where family, peers, religion and community norms were reported to be having an influence on health service utilisation by young people. Basically, the absence of interventions at community level compromise the distribution of information on health services within the community amongst young people, hence the utilisation of services is also compromised. Restless Development (2012) however, argues, based on the study conducted in Sierra Leone, the contrary by stating that knowledge levels do not translate to adoption of health seeking behaviours by young people. In fact, Restless Development (2012) states that despite that knowledge levels on health needs to be improved the low levels of knowledge on health issues is not the main barrier to service utilisation.

This statement by Restless Development (2012) challenges the significance of dialogues and education sessions in facilitating the increased health service utilisation as listed in the study conceptual framework. According to WHO (2015) adolescent literacy is one of the youth friendly

health service standards and it is, according to WHO (2015) equally influential on health service utilisation by young people as HCW capacity and attitude. Despite these arguments by Restless Development (2012), dissemination of health information to young people in communities remain a critical component of facilitating health service utilisation by young people.

As highlighted earlier, some of the sources of stigma include fear of being reported to parents or parents knowing that a young person was utilising certain health services. The involvement of parents in adolescent and youth health related programmes at the community level will address the fear of young people being reported to parents. Furthermore, Bayissa (2016) states that the use of SRH services is strongly associated with young people discussing SRH issues with their parents. Concurring with Bayissa (2016), Ayehu *et al* (2016) states that service utilisation by young people was higher amongst those that discussed health issues with their parents yet Godia, Olenja, Hofman, & van den Broek, (2014) argue that the discussion of such issues between parents and young people is considered unacceptable and taboo. The different reasons why parents don't discuss health issues with their children, especially SRH issues, include the lack of parental knowledge and the belief that some health discussions encourages wayward behaviour amongst the young people (Svanemyr, Amin, Robles and Greene, 2014). Eveila, Ndayala, Njue, Wanjiru, Baumgartne and Westeneng (2016) states that one of the key barriers for health service utilisation by young people in Kenya is the parents' none acceptability of the service package offered to young people in local health facilities.

According to UNESCO (2009) and Kesterton & Cabral de Mello (2010) parents are one of the key stakeholders in young people health status given their influence on the young people. UNESCO (2009) states that the views that parents have on health issues need to be addressed to improve the health status of the young people and also state that there is need to mobilize parent support for

health programmes. This can be achieved through different ways including implementing parallel programmes for parents, further states UNESCO (2009). Aligned to the importance of parent involvement in adolescent and young people's health issues is IPPF (2007) underscoring the effectiveness of having parent involvement as one of the strategies for ensuring increased health service utilisation by young people. The involvement of the parents in health related programmes does not only directly influence the service utilisation by young people but also influences the use of services through making parents allow their children to participate in health related programmes which then exposes young people to information and services (IPPF 2007). The parental support according to IPPF (2007) also ensures some financial investments on the health programme and implicitly on the use of health services by young people where relevant. A case in hand is presented by CDC (2012) through highlighting that parent involvement in school health promote positive behaviours amongst young people whilst also the collaborative working of programme staff and parents facilitate the dissemination of clear and consistent health information to young people. The implication here is that parental involvement in health programmes targeting young people will ensure that the fear for utilising health services by young people will be addressed similarly to the young people's huge need for anonymity when utilising health services.

Newton – Levinson (2016) states that main barriers to service utilisation by young people in a study focusing on middle and low-income countries were mainly associated with stigma and cultural practices and beliefs. In the case of young people, the strength of stigma and cultural norms is facilitated by the limited involvement of parents and other community stakeholders. This is given that in as much as young people in in the different literature utilised for the study stated both fear of parents and friends as the main fears they have. However, the fear of parents was more prevalent compared to the fear of friends.

In the study conceptual framework, peer influence and parental involvement can be categorized in the social and cultural factors that influence demand for health services. This is mainly because the peer influence and parents' reaction to young people's use of health services are greatly influenced by the social environment.

Facilitators

The main facilitators of service utilisation by young people identified by the study are youth friendly service providers and HF characteristics on the supply side of the framework. In terms of the HF characteristics, the focus is mainly on costs attached to the utilisation of health services and the location of the health facilities. The only facilitator from the demand side of the framework is the young people's ease of movement from a residential area to HF.

Youth friendly Service Providers

A friendly service provider is a compassionate, non-judgmental service provider; a service provider who asks few questions, who takes good care of clients, who don't use abusive language and understand young people. These characteristics are also mentioned by UNFPA Egypt and Family Health International (FHI) (2011) when listing the characteristics of a youth friendly service provider.

Table 4: YF SP characteristics by Young people and from existing literature

Youth friendly SP Characteristics by study respondents	Youth friendly SP Characteristics by UNFPA and FHI
Compassionate	Competent
Non-Judgmental	Have interpersonal and communication skills
Ask few questions	Motivated and supported
Take good care of clients	Non-judgmental
Use good and none offensive/abusive language	Allocate adequate time to clients
They understand young people	Share information with clients

Despite not requesting respondents to chronologically list characteristics of youth friendly service providers and not being able to ascertain whether UNFPA and FHI (2011) list was arranged chronologically, the chronology of the characteristics is worth noting. Young people begin their list with compassionate which basically enshrine issues or empathy whilst UNFPA and FHI (2011) starts the list with competent service providers. The importance of being compassionate when providing services to young people is also highlighted by Population Council, International Planned Parenthood Federation and London School of Hygiene and Tropical Medicine (2014) from a survey in Malawi where young people stated that a warm welcome from a service provider was critical for them. The young people noted the issue of being asked few questions in the consultation room whilst UNFPA and FHI (2011) states the need to spend adequate time with clients.

The characteristics of using good and none offensive language as well as being nonjudgmental were also noted by Newton – Levinson *et al* (2016) from a study on barriers to STI service utilisation by adolescents and young people in low and middle-income countries. In a study conducted in Ethiopia by Ayehu *et al* (2016), the non-judgmental and competent characteristic of a youth friendly service provider is confirmed. Amongst the listed characteristics, Geary *et al* (2014) highlight non – judgmental attitude as a characteristic of a youth friendly service provider. With reference to WHO (2015), the fourth standard address the issue of service provider characteristics and as such prioritizes the competency of the service provider and availability of supportive supervision as well as tools to facilitate effective decision making. The standards also highlight nondiscrimination and non-judgmental attitude towards young people. Based on the views of the young people in the study, some service providers in the country, in particular younger service providers, male service providers and doctors, do have the six characteristics of the youth friendly characteristics of service providers.

The asking of fewer questions by a service provider, as much as it might be categorized in the interpersonal and communication skill characteristic, has not been identified by the other studies. The implication of this character reflects, to some extent, the level at which young people are not happy with the amount and focus of questions asked by SPs during consultations. The set of questions asked by SPs during consultations are, however, linked to the data collection tools and procedures for providing comprehensive services to the young people. With reference to the study conceptual framework, youth friendliness of service providers is linked to the health system. However, the framework does not reflect the influence of the social and demographic characteristics on the health system, specifically youth friendliness of service provider.

Health facility characteristics

The findings of the survey reflect that the cost attached to utilising health services and the location of health facilities facilitates health service utilisation by young people in the country. According to the MoH (2013a), 85% of the national population resides within an 8km radius of a health facility. Despite this being lower than the WHO (2010) recommended distance to health facility it is still within the acceptable distance. The distance to health facilities and costs of health services has been identified by Newton – Levinson *et al* (2016) from a study on barriers to STI service utilisation by adolescents and young people in low and middle-income countries whilst Ayehu *et al* (2016) based on a study conducted in Ethiopia, the cost of service was amongst the main reasons why young people missed a service they needed when visiting a health facility. This study, however, highlights that what can be barriers to some young people were not barriers in the case of the young people involved in this survey. Evidently, a service barrier can also be a service facilitator and vice versa.

Ease of movement from residential area to health facility

Moving from a residential area to a health facility is not a challenge for young people. This might be due to the earlier highlighted distribution of health facilities in the country. The implication of this distribution is that young people can move outside of their communities to utilise services in health facilities located in other communities. PEs highlighted that young people were travelling/walking long distances to use services they believed were confidential and also satisfy their definition of youth friendly services. The ability of the young people to overcome the distance barrier is either their ability to walk or affordability of transport.

Effects of supply and demand factors on service utilisation by young people

The survey findings reflect that supply factors affect the subsequent utilisation of health services whilst demand factors affect the initial use of health services by young people. This is derived from the data where young people state that someone they knew once visited the HF and did not have a good experience, hence never returned to use services in the HF. The effect of the demand side factors is mainly on the initial use of the services. In a study conducted in Ethiopia by Ayehu *et al* (2016), young people state that they do not go to access services because of fear, stigma and discrimination related issues. Evidently, the demand side barriers are affecting the initial use of services. Once young people overcome the demand - side barriers, they have to also overcome the supply side barriers which include high waiting times and costs attached to services. In Swaziland, as earlier stated, costs of services are not that much of a barrier compared to HCW capacity and attitude.

However, the barriers need not be experienced by the individual young person to influence his or her use of services. Other young people's experiences are adequate to make one young person not to use the health services in one HF. The literature reviewed in this study did not reflect on the impact of the supply and demand factors on the use of services besides prohibiting the use of services by the young people. The study conceptual framework present service utilisation as a single thing yet service utilisation can be subdivided into initial utilisation and subsequent utilisation. The framework, therefore, needs to address both the initial and subsequent use of services through highlighting the factors that facilitate each. For Swaziland, both the supply and demand factors are active, that is, young people are not using health services because of the social context and also because of the environment in the HFs. Therefore, improving health service utilisation by young people in the country demands interventions at both the HF and community

levels. However, it is worth noting that the interrelatedness of the barriers at HF level and the community level dictates a need for collaborative effort, where interventions are implemented both at the HF and the community. As mentioned earlier in the above sections, the community cultural belief system and norms are transferred to the HF whilst the service delivery system at HF strengthens community level barriers. Hence to address the stigma and discrimination barrier at HF level there is need to address the prevailing cultural belief systems and norms at the community level whilst also addressing the service delivery system of the health facilities.

Strengths and Limitations of the Study

Being a qualitative study, the study provides deeper, rather than accurate, understanding, of the barriers and facilitators of health service utilisation by young people. However, it is not able to quantify some of the findings like the variations of the levels of youth friendliness according to service provider's age, sex and qualification; and the prevalence and levels of stigma and discrimination and its associated variations amongst young people utilising services especially amongst the LGBTIs, YPLHIV and CSWs.

The one – on – one interviews conducted in the initial assessment with exit clients were not utilised to undertake the current analysis. The study did not also undertake one – on – one interviews with none service users to ascertain the magnitude of facilitators and barriers from their perspective. Young people involved in the study were residing in communities where HFs involved in the assessment were located. The issue of facility location was, therefore, most likely to be viewed as a non - issue or weaker issue.

Recommendations

This section presents the recommendations for improving the utilisation of health services by young people. The recommendations are divided into three main areas; policy and guideline level; practice level and future research.

Policy and Guideline level

1. Rather than having issue specific AYFHS guidelines and programme within the health sector there is need to make the health sector responsive to adolescent and young people's health needs. This can be achieved through institutionalizing AYFHS which can be operationalized through the strengthening of pre-and in-service training to ensure that all nurses who graduate are able to provide services to young people.
2. The review of national policies and guidelines and the interdependency of the supply and demand factors reflect a rather bias approach for improving service utilisation by young people in the country. The approach is biased towards addressing the supply side of the service utilisation by young people. There is, therefore, the need to ensure that supply and demand issues are well addressed in national health policies and guidelines as well as interventions.

AYFHS Practice

3. The interdependency of the supply and demand factors compel for a rather simultaneous implementation of interventions addressing both the supply and demand factors. However, given the effects of demand factors on service utilisation, interventions aimed at addressing demand barriers can be prioritized over interventions aimed at addressing supply barriers.
4. The clinic routines, procedures and systems as well as service delivery approaches should be tailor - made to suit the dynamics of young people. This implies that health sector information management systems and the health facility administration systems need to be adequately

flexible to suit the needs and preferences of young people. The first step towards ensuring this is to facilitate the alignment of the young people's characteristics of a youth friendly SP and HF with the existing technical perspective on the same subject matter.

5. All cadre of HCWs, including support staff, need to undertake pre-and in-service training on youth friendliness using the contextualized youth friendly health service standards and aligned youth friendly SP and HF characteristics.
6. The distribution and dissemination of AYFHS related policies, guidelines, laws and regulations need to be institutionalized at all levels.
7. All stakeholders at all levels, including young people and parents, need to be involved in all steps of strengthening AYFHS utilisation. This involvement needs to be in all components of the programme cycle.

Implications for future research

8. There is a need to review the relevance of the WHO standards for youth friendly health services to facilitate the contextualization of the same for the country. This also entails the weighting of the YF characteristics or standards according to their importance or value in the utilisation of health services by young people.
9. Given that young people view traditional healers as an alternative to primary health care services and that some young people prefer traditional healer compared to primary health care facilities, there is a need to study the operations of the traditional healers' health provision system. This will facilitate the documentation of the differences and learn from the best youth friendly characteristics observed from the traditional healers.

10. There is need to quantitatively explore further the variations of youth friendliness to facilitate the estimation of the significance of these variations on youth friendliness. The findings will be used to strengthen the training of SPs on youth friendly services.

CHAPTER 6: CONCLUSION

The aim of the study was to study the barriers and facilitators of health service utilisation by young people from the supply and demand framework perspective. The literature review conducted in the study highlighted a common challenge of the interchangeable use of service utilisation and service access. This, to a larger extent, result to misdiagnosis of the barriers and facilitators of service utilisation by young people. Evidence to this is the continued low service uptake by young people in the country which to a significant extent is a result of limited health interventions being implemented at the community level. The shortage of these interventions at the community level implies limited support for adolescents and young people to use health services through minimised involvement of stakeholders, including parents and young people. The implication of the limited stakeholder involvement at the community level is that prevailing societal norms, practices and beliefs on health issues will remain prevalent.

These societal norms, practices and beliefs are transferred from the community to the health facility by the community members and the HCWs. Given the current state of affairs; absence of comprehensive AYFHS policy and guidelines; the service integration methodology; and having young people and adults use the same health facilities, the cultural norms, practices and beliefs influence or guide the provision of health services in the health facilities. One of the cultural practices taken to the health facility from the community is the none discussion of health issues between adults and young people which in turn negatively affects the youth friendliness of the service providers and subsequently the health facility. Being one of the key supply factors that facilitate service utilisation by young people, youth friendliness also varies with the socio demographic characteristics, age, sex and qualification, of SPs and the health care delivery system

of each health facility. Despite youth friendliness being one of the key health service utilisation factors, there is a none alignment between the professionally embraced characteristics of a youth friendly service provider and youth friendly health facility with the characteristics identified by young people. The result of the none alignment of the characteristics is the adoption and implementation of procedures and processes that are counter youth friendly in the health facilities. These procedures and processes identified by the study include the mandatory HIV testing in health facilities and the service delivery system utilised in health facilities.

These counter youth friendly procedures and processes act as push factors for young people to seek alternative health services, either another health facility or change from primary health care facilities to pharmacies or traditional healers. Despite the traditional healers being categorized as one of the institutions that make up the first level of the national health care system, traditional healers are viewed by young people as an alternative to the primary heal care delivery facilities. Young people prefer to visit traditional healers instead of primary health care facilities because traditional healers are convenient and youth friendlier compared to primary health care facilities. The youth friendliness characteristics of the traditional healers might be aligned to the characteristics of youth friendliness as outlined by young people.

However, some HFs and SPs are also considered to be youth friendly by the young people. In terms of the SPs, the younger and male SPs as well as the doctors were reported to be youth friendlier compared to females, older SPs and nurses. The youth friendlier SPs were reported by the young people to be compassionate, none judgmental, ask few questions, take good care of clients, use good and none offensive/abusive language and understand young people. In terms of the main characteristics of a youth friendly HF, young people noted that a facility that; allows them to utilise health services anonymously; ensure that their information is kept confidential; and

ensure that adults and young people do not use same waiting areas and consultation rooms. The above listed SP and HF youth friendliness characteristics facilitate the subsequent visit of the young people to the health facility through weakening other existing barriers like the costs of services and the location of HF. Despite these two being categorized as barriers in some studies, they are categorized as both a facilitator and a weaker barrier in this study, respectively. This is mainly because of; the distribution of health facilities; and the heavy involvement of the national government and none governmental organizations in provision of health services in the country.

Finally, the findings of the study also present service utilization as an outcome of the interplay between supply and demand factors. The demand factors affect mainly the initial use of health services/visit to HF whilst supply factors affect mainly the subsequent use of services/visit to the same HF or other HF. However, the supply and demand factors influence each other given that some of the supply factors result to the demand factors and some of the demand factors result to the supply factors.

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