

**EXPLORING ADOLESCENTS' PERCEPTIONS REGARDING
YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH
SERVICES IN A SELECTED COMMUNITY HEALTH CENTRE
(CHC) IN UMGUNGUNDLOVU DISTRICT**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT
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DECLARATION

I, Kwenzile Lungile Hlatshwayo, hereby declare this research dissertation titled “Exploring Adolescents’ Perceptions Regarding Youth-Friendly Sexual and Reproductive Health Services in a Selected CHC in uMgungundlovu District” is my original work. It has never been submitted for any other purpose or to any other academic institution. Sources of information used in this work have been acknowledged in the reference list.

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DEDICATION

I dedicate this study to my husband Mr Sibusiso Vincent Hlatshwayo, my mother Makhosi Patricia Yende, my grandmother Josephine Shezi, and my daughter Olwakheuthando Hlatshwayo whom I love dearly and who at times could not get my attention as I attended to my studies.

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ABSTRACT

Background

One of the key concerns globally is the sexual and reproductive health of adolescents, especially in developing countries and regions like sub-Saharan Africa, where the largest number of deaths is due to the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS), (World Health Organization, 2014). According to the WHO, 2014, an estimated 16 million girls between the ages of 15 and 19 years give birth every year, and most of these girls come from low- and middle-income countries.

Purpose

The purpose of this study was to explore adolescents' perceptions regarding youth-friendly sexual and reproductive health services in a selected community health centre (CHC) in uMgungundlovu District in the KwaZulu-Natal province of South Africa.

Methodology

A quantitative research design, utilising a survey, was chosen for the study. A non-probability convenient technique was selected. A sample of 169 adolescents was included in the study using the convenience sampling method.

Findings

The study revealed that healthcare staff generally has positive attitudes towards rendering sexual and reproductive health services to adolescents in the selected CHC.

Recommendations

The recommendations arising from this research, therefore, focus on nursing practice and the formulation of policies for addressing adolescents' perceptions regarding youth-friendly sexual and reproductive health services, and the involvement of youths in its delivery if one is already in place. Nursing education regarding the inclusion of adolescent youth-friendly sexual and reproductive health in the curriculum, as well as further which will focus more on male adolescents' perceptions.

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Exploring Adolescents' Perceptions Regarding Youth-Friendly Sexual and Reproductive Health Services in a Selected CHC in uMgungundlovu District

CHAPTER 1: INTRODUCTION

1.1 Introduction and background

One of the key concerns globally is the sexual and reproductive health of adolescents, especially in developing countries and regions like sub-Saharan Africa, where the largest number of deaths is due to the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS), (World Health Organization, 2014). Despite being aware of where HIV testing is provided, adolescents are not usually keen to access these services (UNICEF, 2012).

Approximately 1.8 million adolescents aged 10 to 19 years were living with HIV in 2015 which is 28% higher than a comparable estimate in the year 2005 of 1.4 million (UNICEF, 2016). Almost 50% of the adolescents living with HIV in 2015 were from five countries, India, Kenya, Nigeria, Tanzania, and South Africa. The heightened number of adolescents living with HIV is partially due to the fact that numerous adolescents living today contracted HIV through vertical transmission (HIV transmission from an infected mother to her child during pregnancy). Programmes have seldom concentrated on enhancing methods for pinpointing adolescents growing up with HIV and providing them with treatment and care. About 250 000 adolescents aged 15 to 19 years contracted HIV around the world in 2015. Approximately 29 new infections took place hourly among older adolescents of 15 to 19 years. Two of three new infections took place in sub-Saharan Africa. Methods of preventing new infections remain sluggish with an 8% decrease in new infections since 2009 (UNICEF, 2016). According to Njoki (2015), teaching adolescents about sexual health and HIV and AIDS does not persuade them to increase sexual activity. It is better for education to be provided early preferably prior onset of sexual activity. The inability of SRH programmes to meet the health needs of adolescents places them at risk of acquiring STIs, getting unwanted pregnancies and HIV and AIDS.

According to the WHO, 2014, an estimated 16 million girls between the ages of 15 and 19 years give birth every annum, and most of these girls come from low- and middle-income countries. The second cause of death among these girls aged 15 to 19 years are complication which they incur during childbirth. Socio-cultural norms, access to health services, education and employment opportunities are some of the factors which depict the outcomes of adolescent sexual and reproductive healthcare. Youth-friendly health services have significance in the sexual and reproductive health (SRH) of youth. The WHO, 2012 defines adolescence as a stage that occurs in which a person changes physically and psychologically beginning at a young age. These changes are associated with adjustments in social relations with peers. It is an intermediate phase where the person is neither a child nor an adult. Various decisions are made by youths during adolescence, many of the decisions and actions taken influence their future health. Actions like unprotected sexual activity may result in unplanned pregnancies and sexually transmitted infections including HIV (World Health Organization, 2012).

At the forefront of the HIV and AIDS epidemic are adolescents, who remain susceptible to HIV. Physical and emotional changes with an increase in hazardous behaviour heighten their vulnerability to HIV. According to the WHO, approximately 2.1 million adolescents were living with HIV in 2012. From 2005 till 2012 deaths among adolescents associated with HIV raised by 50% compared to the global number of deaths associated with HIV which declined by 30%. Improper prioritisation of adolescents in healthcare services, poor provision of satisfactory HIV testing and counselling (HTC) and treatment and inadequate support for adolescents to adhere to antiretroviral therapy are some of the causes which increased HIV associated deaths among adolescents (World Health Organization, 2013).

A study conducted in South Africa by (Debbie Bradshaw et al., 2016) showed that the number of AIDS deaths in South Africa increased from the year 1997 to 2006 at a rate of 283 000 deaths per year. However, the number of AIDS deaths started to decrease and reached 207 000 in 2010. These results are in line with the extensive roll-out of antiretrovirals in South Africa from 2004 and effective prevention of mother to child transmission from 2003.

Pregnancy among adolescents is of significance due to the potential complications it possesses for both mother and child. In Latin America, adolescents begin sexual activity at an early age – between 10 and 19 years. A small number of them take precaution to use barrier methods such as the condom to prevent sexually transmitted infections or pregnancy. From a global perspective, Latin America is the only region with an increase in the number of births by girls under 15 years of age. The number of births is expected to rise to 2030. Young girls with unwanted pregnancies often choose unsafe abortions because abortions are highly restricted or illegal. Twenty-five girls in 1000 between the ages of 15 and 19 years have unsafe abortions in Latin America. In reaction to the pregnancy and abortion rates, a project was begun called the Community-Embedded Reproductive Healthcare for Adolescents (CERCA) in Nicaragua, Bolivia and Ecuador. The project was intended to enhance communication between the adolescents, their parents and peers on SRH, access to appropriate SRH information, utilisation of SRH services in primary healthcare facilities, and management of modern contraceptives (Olena Ivanova, 2016).

A selected number of adolescents who are alive and in school to owe their life who pledged to assist them to live their lives to the fullest through the United Nations Millennium Declaration which was adopted in the year 2000. Globally a large number of adolescents are educated than in the past decades (UNICEF, 2012). According to UNICEF, an estimated 1.4 million adolescents die per annum. The causes of the deaths differ and they include childbirth, violence, suicide, road traffic accidents and AIDS. Deaths vary according to regions. In Latin America the main cause of death among adolescent males is injuries; pregnancy and birth complications are the main cause of death among adolescent girls aged 15 to 19 years old. About 11% of all births globally are among adolescents aged 15 to 19 years. In the face of a decrease in the general birth rates globally, it still remains heightened in some countries. About 2,2 million adolescents, 60% of them being females live with HIV today. Generally, the knowledge of HIV in older adolescents aged between 15 and 19 years is minimal, with females having less knowledge than males.

In many countries, male adolescents have more educational opportunities than female adolescents. The males are more likely to obtain secondary education than the females, who may be forced into early marriage and its premature sexual activity. A large number of the adolescents who get married usually do so against without their consent and at times with men

who are older. According to UNICEF, some studies have shown that the age gap is great among spouses when women marry at a young age when compared to women who get married at an older age. Huge age differences among spouses are likely to influence power relations in the marriage, at times placing the woman at risk of domestic violence. Having older husbands place the women at risk of becoming widows early in life, with possible financial instability and negative effects on their social status. Internet and social media usage by adolescents such as Facebook enable adolescents to get access to information and to connect with others; it also has its disadvantages such as exposing the youth to unsuitable content, unwelcome invitations from others and the risk of engaging themselves in inappropriate behaviour. Adolescent contact with the media is constantly changing from time to time. However, 28% of girls and 17% of boys between the ages of 15 and 19 years old do not have access to a television. In general, studies show that higher income and education provide the benefits of internet usage. A huge division is shown by studies where those residing in the urban areas are likely to use the internet when compared to those residing in rural areas. More persons under the age of 25 years use the Internet compared to those over 25 years. Adolescents aged 10 to 14 years are less likely to use the Internet than youths aged 15 to 24 years (UNICEF, 2012).

The United Nations Population Fund (UNFPA) considers adolescence to be divided into three phases, mainly early, middle and older adolescence (UNFPA, 2012a). Early adolescence begins from 10 to 14 years and is portrayed by the start of physical changes. Middle adolescence is from 15 to 16 years and is illustrated by progressive changes in sexual alteration. Followed by older adolescence where the individual has adult-like behaviour. The protection of adolescent health is crucial in the long run achievement of developmental goals and in the reduction of poverty. An estimated one in three female adolescents become pregnant prior to the age of 18 in some of the poverty-stricken regions of the world. Being of a young age predisposes the girls to maternal death. Approximately three million unsafe abortions take place per annum among girls aged 15 to 19 years. There is a higher incidence of stillbirths and newborn deaths among infants from adolescents when compared to the infants from women between the ages of 20 and 29 years. The risk of low birth weight is high among infants born to adolescent mothers and likely to be accompanied by long-term effects. A study conducted in sub-Saharan African countries showed the underuse of maternal healthcare services by adolescents aged 15 to 19 years when compared to women between the age of 20 and 39 years. Poor quality healthcare was more likely to be

provided to those adolescents who had a premarital and unintended pregnancy. Unmarried adolescents face social disapproval in the majority of developing countries when they seek family planning (UNFPA, 2012).

Adolescent sexual and reproductive health is considered by (Rita Moses Mbeba et al., 2012) as the provision of sexual and reproductive health services that cover adolescent early sexual debut, unplanned teenage pregnancy, sexually transmitted infections (STIs) and HIV and AIDs as well as safe abortions sexual abuse and violence.

When compared to sexual and reproductive health, adolescent youth friendly services are referred to by (Africa, 2011) as health facilities which generally offer information regarding sexually for adolescents. The services offered to youth also include STI and HIV services such as prevention, testing, treatment, partner notification and pre and post test counselling for HIV. These facilities provide family planning, pregnancy testing, safe abortion, post abortion care, antenatal care and post natal care as well as normal growth and development for youth. Counselling and mental health services are also provided.

According to research done by (A.S. Erulkar et al., 2005) having sufficient staff at health facilities is of importance in the delivery of adolescent sexual and reproductive health services. The study conducted by (A.S. Erulkar et al., 2005) in Kenya and Zimbabwe on adolescents preferences for sexual and reproductive health services revealed that confidentiality, a short waiting time and friendly staff were some important characteristics that adolescents wanted in their service provision.

The State of the World's Population report (Williamson, 2013) illustrates that social norms create barriers to the accessing information on family planning. However, despite the limited access, the early commencement of sexuality is still on the rise. When family and social structures which provide support in an individual's life are disrupted by incidents such as natural disasters, adolescents are more likely to involve themselves in sexual activity as a source of comfort. This was confirmed by a study which was conducted in a refugee camp in Congo, which showed that approximately 30% of all births were incurred by girls between the age of 14 and 18 years (UNFPA, 2012). A great deal of knowledge has surfaced globally regarding effective SRH programmes. Knowledge obtained by youth from SRH programmes influence the

knowledge and attitude of the adolescents. However, this does not routinely lead to change in behaviour among the adolescents. Some research shows that the implementation of efficient SRH programmes requires skills building combined with sex education for clinicians on discussing sexual behaviours with the youth (UNFPA, 2012).

A momentous event for adolescent sexual and reproductive health (ASRH) took place in 1994, in the International Conference on Population and Development (ICPD) when the need to address the sexual and reproductive health of adolescents was acknowledged (Venkataraman Chandra-Mouli, 2015). Since the ICPD much has happened regarding ASRH in the past two decades. The rights of adolescents have been taken into account and interventions have been put in place to address their health needs. Even though there are still disparities in knowledge and understanding the ASRH, much has been displayed regarding the needs and problems faced by adolescents in middle and low-income countries. According to Chandra-Mouli et al. (2015a), the current methods of advancing adolescent health have concentrated on single behaviours which encompass abstinence, and the use of barrier contraceptive methods such as the condom. A large number of high-income countries have welcomed the idea of prevention science. The Society for Prevention Research specifies that the chief goal of prevention science is to better public health by pinpointing risk factors and assessing the effectiveness of the current preventive intervention methods including ASRH preventive methods. The research base developed in these high-income countries is now applied in middle and lower income countries by the translation of existing methods and the creation and testing of new preventive interventions (Chandra-Mouli et al., 2015a).

In Kenya, similar to other parts of Africa adolescents encounter a number of SRH problems. These problems encompass early pregnancies, which are usually unwanted, complications from childbirth and unsafe abortions. There are a high number of maternal and perinatal mortality due to adolescent's poor access to friendly healthcare services, antenatal care, prevention and provision of treatment for sexually transmitted infections (STIs) and provision of safe abortion services (Njoki, 2015). In 2003, the Kenyan Government created a national Adolescent Health and Reproductive Policy which aimed to tackle the challenges which were faced by the adolescents in Kenya. Another Health Policy was further formulated in 2007 which aimed to better the reproductive health of the youth and to provide them with access to complete SRH

information. The use of family planning method among adolescents in sub-Saharan Africa is low. Adolescents aged 15 to 19 years, those who are married and the unmarried, have the highest unmet need for family planning. This group of adolescents usually has poor access to contraceptives. Some of the barriers to access contraceptive are laws which prohibit or restrict the young or unmarried girls from getting contraceptives, needing consent from the parents or spouses for contraception to be given. Pregnant unmarried girls often feel shy obtain healthcare due to the judgmental healthcare providers. With married adolescents, the spouse makes the decision whether or not healthcare should be sought and the whereabouts where it should be obtained. Cost may also hinder adolescent girls from seeking healthcare due to having little money of their own and being dependent on others for financial support (Njoki, 2015).

According to (Urindwanayo, 2011), an estimated 79 million new babies are born into the world each year. This adds to an estimated 67 billion people who are alive in the world constantly. This is accompanied by highest mortality rates among women and children. The appropriate means to better the lives of these women is family planning. Family planning has been confirmed by a number of studies to save the lives of women and children, through a reduction in the number of unwanted pregnancies. Numerous countries have high fertility rates with a land for living which is scarce. For the growth of a country, a limitation and spacing in the number of births is important. Fewer unsafe abortions take place when women have control over their fertility. Long birth intervals help in the reduction of maternal and infant mortality rates. In numerous countries in the sub-Saharan Africa and other countries especially Rwanda, the use of contraceptives is low. Condoms play an important role in the prevention of STIs, HIV/AIDS and unplanned pregnancies. Among all the currently available contraceptives, condoms provide dual protection: from STIs and from unwanted pregnancies. In 2003, condoms were being used 5.7% globally. Other family planning methods include sterilisation, implants, injectables, and abstinence (Urindwanayo, 2011).

In Uganda, abortions are legally controlled. Medical officers, clinic offers and midwives offer post-abortion care (PAC) services. Regardless of female and male adolescents having numerous reproductive health challenges, additional burdens are laid on female adolescents which are gender related. An estimated 24% of adolescents aged 13 to 19 were pregnant with their first child or already mothers in the year 2011 (Lynn M. Atuyambe et al., 2015). Although adolescent

pregnancy had been decreasing over the years (41% in 1995, 31% in 2000, 25% in 2006 and 24% in 2011), it still remains high. Not only is pregnancy among adolescents associated with high mortality and morbidity rates for the mother and child, it is also accompanied by psycho-social consequences which affect their well-being. Early marriages among adolescents in countries like Uganda and Ethiopia often lead to complications during pregnancy and childbirth. Regarding healthcare providers, adolescents require specific types of services. Privacy is of importance during adolescent service delivery. Adolescents are often hesitant to request SRH services due to poor understanding of adolescent reproductive health needs, lack of private working rooms, supplies and equipment and judgmental healthcare providers. Policies which cater to adolescent health and development are present in Uganda but have not been put into practice. Although almost half of the Ugandan population comprises of adolescents, there are inadequate sexual and reproductive health services which do not address the health needs of adolescents (Atuyambe et al., 2015).

Adolescent pregnancy is a worldwide concern and risen rapidly in South Africa (Mushwana et al., 2015). A report in 2006 showed that approximately 5868 pupils in KwaZulu-Natal, 5000 in Limpopo, 2542 in Gauteng, and 1748 in the Free State province were pregnant. Pregnancy brings about changes in the life of adolescents. In numerous cases, the changes are negative and associated with negative social consequences which include dropping out of school and interrupted education. Adolescent pregnancies have negative effects on society's socio-economic status such as unemployment and poverty (Mushwana et al., 2015).

The increase in the expansion of contraceptive information, services and technologies have increased right into the 20th century on a global basis. Despite this mainstream contraceptives are still more limited in sub-Saharan Africa than in any other region in the world (Dorah U. Ramathuba, 2012). On average the commonness use of contraceptives in Africa is 27% which is smaller than the average throughout the world. The concept of contraceptive use as a means of birth control has changed in the Republic of South Africa over the past years. In the past, teenage pregnancy was unacceptable according to cultural norms, but this appears to be changing. In black communities, cultural beliefs are some of the chief causes which prevent adolescents from gaining information regarding sexuality due to its culture in acceptance by parents. In spite of the Government's efforts to provide free contraceptives for all, adolescents are still at risk of falling

pregnant. Adolescents in South Africa are at risk of unwanted pregnancies due to improper use of contraceptives and poor consultation of contraceptive services. A number of studies on pregnant adolescents in SA have indicated that the adolescents had some knowledge regarding one or another method of preventing pregnancy but failed to use them. A study done in Tshwane in SA showed that 60% of the adolescent mothers had knowledge regarding contraceptives, but only 43 used the pill, condoms and injectables. Some of the reasons given by the adolescents for not using contraceptives were fear of their parents and of being barren.

1.2 Problem statement

Adolescents are a group with peculiar health needs. They possess different expectations and preferences when it comes to their reproductive and health needs. The mortality and morbidity rates in the modern world among adolescents emphasise the need for quality youth-friendly health services. Adolescents from several parts of the world possess two similar characteristics when it comes to sexual and reproductive healthcare, mainly to be treated with respect and assurance that confidentiality is maintained with the healthcare providers. The largest number of adolescent deaths is due to HIV and AIDS (WHO, 2012). According to the WHO, approximately 2.1 million adolescents were living with HIV in 2012 (WHO, 2013).

Adolescents from sub-Saharan Africa regions are largely affected by HIV. In 2015 an estimated 1.8 million adolescents were living with HIV (UNICEF, 2016). Majority of these adolescents were from countries like Kenya, Nigeria and South Africa. The number of adolescent girls affected by HIV and AIDS remains extremely heightened. The need to prioritise adolescent health needs is evident due to the likelihood that HIV infection among adolescents is likely to increase in the coming years. In the African continent, the population group of 10- to 24-year-olds is estimated to rise by more than three-quarters of a billion by the year 2060. This comes with an estimated addition in the number of new HIV infected adolescents. If the incidence rates remain equal to those of 2015, then HIV infections in adolescents aged 15 to 19 years would rise to 280 000 per annum by the year 2020, to 330 000 per annum by the year 2025, and to 390 000 by the year 2030. The regions particularly burdened by HIV among adolescents are Eastern, and Southern Africa and West and Central Africa (UNICEF, 2016).

According to (Anna Newton-Levinson et al., 2016), adolescents have insufficient knowledge and awareness of STIs, and these are some of the barriers that inhibit adolescents from seeking healthcare. Some of the youths in the study by Newton-Levinson et al. (2016), which included data from 15 countries, had heard about certain STIs, but large numbers of them were not able to identify symptoms and others had misconceptions. Poor knowledge was usually related to a delay in seeking healthcare (Anna Newton-Levinson et al., 2016).

1.3 Research purpose

The purpose of this study is to explore adolescents' perceptions regarding youth-friendly sexual and reproductive health services in selected community health centres (CHCs) in the uMgungundlovu District of KwaZulu-Natal.

1.4 Research objectives

1. To explore the attitudes of staff towards giving sexual and reproductive healthcare services to youths.
2. To explore the implementation of the sexual and reproductive healthcare youth-friendly policies.
3. To describe the environment and facility characteristics of the CHC settings.
4. To explore services rendered to adolescents with regard to youth-friendly sexual and reproductive healthcare services.

1.5 Research questions

1. What are the staff attitudes when giving sexual and reproductive healthcare services to youths?

2. Are the Sexual and Reproductive Health Policies for rendering services to youths implemented correctly?
3. What are the environment and facility characteristics of the CHC settings?
4. Which services are rendered to adolescents with regard to youth-friendly sexual and reproductive healthcare?

1.6 Significance of the study

Adolescents

The current study may reveal the need for an improvement in adolescent sexual and reproductive health services, and the importance of the provision of youth-friendly sexual and reproductive health services for adolescents.

Nursing Practice

The current study may generate a new body of knowledge in nursing and therefore contribute to the development of the nursing profession and the way nurses approach adolescents who seek sexual and reproductive health. Improved health services might be rendered to the youth due to relevant training and education of nurses who are socially responsible, thus promoting a better health for all.

Nursing Education

The findings of this study may help nurse educators understand how adolescents perceive youth-friendly services regarding sexual and reproductive healthcare and this may highlight the importance of including youth-friendly sexual and reproductive healthcare in the curriculum.

Policymakers

The findings of this study may play an important role in identifying and the drawing of interventions to overcome social determinants of Sexual and reproductive health inequalities and health system shortcomings which stand in the way of achieving the highest attainable level of youth-friendly sexual and reproductive healthcare for adolescents. In this way, the health facilities can help in the social development of behaviours of young people.

1.7 Operational definition of terms

Adolescence

According to the WHO (2012), adolescence is a stage that occurs in which a person changes physically and psychologically beginning at a young age. These changes are associated with adjustments in social relations with peers. It is an intermediate phase where the person is neither a child nor an adult. This period of adolescence is further categorised into three stages, namely, early adolescence, mid-adolescence and late adolescence. Early adolescence comprises of persons between the ages 10 to 13 years which is categorised by growth along with sexual maturation. Similarly, mid-adolescence comprises of persons between the ages 14 to 15 years which is categorised by the development of a stronger sense of identity and late adolescence comprises of individuals between ages 16 to 19 years and is categorised by the development of adult behaviours (World Health Organization, 2012). In this study, adolescents are all young people between the ages of 18 and 21 years.

Sexual Health

According to the WHO (2002), sexual health is defined as a state of physical, emotional, mental and social well-being in relation to sexuality. It is not just the absence of disease, dysfunction or infirmity. It necessitates a respectful and positive approach to sexuality and sexual relationships and the possibility of having safe and unharmed sex (World Health Organization, 2002).

Reproductive Health

The International Conference on Population and Development (ICPD) (1994) defined reproductive health as:

a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies the people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this

last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant(World Health Organization, 2002).

Community Health Centre (CHC)

According to the KwaZulu-Natal Department of Health (2001), a CHC is a facility that normally provides primary healthcare services, 24-hour maternity, accident and emergency services, as well as beds where patients can be observed for up to 48 hours, and which normally has a procedure room, but not a full operating theatre.

Youth-Friendly Services

According to the African Youth (alliance, 2003), youth-friendly services should be characterised by a convenient location, by separate times which are set aside for the young patients, by adequate space and sufficient privacy in the consultation rooms and by the maintenance of confidentiality and privacy. The staffs who deal with youth are friendly and approachable.

1.8 Theoretical framework

According to (Grant and Osanloo, 2014), a theoretical framework is a blueprint for the entire research which helps the researcher to organise the study. It creates a context in which the researcher can examine the problem and gather and analyse data. The Health Belief Model will be used as a theoretical framework for this study. The focus of the Health Belief Model is on an individual's beliefs and attitudes. The model deals with the individual's perceptions of threat created by a health problem, regarded as susceptibility and severity, the benefits of avoiding the threat and factors which influence the decision to act referred to as barriers, cues to action and self-efficacy(Carpenter, 2010).

According to (Carpenter, 2010), the Health Belief Model was created in the early 1950s by a group of social psychologists in the US Public Health Service to explain which beliefs should be the focal point in communication campaigns in order to create positive health outcomes.

The constructs in the Health Belief Model are described below and the discussion is based on (Tavafian, 2012).

Perceived Susceptibility

Perceived susceptibility refers to ideas about the likelihood of acquiring a disease or condition. For instance, an adolescent must believe there is a likelihood of becoming infected with an STI or becoming pregnant before they are convinced to use a condom. The Health Belief Model predicts that adolescents are likely to adhere to contraceptive use if they feel susceptible to STIs and pregnancy (Tavafian, 2012).

Perceived Severity

The perceived severity of a disease refers to the seriousness of a health problem as viewed by an individual. It refers to the seriousness of contracting the disease or of leaving it untreated. It takes into account an assessment of clinical and medical consequences such as disability, pain and death. The grouping of ‘susceptibility’ and ‘severity’ has been referred to as ‘perceived threat,’ (Tavafian, 2012).

Perceived Benefits

Perceived benefits refer to an individual’s perception regarding taking numerous actions to reduce the threat of illness or to cure the disease. The course of action which an individual takes in preventing or curing a disease is dependent on the consideration and assessment of both perceived susceptibility and perceived benefit (Tavafian, 2012).

Perceived Barriers

Perceived barriers refer to the negative aspects of health-orientated actions which exist and prevent the successful implementation of a recommended health action. Perceived barriers are the potential negative health aspects of a particular action which may act as an impediment to undertaking recommended behaviours. For instance, if adolescents believe that the anticipated

benefit of doing contraceptive use to prevent STIs and pregnancy outweigh the barriers of obtaining contraceptives they are more likely to use sexual and reproductive health services available to them (Tavafian, 2012).

Cues to action

Cues to action refer signals which are needed to kick-start the decision-making process to accept a recommended health action. These cues can be internal such as the presentation of STI symptoms, for instance, a yellow vaginal discharge in sexually active female adolescents or genital warts. They may also be external, such as advice to obtain treatment given by a family member (Tavafian, 2012).

Perceived self-efficacy

Perceived self-efficacy refers to the certainty that an individual can successfully execute the required behaviour to produce the outcomes. In order for an individual to be transformed, they must feel threatened by their present behavioural pattern which is regarded and perceived susceptibility and severity; they must believe that a particular change will result in an esteemed outcome at an acceptable cost referred to as perceived benefit. They must also feel competent to overcome perceived barriers to take actions referred to as being self-efficacious (Tavafian, 2012).

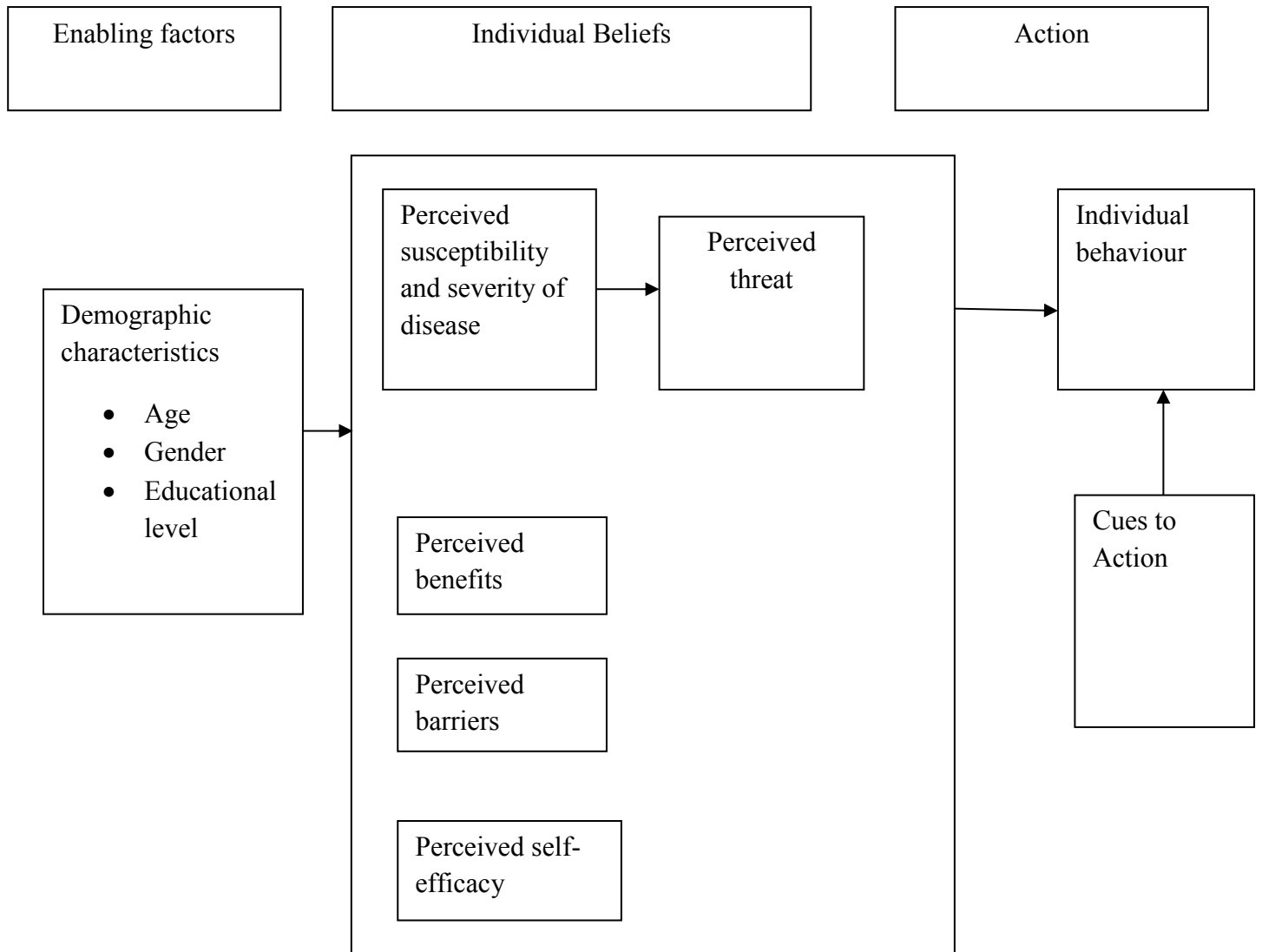


Figure 1.1: Health Belief Model components and links, adapted from (V.L. Champion and C.S. Skinner, 2008)

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents the reviewed literature. A literature review is defined by (Burns and Grove, 2005) as a methodical approach to the identification, retrieval and bibliographical organisation of studies for the intention of locating information on a topic, creating conclusions, ascertaining areas for future studies and creating guidelines for clinical practice. This chapter covers research studies on adolescent friendly sexual and reproductive health services.

2.2 Adolescent sexual and reproductive health, a global concern

The sexual and reproductive health of adolescents is a great concern globally with the occurrence of HIV remaining alarmingly high in youth between the ages of 10 to 24 years in Africa. According to UNAIDS, 37% of new HIV infections occurring in sub-Saharan African adults in 2015 were among adolescents and youth aged 15 to 24 years (Desire Lucien Dahourou et al., 2017). The giving out of antiretroviral therapy has enabled perinatally HIV-infected children to survive into adulthood. Youth living without HIV are at an advantage when compared to their HIV infected counterparts who face numerous challenges. They are a vulnerable group who encounter developmental, psychosocial and co morbidity issues while dealing with a chronic and partially stigmatising disease. They encounter clinical problems as a result of their long-term exposure to the virus and ART including drug toxicity, metabolic and cardiovascular disorders, chronic lung disease, renal and bone diseases (Desire Lucien Dahourou et al., 2017).

According to Njoki (2015) and (Jimmy-Gama, 2009), adolescence is regarded as a period of transition from childhood to adulthood where the individual experiences changes associated with puberty. The time of adolescence is outlined by a number of changes which include physical and emotional changes. During this period the youth may develop habits which they later take into their adult lives. Adolescents form a large portion of the population when compared to adults however they are at a greater risk of illness and death from reproductive causes such as STIs, early pregnancies, abortions and HIV/AIDS. The vulnerability of the adolescence is due to a combination of factors which are physiological and behavioural.

During adolescence, a big challenge takes place because this developmental stage is accompanied by new feelings and friends assume greater importance and interest in the opposite sex increases (E. Gouws et al., 2008). According to Erikson's theory of psychosocial development, from the age of 12 onwards, adolescents may face a psychosocial crisis referred to as identity versus role confusion and this can certainly be experienced if an adolescent becomes pregnant (D.R. Shaffer and K. Kipp, 2007). In a study conducted by (Mushwana et al., 2015), it was found that adolescents perceive pregnancy as something which is unintended. Pregnancy is usually associated with particular characteristics such as knowledge, maturity, skill and age at first sexual intercourse encounter.

There are currently 1.2 billion adolescents globally who are important resources for their countries, but they are also at an elevated risk of mortality and morbidity as a result of intentional and unintentional injuries, mental health problems, pregnancy-associated complications and a number of various life-threatening communicable diseases such as HIV (Manisha Nair et al., 2015). According to (Manisha Nair et al., 2015) with the purpose of improving the quality of healthcare services for adolescents globally, the WHO embarked on a process to develop eight Global Standards.

The Global Standards were developed through a four-stage process: (1) conducting a needs assessment; (2) developing the Global Standards and their criteria; (3) expert consultations; and (4) assessing their usability (Manisha Nair et al., 2015). The needs assessment involved conducting a meta-review of systematic reviews and two online global surveys in 2013, one with primary healthcare providers and another with adolescents. The Global standards were established based on the needs assessment in concurrence with the analysis of 26 national standards from 25 countries. The final document was reviewed by experts from the WHO regional and country offices, governments, academia, NGOs and development partners. "The process resulted in the development of eight Global Standards and 79 criteria for measuring them" (Manisha Nair et al., 2015). The eight Global Standards are: (1) adolescent health literacy; (2) community support; (3) an appropriate package of services; (4) providers' competencies; (5) facility characteristics; (6) equity and non-discrimination; (7) data and quality improvement; and (8) adolescents' participation (Manisha Nair et al., 2015).

In a study on interventions addressing structural drivers of adolescent's sexual and reproductive health, it was found that women and girls in sub-Saharan African countries are mostly affected by the HIV epidemic (Wamoyi, Mshana, Mongi, Neke, Kapiga & Changalucha, 2014). Young people between the ages of 15 and 24 years account for an estimated 45% of new infections worldwide. In this age group, females between the ages of 15 to 24 years are eight times more likely to acquire HIV than young men. The researchers further stated that adolescent behaviour is affected by their social and economic context (Wamoyi et al., 2014). Factors which increase or decrease an individual's chance of acquiring HIV or other STIs are poverty, gender issues in relationships and families and social norms. Some data has revealed that, in Tanzania, in order to fulfil their material needs, some young women from poverty-stricken families may involve themselves with many partners in transactional sexual activity, even without the use of a condom (Wamoyi et al., 2014).

In the study conducted by (Silvia Huaynoca et al., 2015), through a comprehensive literature review on SRH services for young people and national efforts to improve the quality of care in Colombia and neighbouring states, aimed at scaling up the youth-friendly model in Colombia revealed that in seven years, from 2007 to 2013 of the implementation of the Youth-Friendly Health Service (YFHS) model more than 800 clinics have become youth-friendly. The analysis in the study using the WHO-ExpandNet framework identified five components that enabled the expansion in the YHFS which were clear policies and implementation guidelines on YFHS, identification of and support to stakeholders and advocates of YFHS. The elements that limited or decelerated the scale-up effort were too few healthcare personnel trained in youth health and SRH, a high turnover of healthcare staff, insufficient supply of financial and human resources, and negative opinions among community members about the provision of SRH information and services to youth (Huaynoca et al., 2015).

2.3 Providing adolescents with appropriate SRH services

Various evaluations have proved that adolescents use of SRH services is raised when four complementing approaches are implemented together, these are the provision of healthcare providers who are trained and supported to be non-judgmental and friendly to adolescent clients,

the provision of Health facilities which are welcoming and appealing, the introduction of communication and outreach activities to inform adolescents about services and encourage them to make use of services and making community members aware of the importance of providing health services to adolescents. Although various projects and programmes globally aim to offer youth-friendly services, assessments suggest that programmes do not put into action the four approaches together. This is shown by a study which was conducted in Brazil which revealed that findings which were found in an integrated school and health clinic-based adolescent reproductive health initiative were successful in raising the flow of sexual and reproductive health information to secondary school students and it had an influence on adolescents aims to use public health clinics in future (Venkataraman Chandra-Mouli, 2015).

According to (Michelle J. Hindin et al., 2012), in the past five decades, the health of adolescents has developed at a slow pace when compared to that of younger children. This is partially because early pregnancy carries an increased risk of serious complications and because an estimated 40% of new HIV infections that occur in young people aged 15 to 24 years. Although governments have committed to addressing health problems which commonly affect adolescents, little evidence has shown whether or not these commitments have made a difference. The support which has been provided by the WHO to research on adolescent sexual and reproductive health since the mid-1980s has added to the development of programmes in this area in numerous countries. The aim of the study done by (Michelle J. Hindin et al., 2012) was “to conduct an expert-led process for identifying research priorities in adolescent sexual and reproductive health in low and middle-income countries.” The study revealed that seven areas of adolescent sexual and reproductive health were identified as important which included maternal health; contraception; gender-based violence; treatment and care of patients with HIV infection; abortion and STIs.

The International Conference on Population and Development (ICPD) in Cairo 1994 clearly outlined the definition of reproductive health and called for countries to provide educational and service needs of adolescents to allow them to face their sexuality positively and in a responsible manner (Venkataraman Chandra-Mouli et al., 2014b). At the ICPD the Governments established that investing in the health of adolescents is of importance both for the current and future well-being of the adolescents and of their societies and communities. This was a confirmation of the

importance of adolescent sexual and reproductive health rights (ASRHR). In 2012 from a global intergovernmental negotiation, the resolution of the right of young people to comprehensive sexuality education (CSE) came about to decide on all matters related to their sexuality; access to SRH services which included safe abortion where it was regarded as legal and the protection and promotion of young people's rights to control their sexuality free from violence, discrimination and coercion. According to (Venkatraman Chandra-Mouli et al., 2014b) There are solid public health, human rights and economic grounds to invest in adolescent SRH, encouraging respect among adolescent boys and girls in relation to their sexuality and other and other behaviours like the reduction of harmful substances such as drugs and alcohol.

As stated by (Svanemyr et al., 2015), after many years of the implementation of programmes to enhance adolescent sexual and reproductive health it has become increasingly evident that the strengthening of access and the quality of adolescent sexual and reproductive health services is not sufficient to improve health outcomes. Adolescent SRH is powerfully influenced by cultural, social, political and economic factors. These factors enhance adolescents susceptibility to SRH risks such as unsafe sexual intercourse, sexual abuse and early pregnancy and create barriers to their SRH information and services. Tackling the underlying factors by involving different stakeholders such as parents, community members and policymakers is important in the recognition of adolescent SRH and their rights. According to (Svanemyr et al., 2015), this approach is referred to as building an enabling environment. The enabling environment mirrors a set of interconnected conditions such as political, legal, social and cultural conditions which influence the capacity of youth to live healthy lives and access necessary services and information.

According to (Jessica L. Morris and Rushwan, 2015), adolescent sexual and reproductive health is part of a big component of the universal burden of ill health. Although in the past it has been overlooked international agencies are currently concentrating on improving ASRH. ASRH rights are based on a number of legal instruments. In 2002, the UN General Assembly Special Session on Children recognised the need to develop physical and mental health. In the year 2003, the Committee of the Convention on the Rights of the Child gave out a general comment recognising the special health and development needs and rights of adolescents and young people. Despite the fact that sexual initiation and activity differ from region to region and country to country in

all regions youth reach puberty at a tender age and often engage in sexual activity at a young age and marry at a later stage. Adolescents' SRH is tightly linked to their particular social, cultural and economic environment.

According to (Sinead Delany-Moretlwe et al., 2015), youth between the ages of 10 to 24 years represent at least one-quarter of the global population are highly affected by HIV. Universally the health of youth is of importance as it is a display of future population health, economic and social growth. Despite the rate of new HIV infections having declined in numerous populations, more than one-third of new HIV infections continue to take place among youth aged 15 to 24 years of age. This is congruent with (Vanessa Woog et al., 2015) in that numerous biological, social and economic factors can place youth at an elevated risk of unpleasant sexual and reproductive health outcomes which may consist of HIV, unintended pregnancies, unsafe abortions and other STIs. If the adolescents give birth, they are at high risk of poor health outcomes for their newborns and themselves. Access to required health services among youth is of importance in helping to avoid these outcomes.

2.4 The environment and facility characteristics of the CHC setting

According to (Vanessa Woog et al., 2015), in various developing countries, providing universal access to sexual and reproductive healthcare is above the capacity of the country. In some instances, the health facilities may exist but there is an inadequate number of trained staff to give the required services, and there may be a shortage of drugs and contraceptives. Poor healthcare infrastructure, communication and transport services can make access to services in rural areas difficult. Usually, key structural barriers that prevent young people from acquiring sexual and reproductive health services include inconvenient location areas and the operational times of the facilities, and not being aware of where the services are provided.

A study done by (Fadia S. Albuhairan and Tina M. Olsson, 2014) in Saudi Arabia revealed that although the country has a large adolescent population, adolescent healthcare has only started to emerge as an important service in recent years. According to Albuhairan and Olsson (2014), healthcare providers are of great importance in addressing and providing essential healthcare services for adolescents. In the study, a web-based cross-sectional study was carried out at four

health institutions in Saudi Arabia. Physicians and nurses were invited to take part in an online survey addressing their contact with adolescent patients and providing the necessary healthcare services for adolescents. A total of 232 health professionals participated. Nurses saw themselves as having more knowledge regarding the healthcare needs of adolescents when compared to physicians. This study showed that “a gap exists between the training, knowledge and skills of health-care providers, and the needs to address health-care issues of adolescents in Saudi Arabia”(Fadia S. Albuhairan and Tina M. Olsson, 2014).

The study conducted by (Linda-Gail Bekker et al., 2015) showed that the largest number of HIV positive adolescents are in sub-Saharan Africa and South Asia. From a 2.1 million adolescents who are infected with HIV aged 11 to 19 years, about 1.3 million (62%) live in Eastern and Southern Africa. Girls and young women from the ages of 15 to 30 years old have a high occurrence of HIV especially in countries such as South Africa. This is congruent to what is stated in the study by (F.M. Gore et al., 2011) on the Global burden of disease in young people, that globally sub-Saharan Africa has the highest disability-adjusted life years for youth aged 10 to 24 years followed by South East Asia. Despite these regions together having 42% of the global population of youth they account for an estimated two-thirds of the deaths in this age group (G.C. Patton et al., 2009).

According to (Fatusi, 2016), the youth of today of young people aged 10 to 24 years is the largest group in history, with a population above 1.8 billion 90% of which reside in developing countries. When compared to the more developed countries of the world, developing countries have a larger proportion of their population as young people. In addition, youths from developing countries have a bigger burden of diseases and higher mortality rates compared to high-income countries. The study conducted by (G.C. Patton et al., 2016) also agrees with (Fatusi, 2016) and states that majority of developing countries as regarded as multi-burdened countries, distinguished by high levels of all kinds of adolescent health problems, including diseases of poverty, HIV, other infectious diseases and poor sexual and reproductive health. Adolescent pregnancies bring the increased risk of maternal and neonatal mortality. Adolescent childbearing creates a huge obstacle to development and is highly linked to school drop-out, loss of productivity and a generational spread of poverty (UNFPA, 2012c). (Viner R.M et al., 2012) state that the variety of implementation approaches involved in dealing with the SRH challenges

visibly indicates that there is no particular magical bullet or one-fit-all answer when it comes to the question of effective interventions to deal with young people's SRH issues, rather different approaches are able to produce different and successful effects.

In line with the above, (Venkatraman Chandra-Mouli et al., 2014a), conducted a study on the needs, barriers and access of contraception for adolescents in low and middle-income countries. According to (Venkatraman Chandra-Mouli et al., 2014a) many adolescents in low and middle-income countries especially unmarried ones face a number of barriers in getting contraception and in using them correctly and in using them unfailingly. To establish the contraceptive needs of adolescents in developing countries data from Demographic and Health Surveys was used to explore the age of sexual debut (first sexual intercourse), the use of contraceptives, and unmet needs for contraceptive services by married and unmarried adolescents. Evidence from the Demographic and Health Surveys from 16 different countries, with data on married and unmarried adolescents, showed that a small number of adolescents were sexually active (had encountered sexual intercourse) in most of these countries. Some retrospective data showed that more than a quarter of women aged 20 to 24 years in Mali and Bangladesh and between 27% to 35% of men in Brazil, Dominican Republic and Haiti reported that they had sexual intercourse before the age of 15. One to three-quarters of men between the age of 20 to 24 years in the African and the Latin American/Caribbean countries which were examined reported having had sexual intercourse before the age of 18. In various poor communities of low and middle-income countries contraceptives are sometimes not available to adolescents. When they are available, at times laws and policies are in place to prevent their availability to adolescents. When there are no legal restrictions, health workers in various places withhold contraceptives from unmarried adolescents because they do not believe in premarital sexual intercourse (Venkatraman Chandra-Mouli et al., 2014a).

In various settings very young adolescent girls are socialised towards being helpful with them taking on adult chores at home while boys have fewer responsibilities (Susan M. Igras et al., 2014). Males tend to have more freedom going outside their homes giving them more advantage than girls to involve themselves in leisure activities. These gender role expectations lead to behaviours that disadvantage boys and increases their exposure to violence, substance abuse and accidents. Regardless of this, information from lower and middle-income countries on sexual and

reproductive health knowledge and behaviours of younger adolescents is limited (J. Bruce, 2011).

2.5 Exploring the attitudes of staff displayed in giving SRH services to youth

According to (Anna Newton-Levinson et al., 2016), access to sexual and reproductive health services is important for all sexually active adolescents, however, their sexual and reproductive health needs are usually not fulfilled. A systematic qualitative review of mixed methods was conducted by (Anna Newton-Levinson et al., 2016) to examine barriers that adolescents encounter when seeking appropriate medical care for sexually transmitted infection (STI) services for youth. The literature used was studies published between 2001 and 2014 with a study population of youth aged 10 to 14 years. Nineteen studies were used from different countries and the findings were associated with acceptability of the services. Youth reported avoiding the health services or having anxiety relating to confidentiality, based on the some behaviours of the healthcare providers. The incidents of shame and stigma were also common barriers to seeking care. In the study by (Anna Newton-Levinson et al., 2016) in 15 countries, many adolescents and healthcare providers noted that adolescents did not feel at ease when speaking to a healthcare provider who they perceived to be older. The majority of the healthcare providers were described by youth as being judgmental or having a poor attitude. Some of the negative behaviours mentioned by youth were rude or unfriendly treatment, blaming, lecturing, or scolding, or yelling at youths.

It is stated by (Rehana A. Salam et al., 2016), as well as by (Chandra-Mouli V et al., 2014), that a considerable number of youths globally are sexually active and this number increases progressively from mid to late adolescence. The sexual activity of youth differs according to gender and region. When compared to boys, girls are more sexually active in sub-Saharan Africa, Asia and Central Asia while in Latin America and the Caribbean, boys are more sexually active. An estimated three in 10 unmarried adolescent women in sub-Saharan Africa and one in four in South America have ever had sexual intercourse. Early engagement in sexual activity elevates the risk of STIs including HIV and can create unintended pregnancies. Youth have

inadequate and in some areas, no access to sexual and reproductive health education and contraception, making adolescent girls more likely to get unwanted pregnancies (Williamson N, 2013).

In a study conducted by (Pozo et al., 2015) in Latin America, it is stated that one of the key barriers to adolescents access to contraception is that they do not have a reliance on the confidentiality of staff in the health facilities and become worried about being negatively judged for being sexually active. This particularly applies to young adolescent girls. In addition to this, the healthcare providers also feel insufficiently equipped to assist adolescents seeking contraceptive counselling, they are puzzled about parental consent and moral concerns, while also being unable to cope due to limited staff members and long opening hours.

The reproductive health of African youth and their requirement for youth-friendly reproductive health services has been the focal point of significant policy and intervention activity since the beginning of the 21st-century states (Zaina Mchome et al., 2015) in a study conducted in Tanzania. Barriers to service uptake have been well depicted and the characteristics of youth-friendly services provision identified and the access to youth-friendly health services maintained within the Millennium Development Goals. However, in the decade since the WHO launched its call for youth-friendly services, strong confirmation of translation of national and international youth-friendly reproductive health service policies into practice has been poor (Sawyer S.M et al., 2012). The large-scale cluster randomised study done in Tanzania by (Zaina Mchome et al., 2015) provided a chance to evaluate the current state of service provision in a country where reproductive health policies for youths have been created and supported by the government. Regarding health worker attitudes to adolescent use of SRH services in various cases in two regions where the study was done, the health workers showed negative attitudes toward adolescent use of SRH services, including verbalising their views that family planning should be reserved for adults especially married couples. This may have come from a familiar perspective that family planning services are mainly meant for child spacing. Knowledge and attitude towards condom use among health workers varied. A number of health workers had positive attitudes to condom use but others openly discouraged young people from using them.

This is congruent with the discovery made in the study by (Kennedy et al., 2013) in Vanuatu, a Melanesian country which is one of the poorest in the Pacific. According to them, youths

between the aged 10 to 19 years account for 20% of the population of Pacific Island countries. “Sexual activity during adolescence is common in Vanuatu”, yet a large number of adolescents lack access to key sexual and reproductive health (SRH) services and, consequently, they suffer from poor SRH. Sexual activity is prevalent during adolescence and up to 65% of girls and 72% of boys aged 15 to 19 years have had sexual intercourse in this region. Early sexual encounter, less than 15 years is also popular, with 15% of the girls and 35% of the boys having had sexual intercourse before the age of 15 years (Kennedy E et al., 2011). In the study, 66 focus group discussions were conducted with 341 male and female adolescents between the ages of 15 to 19 years in rural and urban communities. Additionally, 12 semi-structured interviews were done with policymakers and service providers. Sociocultural norms and taboos for adolescent sexual behaviour were the most prominent factors that prevented adolescents from accessing healthcare services. These added to adolescents own fear and shame, the judgmental attitudes of the service providers, disapproval from parents, lack of confidentiality and privacy, and adolescents lack SRH knowledge were also “barriers preventing adolescents from accessing services... These contributed to adolescents’ own fear and shame, judgmental attitudes of service providers, and disapproval from parents and community gate-keepers. Lack of confidentiality and privacy, costs, and adolescents’ lack of SRH knowledge were also important barriers”(Kennedy et al., 2013).

The above is echoed in the study by (Rebecca Sally Geary et al., 2014) which mentions that knowledge about sexuality and reproductive health among youths is limited and that youths “report a need for more information on relationships, pregnancy and STIs. Fear of judgmental attitudes of healthcare workers has been reported as a barrier to young people’s use of a range of health services in South Africa”(R. Jewkes et al., 2005); Alli, Maharaj & Vawda, 2013).

In line with this, (Lynn M. Atuyambe et al., 2015), in a study on understanding the SRH needs of adolescents in Uganda, note that when it comes to sexual and reproductive healthcare adolescents are quite precise in their expectations. Privacy and identity is of importance to them and they desire to make decisions for themselves based on correct information provided. The WHO stipulates that there are various elements that motivate adolescents to seek healthcare. These elements include confidentiality, provision of required information and services, the acceptance of adolescents as they are, allowing them to make their own decisions, making sure

that adolescents feel welcome and comfortable at the health facilities they present themselves at and the provision of services at times which are convenient for adolescents. In Uganda, adolescent girls become sexually active earlier than boys. Adolescents are usually hesitant to seek sexual and reproductive health services due to barriers such as judgmental health workers, and the lack of supplies, equipment and private consultation rooms (A. Tylee et al., 2007).

In agreement with (A. Tylee et al., 2007), (Pamela M. Godia et al., 2014), in a study conducted in Kenya, sum up that a large number of the males and female adolescents in the study indicated that the healthcare provider attitude had a big influence on their uptake of and satisfaction with the sexual and reproductive health services. The female described how small things really mattered to them such as the healthcare provider's reception, facial expression, simple greetings and being permitted to express themselves and to explain their problems. The male adolescents specified that the layout at the integrated healthcare institutions including the waiting area had been designed for women and children. They further indicated that the services at the integrated facilities were ideal for women and girls, but males had been neglected by the system.

In line with the studies reflecting staff attitudes towards the provision of SRH services to youth, the study conducted by (Andrew G. Onokerhoray and Johnson Egbemudla Dudu, 2017) on the "perception of adolescents on the attitudes of providers on their access and use of reproductive health services in Delta State, Nigeria" also indicated that the unfriendly attitudes of staff keep adolescents waiting. In the study, a survey was used to collect data using questionnaires and focus group discussions (FDGs) from adolescents in a sample of schools. The results of the study showed that an average of 66.8% of the respondents were not comfortable with the waiting time at the facilities where they went to seek SRH, this together with the lack of friendly attitudes from the healthcare providers together with the inadequate duration of consultations, the judgmental attitudes of some providers, lack of satisfactory services and lack of confidentiality puts off adolescents from accessing and using adolescents reproductive health services.

This was also echoed in the study conducted by Iqbal, Zakar, Zakar and Fischer (Sarosh Iqbal et al., 2017) who state that sexual and reproductive health is an important aspect of adolescents' growth which is shielded by SRH rights. In spite of a number of global efforts to promote adolescent sexual and reproductive health rights many adolescents still lack awareness and independence in accessing SRH related information and services. The study was conducted in

the district of Lahore, in Pakistan. Mixed methods approach which included both quantitative and qualitative approaches was used to collect data. For the quantitative component, a survey was conducted with 600 respondents of adolescents aged 15 to 19 years and their parents/caregivers. For the qualitative data, 12 in-depth interviews with teachers and doctors and focus group discussions with adolescents were conducted. The researched revealed a low level of perception of adolescent sexual and reproductive health rights and socio-cultural and structural constraints were the major underlying issues (Iqbal et al., 2017).

A study was conducted by (Alfred Meremo et al., 2016) in Tanzania on the barriers to accessibility and utilisation of HIV testing and counselling services in Tanzania. A mixed methods study was conducted using both quantitative and qualitative approaches. Data was collected in nine regions of Tanzania. Twelve (12) in-depth interviews, eight focus Group Discussions and 422 clients were approached for data collection. The study revealed that 4.09% of the clients reported spending more than two hours at the HTC centre before they were attended. Of those clients who received counselling 21.8% reported counselling to be done in groups. The findings showed that although the coverage of the HTC was high, long waiting time, and lack of confidentiality impeded its accessibility and utilisation (Alfred Meremo et al., 2016).

A study was conducted by (Kim Jonas et al., 2016) “to examine the trends in teenage pregnancy and to identify associations with other health risk behaviours in South Africa.” A total of 31 816 South African school-going adolescents between the age of 11 to 19 years “were interviewed in three cross-sectional surveys. Data from the first (2002, n = 10 549), second (2008, n = 10 270) and the third (2011, n = 10 997) nationally representative South African youth risk behaviour surveys (YRBS) were used” (Jonas et al., 2016). The study revealed that girls continue to become pregnant at unacceptably high rates in the country. “However, among those who are sexually active pregnancy prevalence rates have increased” ((Kim Jonas et al., 2016).

(Kim Jonas et al., 2017) state that healthcare workers may influence the utilisation of SRH services by adolescents through the quality of care they provide and the behaviours or attitudes they hold. This can become a hindrance to accessing and utilisation of SHR services by youth. In the study, a systematic review was conducted to pinpoint literature which focused on healthcare workers’ behaviours and personal determinants related to providing proper SRH services in sub-Saharan Africa. The data used was from January 1990 to October 2015. The study showed that

negative behaviours and attitudes of healthcare workers together with other personal determinants such as poor knowledge and skills in relation to SRH services and other factors like the availability of essential drugs and equipment are related to the provision of improper SRH services. The study also indicated that healthcare workers negative behaviours and attitudes are unlikely to encourage women, in general, to access and utilise SRH services, specifically young women.

According to (Rebecca S. Geary et al., 2015), few youth-friendly health services globally “have been scaled up or evaluated from young people’s perspectives. South Africa’s Youth Friendly Services (YFS) programme is one of the few to have been scaled up.” The study conducted by (Rebecca S. Geary et al., 2015) investigated young people’s experiences of using sexual and reproductive health services at the clinics providing the YFS compared to those that did not, using the simulated client method. In the study fifteen primary healthcare clinics in Soweto were randomly sampled, seven provided the YFS programme. The stimulated clients conducted 58 visits; young men requested information on condom reliability and young women on contraceptive methods. The results showed that the “health facilities providing the YFS programme did not deliver a more positive experience to young people than those not providing the programme” ((Rebecca S. Geary et al., 2015). More positive experiences were characterised by young people as those where healthcare workers were friendly, respectful and knew how to talk to young people. “Less positive experiences were characterised by having to show soiled sanitary products to obtain contraceptives, healthcare workers expressing negative opinions about young people seeking information, lack of privacy and inadequate information”(Rebecca S. Geary et al., 2015)

2.6 Exploring the implementation of SRH youth-friendly policies

A great deal of research has raised the causes and consequences of teenage pregnancies taking into account policies which are in place in different countries regarding teenage pregnancies (Gilda Sedgh et al., 2014). According to (Coyne C.A and D'Onofrio B.M, 2012), some data have insinuated that teenage pregnancy compromises young girls educational prospects and financial opportunities. In a study conducted by (Gifty Apiung Aninanya et al., 2015) in Ghana, the

promotion of youth sexual and reproductive health service usage was noted to be a universal challenge. Numerous governments have looked for ways in which to address the SRH needs of adolescents since the 1994 International Conference on Population and Development (ICPD) placed the adolescent sexual and reproductive health on the global policy agenda. Regardless of the large proportion of adolescents in low and middle-income countries and related elevated rates of HIV, unintended pregnancies, maternal mortality and unsafe abortion suggest greater needs for improvements in service usage. Numerous adolescents in sub-Saharan African countries make little use of sexual and reproductive health services due to challenges such as service costs, distance, little knowledge of where to obtain contraceptives and STI treatment, poor confidentiality and privacy as well as negative health provider attitudes. Findings in Ghana are comparable to those found regionally. After the ICPD, the Government of Ghana worked to support adolescents through the Adolescent Reproductive Health Policy of 2000 and through the National HIV/AIDS and STIs Policy of 2001 while the Ghanaian Health Services (GHS) promote youth-friendly policies. Despite the efforts made by the Ghanaian Government, data has revealed that adolescents in Ghana continue to avoid SRH services due to the stigma regarding premarital sexual activity while more than 750 000 adolescents become pregnant on an annual basis.

In line with this, (Adrienne Germain et al., 2015) indicate that the persistent implementation of the ICPD, the completion of the Millennium Development Goals (MDGs) and the post-2015 global agenda Governments must put forward equality, quality and accountability in sexual and reproductive health through actions to create and implement health system reform policies that will improve sexual and reproductive health by ensuring that financing, services, supplies, human resources training and management, regulation and monitoring of sexual and reproductive services get the main elements of the right to health which are availability accessibility, acceptability and equality. They should reduce inequalities by making and integrated sexual and reproductive health services available and accessible to all, particularly to women who are disadvantaged and or discriminated against and to all adolescents, particularly girls. They should handle the main causes of women and adolescents' sexual and reproductive health including efforts to eradicate violence against women and to support survivors (C. Garcia-Moreno and M. Temmerman, 2015) .

In a study conducted by (Amy T. Schalet et al., 2014) on broadening the evidence for adolescent sexual and reproductive health, the authors state that science is an important basis for adolescent sexual and reproductive health. Researchers, policy creators, advocates and citizens recognise science as a foundation for policies and programmes related to adolescent sexual and reproductive health. Scientific methods are used to pinpoint the extent of adolescent health problems, contributing issues, and health consequences and to create and evaluate health education and prevention programmes. Over the past six decades, imperative changes have taken place in the timing of adolescent changeover including age at marriage and timing of childbearing. In the US, like in other developed countries, adolescents generally begin sexual contact during their mid or late teens or even early 20s(Halpern C.T and Haydon A, 2012). Worldwide, in general, social and cultural forces, as well as poverty and economic equality, racism and the stigma around youth who do not conform to firm gender and sexual orientation norms also including access to healthcare and education all, characterise adolescent health (Resnick M.D et al., 2012).

As stated in the MDG report of 2015, in various circumstances, adolescent girls are not well informed about their bodies and their health and are usually ill-equipped for the changes they are about to experience when they enter adolescence (United Nations, 2014). As girls advance from older childhood into adolescence as well as early adulthood they need sexuality education that is appropriate for their developmental stages. The sexuality education they acquire should be comprehensive; it should include information on sexuality, reproduction and sexual and reproductive health problems and how they can be avoided (UNESCO, 2009); (UNFPA, 2014).

According to (Patel L, 2011), high school teachers in the Giyani district of the Limpopo province, South Africa gave an account of high levels of absenteeism due to pregnant adolescent girls not attending school or departing early from school to collect their child support grant. The child support grant was reported by (Patel L, 2011) as a means of financial support for children aged 0 to 18 years of age provided by the South African Government. Even though this programme was introduced by the government with good intentions of decreasing poverty and promoting equality and human well-being, it appears to be taken advantage of by some school going teenagers.

A study was conducted by (Brittany Schriver et al., 2014) in urban Soweto and they note that, in 2006, the South African Department of Health adopted and expanded Love Life's Youth Friendly Services (YFS) initiative to a national policy to improve youth utilisation of health programmes by focusing on community sensitisation and counselling services. The purpose of the study was to examine the knowledge and perceptions of current health services oriented towards youth and to examine potential alternative approaches to health service delivery (Schriver et al., 2014). In the study, 25 in-depth interviews were conducted in 2012, the study revealed that knowledge of the YFS was very low. Youths were generally dissatisfied with the current health services in Soweto and mentioned a lack of resources, long waiting times and the poor quality of services (Schriver et al., 2014).

2.7 Exploring services rendered to adolescents with regard to youth-friendly sexual and reproductive health services

According to (N.M. Pritt et al., 2017), the majority of adolescent pregnancies are “unintended and many can be attributed to contraception misuse or nonuse. The etonogestrel implant and intrauterine devices, referred to as long-acting reversible contraceptives, or LARCs, are the most effective reversible contraceptive methods.” These contraceptives include subdermal etonogestrel (ENG) implants and copper and levonorgestrel-releasing intrauterine devices (IUDs). These methods are safe for use by adolescents, however, the use of these long-acting reversible contraceptives remains low among adolescents in the US. In the study by (N.M. Pritt et al., 2017), recent literature was examined regarding barriers and facilitators to long-acting reversible contraceptive use among adolescent women. The factors which influenced adolescents and provision with contraceptives was organised into four categories: (1) cost and clinical operations; (2) adolescent awareness and attitudes; (3) confidentiality, consent, and parental attitudes; and (4) healthcare provider knowledge, attitudes, and counselling (Pritt et al., 2017). The study revealed that long-acting reversible contraceptives are safe, highly effective, and well tolerated by adolescents, yet their use remains low among adolescent women in the US. Logistical considerations, such as clinical operations and cost, interact with low levels of knowledge and negative attitudes to perpetuate barriers to long-acting reversible contraceptive

use among adolescents. Healthcare providers, as well as social networks, are key players in educating patients and their parents about contraceptive options. “Knowledge deficits and misconceptions among adolescents and their health care providers” are major barriers to adolescent contraceptive use (Pritt et al., 2017).

A study conducted by (Jacqueline E. Darroch et al., 2016) on research gaps in adolescent SRH showed that in numerous countries in Asia, Northern Africa and in sub-Saharan Africa, “unmarried women are either excluded from fertility and health surveys or they are included but not asked questions related to sexual activity” and contraceptive use, but studies conducted in these countries show that some of the young women who are not married are sexually active and need sexual and reproductive health services. Regarding sexual activity, (S.E. Neal and V.Hosegood, 2015) state that the percentage of adolescents who are sexually active may be miscalculated because respondents may be unwilling to declare to having sexual intercourse at young ages and outside of marriage. In reference to the assessment of sexual and reproductive health interventions in some studies interventions for adolescents have pinpointed effective approaches as well as some that have not been cost-effective. Regardless of this existing research does not cover all types of sexual and reproductive health-related interventions or care that adolescents need (L.B. Gottschalk and N. Ortayli, 2014).

This is in line with (Santhya K.G and Jejeebhoy J. Shireen, 2015) who summarise that there are approximately 580 million adolescent girls in the world currently and 88% of them live in low and middle-income countries. Many of them remain excluded from sexual and reproductive health, and a number of them are deprived of the right to make safe and informed decisions that affect their health and wellbeing. For adolescent girls, Sexual and reproductive health is amid a number of dimensions of adolescent girls’ health including nutrition and mental health and advancement in sexual and reproductive health are dependent on other dimensions of health. Starting with the Convention on the Rights of the Child in 1989 and continually since 1994, governments have recognised that closing gender gaps in health and education and creating opportunities which are equal for boys and girls are human rights obligations and are important for national and global development security. In 2012, the 45th session of the UN Commission on Population and Development and the Declaration of the Bali Global Youth Forum expanded

on the ICPDPOA commitments to adolescents sexual and reproductive health. Both documents recommended that governments ensure adolescents access to quality sexual and reproductive health services to comprehensive sexuality education (CSE) in and out of schools to reduce forced marriages, to design and implement policies and programmes to eliminate violence against women and girls (UNFPA, 2012b).

In a systematic review conducted by (Anna Kagesten et al., 2014), it is said that worldwide evaluation research has repeatedly shown that the evidence for and effectiveness of a number of adolescent pregnancy prevention programmes is not clear. In the US and internationally the interest has turned to comprehensive approaches that combine activities related to health, education and social support for improving the sexual and reproductive health of adolescents. Globally, the UNFPA (2013) and other organisations have worked together to scale up a comprehensive model for the prevention of early marriage and decreasing adolescent fertility in 12 countries. According to (Anna Kagesten et al., 2014), comprehensive approaches to sexual and reproductive health for adolescents go beyond a sexuality education curriculum, contraceptive distribution programmes and abstinence-only programmes by creating a package of services and programmes that aim to distinguish the root causes of sexual health risks and early pregnancies.

According to (Jaruseviciene et al., 2013), the sexual and reproductive of youth in Latin America is of concern due to the fertility patterns in the region. Although adult women in the region have been experiencing a decline in fertility from the time of the 1970s, this does not apply to the adolescent girls of the region aged 15 to 19 years of age. The rate of contraceptive use among adolescents has increased from 12.7 to 20.5% in the region (Kostrzewa K, 2008). The increase in contraceptive use (including condoms) in Latin America has not proved to be adequate to decrease the risk of adolescent pregnancy and STIs. Inadequate literature, underreporting and poor surveillance of the systems hinders the measurement of the degree of STI incidence in the region (Garcia P.J et al., 2011).

A study was conducted by (Nadine Crossland et al., 2015) on sexual and reproductive health among Ugandan youths. According to (Nadine Crossland et al., 2015) poor sexual and reproductive health increases morbidity, mortality and gender inequality slow down development. In Uganda, youths represent 20% of the population and the burden of STIs

including HIV is extensive. In the study data from a survey was analysed using the lot quality assurance sampling technique (LQAS) from two time periods, 2003, 2004 and 2012. Knowledge, behaviours and access to SRH services of youth aged 15 to 24 years were assessed. All the indicators in the study showed an improvement in SRH between the early and the later time period. The knowledge of youth regarding where to get tested for HIV increased from <40% to 80% for males and females. The number of youth reporting having ever had an HIV test increased from 8% to 48% in males and 10% to 64% in females. Increased age and level of education were associated with a positive change for most indicators (Nadine Crossland et al., 2015).

A study was conducted by (Pamela M. Godia et al., 2014) in Kenya, the study explored perceptions and experiences of young people in Kenya aged 10 to 24 years regarding their SRH needs and whether these are met by healthcare services in the area. In the study 18 focus group discussions and 39 in-depth interview were conducted at healthcare facilities and youth centres in selected urban and rural settings in Kenya. Young people's perceptions were not identical and showed variation between boys and girls as well as the types of service delivery received. Girls that sought antenatal care and family planning services at the health facilities characterised the available services as good and staff being helpful. However, boys that took part in the study perceived the services at the health facilities as designed for women and children and as a result felt uncomfortable in seeking the services (Pamela M. Godia et al., 2014).

According to (Sushanta K. Banerjee et al., 2015), young, rural women in India lack sexual and reproductive health information and agency. In the study by (Sushanta K. Banerjee et al., 2015) a cross-sectional survey was conducted with a representative sample of 1381 married and unmarried young women between the ages of 15 to 24 years from three rural community development blocks in Jharkhand. The study showed that participants married young and bore children early, with 53% first birth by 17 years. Women received low scores on knowledge around sex and pregnancy, contraception and abortion knowledge. Both married and unmarried women had limited agency in decision making, freedom of mobility and financial resources (Sushanta K. Banerjee et al., 2015).

A qualitative study was conducted by (Charlotte T. Galloway et al., 2016) in South Carolina, with the aim of reducing disparities in teen pregnancy and birth rates among African American and Latin teenagers. The purpose of the study was to create an understanding of adolescents' preferences for finding health information, their perceptions regarding accessing reproductive health services and their beliefs about contraception. Eight focus groups were used in the study with African American and Latino male and female youth from two communities in South Carolina. Among the eight focus groups of youth, adolescents most often reported parents, other trusted relatives and the internet as sources of health information. The study revealed that the respondents' comments frequently reflected inaccurate beliefs about the reliability and correct use of contraceptives (Charlotte T. Galloway et al., 2016).

According to (Jonathan Mensah Dapaah et al., 2016) a large number of young people become sexually active before their 20th birthday, and may have to struggle with unplanned pregnancies, unsafe abortions, maternal deaths and injuries. A study was conducted by (Jonathan Mensah Dapaah et al., 2016) to examine young people's sexual knowledge, attitudes and practices and their levels of utilisation of sexual and reproductive health services. A descriptive cross-sectional design was used in sampling 170 youth (150 surveyed and 20 interviewed). The study revealed that 45.2% of youth aged 10 to 24 years had sexual experience and a statistical association was present with youth's knowledge of the available sexual and reproductive health service and reproductive health service utilisation.

A community-based cross-sectional study was conducted by (Senafikish Amalu Feleke et al., 2013) in Ethiopia. According to (Senafikish Amalu Feleke et al., 2013), the use of reproductive health services is an important element in preventing adolescent from acquiring different sexual and reproductive health problems. The study was conducted in 2012 in four randomly selected areas of Gondar. A total of 1290 adolescents between the ages of 15 to 19 years were interviewed using a pre-tested and structured questionnaire. Out of the total participants, 79.5% and 72.2% utilised family planning and voluntary counseling and testing (VCT) services. The study revealed that the majority of the adolescents were using family planning and voluntary counselling and testing services in Northwest Ethiopia. However, the use of FP and VCT services at first sexual intercourse among the sexually experienced adolescents was found to be

low. Educational status, school attendance and discussion of services were important factors affecting the utilisation of FP and VCT services.

According to (Elvis E. Tarkang and Francis B. Zotor, 2015) the Health Belief Model has been applied to a broad range of health behaviours and populations including topics related to health. Since the Health Belief Model is based on encouraging people to take action, like adolescents to use adolescent sexual and reproductive health services, it is applicable to the present study. As is focuses on how adolescents perceive the SRH and youth-friendly services at the selected health facility. The Health Belief Model is thus appropriately used in this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

According to (Burns and Grove, 2009), a research methodology is the manner in which information is gathered for the purpose of making informed decisions. It encompasses the analysis of methods which are applied to a field of study. This chapter discusses the research design and methodology used for the study. This incorporates the paradigm, population, data collection tools, data collection procedures, validity, reliability and ethical consideration.

3.2 Research approach

A research approach is defined as a plan and procedure that contains steps of broad assumptions used to address a problem (Datt and Datt, 2016). It is broadly divided into two research approaches which are quantitative and qualitative (Brink et al., 2012). In this study, a quantitative research approach method was used. Quantitative research is defined as a formal and objective manner in which numerical data is gathered to obtain knowledge about the world (Burns and Grove, 2012). According to (Burns and Grove, 2012, Polit and Beck, 2008), quantitative research begins with preconceived ideas about how concepts are interrelated. It focuses relatively on a small number of concepts which are concise and narrow. It entails the use of structured procedures with formal instruments to collect data. It involves an emphasis on objectivity in the data collection and analysis of information. With quantitative research the researcher does not participate in the events under investigation, the researcher is more likely to collect data from a distance. It involves logistic and deductive reasoning. A quantitative research approach was suitable for this study because the research was defined by a single reality without the involvement of the feelings, values and personal perceptions of the researcher being involved (Burns and Grove, 2012).

3.3 Research paradigm

A research paradigm is defined as a set of assumptions about the basic types of entities in the world, about how they work and the proper methods used for constructing and testing the theories of these entities (Brink et al., 2012). In this study, a positivist paradigm was used. A positivist paradigm is based on the philosophy that factual knowledge obtained through the senses mainly, through observation is trustworthy. In positivism studies, the position of the researcher is limited to an objective approach when collecting and interpreting data, with the research findings being observable and quantifiable. With the positivist paradigm, the researcher is independent of the research meaning that the researcher has minimal interaction with the participants when carrying out the study. The world is distinguished as external and objective with the concepts having to be operationalised in order to be measured. In a positivist paradigm, the objectives in the study are not reliant on the researcher; facts are discovered and confirmed from direct observations or through the measurement of phenomena (Krauss, 2005). The positivist paradigm was selected in the present study because the researcher believed that in science positivism dominates and that independent knowledge about single phenomena can be measured quantitatively through science. Through this paradigm, the researcher aimed to explore adolescents' perception regarding sexual and reproductive health services in selected CHCs in uMgungundlovu District.

3.4 Research design

A research design is defined as a detailed outline of how a research will take place. It includes details of how data will be collected, which instruments will be used in the data collection process and ways which will be used to analyse the data collected (Brink et al., 2012). According to (Brink et al., 2012), quantitative research designs are divided into three categories, namely experimental, non-experimental and non-traditional research designs. With non-experimental designs the independent variable is not manipulated, therefore there is no intervention or control of the setting by the researcher. The study is conducted in the natural setting and phenomena are observed as they take place. The chief purpose of non-experimental research is to describe phenomena and to discover and explain relationships between variables. In the present study a

non-experimental descriptive exploratory research design was used. According to (Burns and Grove, 2011), descriptive designs can be used to identify problems with current practice; to justify current practice and to make judgments or to establish what health professionals in similar situations are doing. A non-experimental descriptive research design was used in this because the researcher collected data by not introducing treatment or creating changes in the variables being studied, but by being a bystander in exploring adolescent's perception regarding SRH services in the uMgungundlovu District (Brink et al., 2012).

3.5 Research setting

The study placed focus on adolescents' perception regarding sexual and reproductive health services at a selected CHC in the uMgungundlovu District Municipality in the province of KwaZulu-Natal. South Africa has nine provinces and KwaZulu-Natal is one of them. The province has one metropolitan municipality and 10 district municipalities which are iLembe, Amajuba, Ugu, Sisonke, uMkhanyakude, uThukela, uMzinyathi, uThungulu, Zululand, and uMgungundlovu. The uMgungundlovu District Municipality has an estimated population of 1,017,763 which are stretched into seven local municipalities. Approximately 60% of the population lives in and around the capital city which is Pietermaritzburg (found in the Msunduzi municipality). The remainder of the population lives in rural and informal settlements (Emmanuel, 2016). The study was conducted at a CHC called Imbalenhle Community Health Centre. The wards that comprise of the Imbalenhle catchment area are, 10,13, 15, 16, 17, 18, 19, 21, 22 and 23 with an estimated 22 000 people who attend the CHC on a monthly basis (District, 2012). The uMgungundlovu District was selected for the study because the selected CHC gives a reasonable representation of rural and township conditions where information regarding adolescent's perception regarding youth-friendly sexual and reproductive health services could be effectively gathered.

3.6 Study population

The study population is defined by (Burns and Grove, 2011) as the group of persons or objects that are of interest to the researcher, and who meet the standards for inclusion in the research by the researcher. The study population for this study were adolescents that attended the selected CHC in the public healthcare setting, who ranged from ages 18 and above and who sought sexual and reproductive healthcare at the selected CHC setting. The population for this study was n=169.

3.6.1 Inclusion criteria

According to (Brink et al., 2012) the inclusion or eligibility criteria are those which a researcher uses to determine whether an individual should be part of the population. To be eligible for inclusion in this study the members of the population had to be: a) adolescents aged 18 to 21 years, and b) seeking sexual and reproductive healthcare.

3.6.2 Exclusion criteria

(Brink et al., 2012) describe exclusion criteria as those which would cause the researcher to exclude certain individuals from the population. Clients were excluded in this study if they were a) 17 years or below, and b) if they were seeking other health care services apart from sexual and reproductive health.

3.7 Sampling and sample size

According to (Polit and Beck, 2008), sampling is a means choosing a portion of the population to represent the whole population so conclusions can be made regarding the entire population. (Brink et al., 2012) classify sampling as having two approaches, namely probability or random sampling and non-probability sampling. In this present study convenience sampling was used. Convenience sampling is also called accidental or availability sampling and it entails the use of

readily available participants for the study. Convenience sampling was suitable for this study because those adolescents who were readily available in the public healthcare setting were used to participate in the study. The population size was based on the number of adolescents that are seen for sexual and reproductive health on a monthly basis which was more than 250 at the CHC. The sample size was calculated using the Raosoft sample size calculator. The following estimates were used, a margin of error of 5%, a confidence level of 95% and a response distribution of 50%. Using these estimates the above mentioned estimates a sample size of 169 was obtained.

3.8 Data collection instrument

A questionnaire is defined as a quick method of obtaining data from a large group of people, which is cost-effective in terms of time and money (Brink et al., 2012). In this study, data was collected using a self-administered questionnaire. The questionnaire was prepared in English. The questionnaire that was used in the study was adapted from (Jimmy-Gama, 2009) and was modified to suit this research. The questionnaire has five main sections: section one, items (1 to 5) pertained the socio-demographic data required from the participants. Section two, items (6 to 17) pertained the exploring of staff attitudes towards rendering sexual and reproductive health services to youth. Section three, items (18 to 35) pertained the implementation of sexual and reproductive health youth-friendly policies. Section four; items (36 to 46) pertained to the environment and facility characteristics of the CHC setting. Section five, items (47 to 78) pertained to exploring services rendered to adolescents regarding youth-friendly sexual and reproductive health services. The questionnaire took approximately 20 minutes for the participants to complete.

3.9 Data collection process

After permission to conduct the study was granted by the Head of the School of Nursing and Public Health and by the Department of Health, and ethical clearance was granted by the Ethics Committee at the University of KwaZulu-Natal, introductory and informative sessions were

conducted with the Nursing Manager from the selected CHC. During the introductory sessions, the researcher explained the purpose of the research and agreed on convenient times for data collection and appointments for data collection to take place. On the selected data appointment collection dates the participants were approached individually at the CHC and informed about the study. Informed consent was obtained if the participants were willing to participate in the study. A questionnaire was directly handed to each participant for completion, and upon completion, of the questionnaire in approximately 20 minutes each participant returned the questionnaire to the researcher and was given an information document with the contact details of the researcher to ensure that they were catered for should they have wished to withdraw from the study. Participants that required further support were referred to the Clinical Psychologists that were available at the Community Health Care Centre. This enabled the participants to acquire more information about their SRH-related problem. This is evidenced by the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, 2014-2019 by the Department of Health (DOH, 2015).

3.9.1 Reliability

(Polit and Beck, 2008) describe reliability as the degree of consistency or dependability with which an instrument measures an element. Reliability of an instrument has three main aspects which are internal consistency, equivalence and stability. The extent to which similar results are attained on different occasions is called the stability of an instrument. In order to test the practical aspects of this study a test re-test was conducted. The data collection instrument was administered to the participants. The instrument was regarded as reliable because the results were above 70. According to (Polit and Beck, 2008), the instrument used in a test re-test is considered as reliable if the results from it are above 70.

3.9.2 Validity

According to (Polit and Beck, 2008), validity is the extent to which an instrument measures what it is meant to measure. In this study, the researcher used content as a way of ensuring that the instrument measures what it is intended to measure and it responding to the research

objectives. During the presentation of the research proposal, the researcher subjected the instrument to the scrutiny of experts in nursing education and research methods.

These experts pointed out the areas which required further attention and the researcher attend to them with the assistance of the research supervisor. The researcher also matched the items in the instrument against the research objectives and the conceptual framework to establish whether there was an alignment. With help from the research supervisor, this was achieved before data collection. The Nursing Manager at the selected CHC was requested to review the questionnaire in order to enhance the content validity of the tool as described by (Polit and Beck, 2008).

3.10 Data analysis

According to (Brink et al., 2012), statistics are the most powerful method of analysing quantitative data. Statistical methods allow the researcher to summarise, to reduce, organise, to evaluate, and to communicate data. Descriptive statistics were used to describe and summarise data. These statistics converted and condensed the collection of data, into an organised, visual representation or picture which create some meaning for the readers of the report (Brink et al., 2012). In this study, Statistical Package for the Social Sciences (SPSS) Version 24 was used to analyse data. The data was reported as frequencies and row percentages in tables and as percentages in graphs. It was also be summarised by means central tendency and measure of variabilities such as mean, standard deviation and mode. The researcher also used different types of graphs like pie graphs, bar graphs and column graphs.

3.11 Ethical considerations

In order to conduct the study, permission was obtained by the researcher from the School of Nursing and Public Health and ethical clearance was granted by the Research Ethics Committee at the University of KwaZulu-Natal. According to (Brink et al., 2012), three fundamental ethical

principles guide researchers during research: respect for persons, beneficence and justice. Adherence to ethical principles is crucial in any research.

3.11.1 The principle of respect for persons

This principle states that individuals are autonomous. This means that they have the right to decide whether or not to participate in the study, without penalties or prejudicial treatment. This makes the participants' decision to participate in the study voluntary (Brink et al., 2012). In this study, the principle of respect for persons was maintained by the researcher because participants voluntarily partook in the study. The confidentiality and anonymity of the participants was ensured by not having any identification information collected with the data collection tool. Relevant indicators were used instead of participants' names so that information could not be traced back to individuals. The data collection tools will be stored in a safe and locked place for a period of five years in the School of Nursing at the University of KwaZulu-Natal and only the researcher and research supervisor will have access to the data collected and copies of relevant documents.

3.11.2 The principle of beneficence

The principle of beneficence implies that participants have the right to be protected from discomfort and harm (Brink et al., 2012). The data collected in the study was not used to exploit or inflict harm on the participants, but rather help in making recommendations based on the research findings that may aid in improving youth-friendly sexual and reproductive health services for adolescents in the uMgungundlovu District.

3.11.3 The principle of justice

The principle of justice refers to the fair selection and treatment of participants (Brink et al., 2012). To maintain the principle of justice in the study, the researcher treated all participants equally and fairly.

3.12 Data management

According to the University of Leicester (2011), data management is defined as part of the research process which aims to make the research process as effective as possible and to meet the expectations of the University and legislation. The data collected through this study will appear on the University of KwaZulu-Natal's database and will be kept with the supervisor for five years after which it will be shredded. The spoilt questionnaire was discarded. Electronic data will be kept in a password controlled personal computer.

3.13 Data dissemination

(Rehmani et al., 2013) describe data dissemination as the distribution of information to numerous destinations. In this study, it will occur through several communication protocols. The thesis will be kept at the University of KwaZulu-Natal's library in the form of a hard copy. The University will keep the thesis on the electronic data base so other researchers have access to it. Upon completion of the study, the report will be shared with the manager of the health facility concerned. The real name of the institution and the names of the participants will not be used to ensure anonymity.

CHAPTER 4: DATA ANALYSIS

4.1 Introduction

This chapter presents the findings of the study whose aim was to explore adolescents' perception regarding youth friendly sexual and reproductive health services in a selected CHC in uMgungundlovu District. The respondents were youth patients that attended the community health centre for sexual and reproductive health. In a sample of 169 youth patients, 168 questionnaires were completed and returned which is 99.40%. A self-administered questionnaire was used to collect the data, which were entered and subsequently analyzed using Statistical Package for the Social Sciences (SPSS) version 24. The results are presented in frequency tables and figures. Pearson's chi-square test was used to test associations between the respondents social demographic variables and adolescents perception regarding adolescents perception regarding the sexual and reproductive health services.

The results have been presented in line with the objectives of the study as follows:

- a) Demographic data.
- b) The attitudes of staff towards giving Sexual and Reproductive Health services to youth.
- c) The implementation of the sexual and reproductive health youth-friendly policies.
- d) The environment and facility characteristics of the CHC settings.
- e) Services rendered to adolescents with regard to youth-friendly sexual and reproductive health services.

4.2 Demographic characteristics of respondents

These include gender, the age, education and place of residence of the respondents.

4.3 Socio-demographics

A total of 168 female adolescents took part in the survey and they were all single.

4.3.1 Age

Figure 4.1 shows the age distribution of the 168 study participants and the largest proportion 35% were aged 20 years. This was followed by those aged 21 years at 28%, while teenagers 18 years made 20% and those who were 19 years made up 17%. Altogether, the mean (average) age was 19.7 years. The minimum is 18, the maximum is 21, the standard deviation is 1.082, and the mean is 19.73.

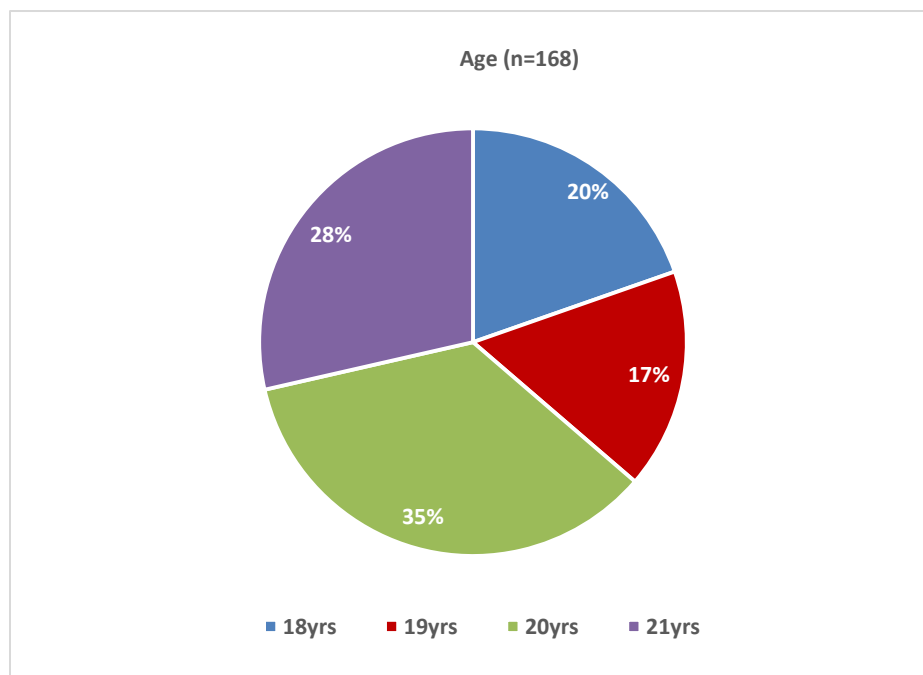


Figure 4.1: Age distribution

4.3.2 Education

Just over a quarter ($n = 27\%$) of the participants are high school students while those who had matriculated but were not studying made up ($n = 15\%$) of the sample. The majority ($n = 58\%$) of the participants were tertiary level students. Figure 4.2 below illustrates this data.

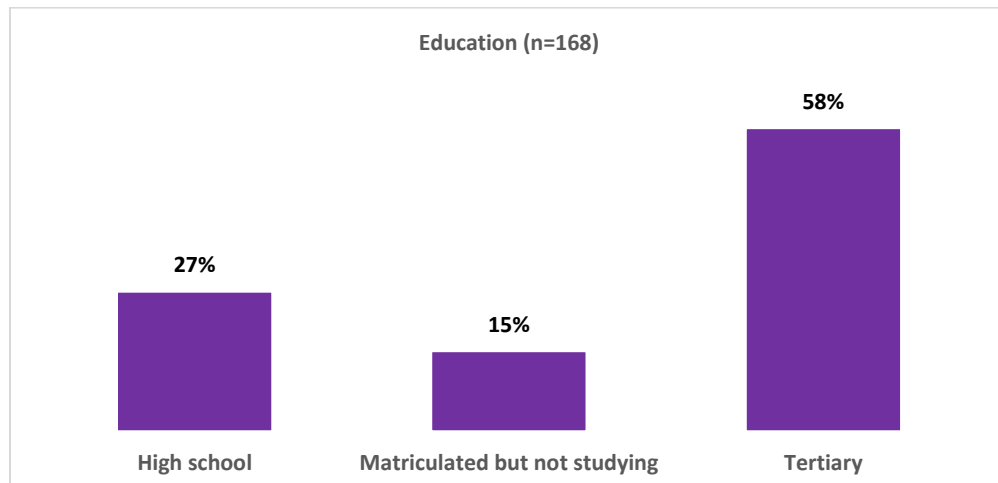


Figure 4.2: Current level of education

4.3.3 Place of residence

Most of the study participants are township residents, accounting for 88% of the study sample. A few individuals live in urban (3%) and rural (9%) areas. This information is illustrated in the pie chart below.

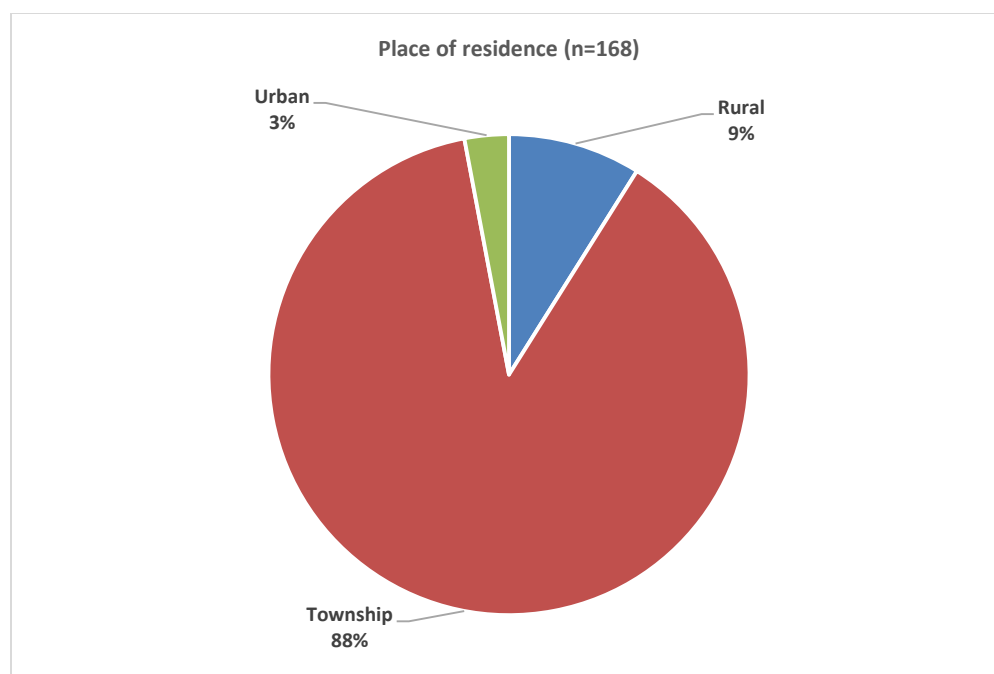


Figure 4.3: Place of residence

4.4 Exploring staff attitudes towards rendering sexual and reproductive health services to youth

The respondents were requested to indicate the type of staff attitudes they experience when they use sexual and reproductive health services on a four-point Likert scale ranging from strongly disagree to strongly agree. The results are displayed in table 4.1.

The majority of the respondents experienced friendliness from the staff to them as youth patients, with (n=141, 84%) agreeing and with (n=27, 16%) strongly agreeing. The mean was 3.16. Most of the respondents agreed that staff respect and ensure the privacy of youth patients with (n=102, 61%) with (n=54, 32%) strongly agreeing and (n=12, 7%) disagreeing. The mean was 3.26. When asked if health staff is knowledgeable about youth concerns and needs, (n=113, 67%) agreed, (n=42, 25%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.18.

The respondents were further asked if counsellors spend enough time with them, (n=116, 69%) agreed, (n=42, 25%) strongly agreed and (n=10, 6%) disagreed. The mean was 3.19. The

majority of the respondents also agreed that counsellors use language that is understandable to them, (n=114, 68%) agreed and (n=54, 32%) strongly agreed. The mean was 3.32.

The majority of respondents further agreed that nurses are non-judgemental and approachable, (n=141, 84%), and (n=27, 16%) strongly agreed. The mean was 3.16. Most of the respondents agreed that nurses spend enough time with youth, (n=131, 78%) agreed, (n=24, 14%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.07. Most of the respondents agreed that nurses use language that is understandable to them, (n=91, 54%) agreed and (n=77, 46%) strongly agreed. The mean was 3.46. The majority of the respondents agreed that information provided during a consultation is clear and helpful, (n=119, 71%) agreed and (n=49, 29%) strongly agreed. The mean was 3.29. Most of the respondents agreed that the information provided for a follow-up visit is clear, (n=101, 60%) agreed, (n=54, 32%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.24. The majority of the respondents also agreed that medical providers offer them choices including abstinence, contraception and withdrawal, (n=96, 57%) agreed, (n=59, 35%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.27. The respondents further agreed that there is an adequate number of staff available at the health facility, (n=144, 86%) agreed, and (n=24, 14%) strongly agreed. The mean was 2.71.

Table 4.1: Staff attitudes towards rendering sexual and reproductive healthcare services

Item	Strongly disagree		Disagree		Agree		Strongly agree		Mean
	n	%	n	%	n	%	n	%	
Staff is friendly and responsive to youth patients	0	0	0	0	141	84	27	16	3.16
Staff respects and ensures that privacy of youth is maintained	0	0	12	7	102	61	54	32	3.26
Health staff is knowledgeable about youth concerns and needs	0	0	13	8	113	67	42	25	3.18
Counsellors spend enough time with youth	0	0	10	6	116	69	42	25	3.19
Counsellors use language that is understandable to youth	0	0	0	0	114	68	54	32	3.32
Nurses are non-judgmental and approachable	0	0	0	0	141	84	27	16	3.16
Nurses spend enough time with youth	0	0	13	8	131	78	24	14	3.07

Nurses use language that is understandable to youth	0	0	0	0	91	54	77	46	3.16
Information provided to youth during a consultation is clear and helpful	0	0	0	0	119	71	49	29	3.29
The information provided to youth for follow visit(s) up is clear	0	0	13	8	101	60	54	32	3.24
Medical providers offer choices to youth including abstinence, contraception and withdrawal	0	0	13	8	96	57	59	35	3.27
There are an adequate number of staff available	0	0	0	0	144	86	24	14	2.71

4.5 The implementation of sexual and reproductive health youth-friendly policies

The respondents were requested to indicate whether sexual and reproductive health policies are implemented in the selected health facility using a four-point Likert scale ranging from strongly disagree to strongly agree. The results are displayed in table 4.2.

The majority of the respondents agreed that youth drop-ins are welcome and accommodated without an appointment, (n=127, 76%) agreed and (n=40, 24%) strongly agreed. The mean was 3.24. Most of the respondents disagreed that there is no long waiting time for patients, (n=87, 52%) disagreed and (n=59, 35%) agreed, (n=14, 8%) strongly agreed and (n=8, 5%) strongly disagreed. The mean was 2.36. When asked whether youth patients are given time to discuss their issues related to sexual and reproductive health, (n=106, 63%) agreed, (n=42, 25%) strongly agreed and (n=20, 12%) disagreed. The mean was 3.13. Most of the respondents agreed that services are offered to both male and female youth patients, (n=129, 77%) agreed and (n=39, 23%) strongly agreed. The mean was 3.23.

The majority of the respondents agreed that the facility provides information and/or audio-visual materials on reproductive health services, (n=101, 60%) agreed, (n=54, 32%) strongly agreed

and (n=13, 8%) disagreed. The mean was 3.24. Most of the respondents further agreed when asked whether the facility provides/stocks contraceptive methods that are most popular among youth patients, (n=108, 64%) agreed, (n=47, 28%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.20. When asked to indicate whether the sexual and reproductive health services are provided on rights-based approaches, (n=116, 69%) agreed, and (n=52, 31%) of the respondents strongly agreed. The mean was 3.31. When asked whether no consent is required for any services, (n=148, 88%) agreed and (n=20, 12%) strongly agreed. The mean was 3.12.

Majority of the respondents disagreed that youth with an STI are forced to bring their partners for them to get treated for an STI, (n=118, 70%) disagreed, (n=35, 21%) agreed and (n=15, 9%) strongly agreed. The mean was 2.38. Most of the respondents agreed that the facility offers a wide range of services, (n=125, 74%) agreed, (n=30, 18%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.10. Most of the respondents agreed that measures to promote continuity of service utilisation are in place, (n=124, 74%) agreed, and (n=44, 26%) strongly agreed. The mean was 3.26. The majority of the respondents reported to be informed of alternative sources of services in their community, (n=134, 80%) agreed and (n=34, 20%) disagreed. The mean was 2.80. When asked whether youth are included in service design and delivery, (n=67, 40%) disagreed, (n=52, 31%) agreed, and (n=49, 29%) strongly agreed. The mean was 2.88.

The respondents further questioned whether the clinic operates at a convenient time for youth, (n=108, 64%) agreed, (n=47, 28%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.20. Most of the respondents agreed that the cost of reproductive health services is free of charge, (n=104, 62%) agreed and (n=64, 38%) strongly agreed. The mean was 3.37. The majority of respondents also agreed that medical supplies and contraceptives are always available at the health facility, (n=92, 55%) agreed, (n=49, 29%) strongly agreed and (n=27, 16%) disagreed. The mean was 3.14. The majority of the respondents agreed that policies and strategies for mobilising youth are in place, (n=102, 61%) agreed, (n=42, 29%) strongly agreed and (n=27, 16%) disagreed. The mean was 3.11. The majority of the respondents further agreed that youth-friendly services are accessible to youth with location and distance, (n=96, 57%) agreed, (n=59, 35%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.27.

Table 4.2 Respondents' feedback on the implementation of sexual and reproductive health youth-friendly policies

Item	Strongly disagree		Disagree		Agree		Strongly agree		Mean
	n	%	n	%	n	%	n	%	
Youth drop-ins are welcome and accommodated without an appointment	0	0	0	0	127	76	40	24	3.24
There is no long waiting time for patients	8	5	87	52	59	35	14	8	2.36
Youth patients are given time to discuss their issues related to sexual and reproductive health	0	0	20	12	106	63	42	25	3.13
The services are offered to both male and female youth patients	0	0	0	0	129	77	39	23	3.23
The facility provides information and/or audio-visual materials on reproductive health services and concerns for patients	0	0	13	8	101	60	54	32	3.24
The facility provides/stocks contraceptive methods that are most popular among youth patients.	0	0	13	8	108	64	47	28	3.20
The sexual and reproductive health services are provided on rights-based approaches	0	0	0	0	116	69	52	31	3.31
No consent is required for any service	0	0	0	0	148	88	20	12	3.12
Youth with an STI are forced to bring their partners for them to get treated for anSTI	0	0	118	70	35	21	15	9	2.38
The facility offers a wide range of services	0	0	13	8	125	74	30	18	3.10
Measures to promote continuity of service utilisation are in place	0	0	0	0	124	74	44	26	3.26
Youth are informed of alternative sources of services in their community	0	0	34	20	134	80	0	0	2.80
Youth are included in service delivery and design	0	0	67	40	52	31	49	29	2.88
Clinics operate at a convenient time for youth	0	0	13	8	108	64	47	28	3.20
The cost of reproductive health services is free of charge	0	0	0	0	104	62	64	38	3.37
Medical supplies and contraceptives are always	0	0	27	16	92	55	49	29	3.14

available									
Policies and strategies for mobilising youth are in place	0	0	24	14	102	61	42	25	3.11
Youth friendly SRH services are accessible to youth (with location and distance)	0	0	13	8	96	57	59	35	3.27

Table 4.3 The relationship between age and no long waiting time for youth patients

	There is no long waiting time for patients					Total	Chi-sqaure	Df	p-value
		Strongly Disagree	Disagree	Agree	Strongly agree				
What is your age?	18	3	16	14	0	33	○	○	○
	19	4	13	11	0	28	○	○	○
	20	3	30	24	2	59	○	○	○
	21	3	30	9	6	48	○	○	○
Total		13	89	58	8	168	○	○	○

4.5.1The relationship between age and no long waiting time for youth patients

The chi-square test was performed to test the relationship between age and no long waiting time for patients. The chi-square test value was 17.589 with df 9, p-value is 0.040, (two-sided) which is statistically significant. Thus there is a relationship between age and no long waiting time for patients.

Table 4.4 Cross tabulation of age and no long waiting times for patients

Age in years		Frequency of no long waiting time		Total
		Disagree	Agree	
18	n	16	14	30
	%	53.3%	46.7%	100.0%

19	n	13	11	24
	%	54.2%	45.8%	100.0%
20	n	30	24	54
	%	55.6%	44.4%	100.0%
21	n	30	9	39
	%	76.9%	23.1%	100.0%
Total	n	89	58	147
	%	60.5%	39.5%	100.0%

4.5.2 Cross-tabulation of age and no long waiting time for youth patients

The results displayed in Table 4.5 show that more youth patients disagreed compared to those agreed that there is no long waiting time for youth at the selected health facility. 60.5% (n=89) of the youth patients disagreed that there is no long waiting time compared to 39.5% (n=58) who agreed that there is a long waiting time.

4.6 The environment and facility characteristics of the CHC setting

The respondents were requested to respond to some statements referring to the environment and facility characteristics of the CHC setting using a four-point Likert scale ranging from strongly disagree to strongly agree. The results are displayed in table 4.3.

When asked whether sexual and reproductive health is provided at convenient hours for youth, the majority of the respondents agreed, (n=118, 70%) agreed, (n=29, 17%) strongly agreed and (n=13, 8%) disagreed and (n=8, 5%) strongly agreed. The mean was 3. The majority of the respondents agreed that the decoration and surroundings at the youth centre are inviting to youth patients (non-medical), (n=109, 65%) agreed, (n=27, 16%) strongly agreed and (n=32, 19%) disagreed. The mean was 2.97. Most of the respondents agreed that the location of the youth-

friendly health facility is close to public transport, (n=108, 64%) agreed, (n=30, 18%) strongly agreed and (n=30, 18%) disagreed. The mean was 2.99. When asked whether the location of the youth-friendly health facility is far from places where adults spend most of their time, the majority of the respondents agreed, (n=126, 75%) agreed, (n=18, 11%) strongly agreed and (n=24, 14%) disagreed. The mean was 2.98. Most of the respondents also agreed that the location of the youth-friendly health facility is close to places where unmarried youths spend their time, (n=98, 58%) agreed, (n=20, 12%) strongly agreed and (n=50, 30%) disagreed. The mean was 2.82. Most of the respondents further agreed that the location of the youth-friendly health facility is close to the place where the general public is found, (n=134, 80%) agreed, (n=20, 12%) strongly agreed and (n=14, 8%) disagreed. The mean was 3.04.

When asked whether the counselling and consultation rooms ensure privacy for youth patients, (n=108, 64%) agreed, (n=48, 29%) strongly agreed and (n=12, 7%) disagreed. The mean was 3.21. Most of the respondents agreed that separate space is used for the consultation of youth patients, (n=101, 60%) agreed, (n=59, 35%) strongly agreed, (n=8, 5%) disagreed. The mean was 3.27. The majority of the respondents agreed that educational materials are displayed, and available to youth patients, (n=123, 73%) agreed, (n=35, 21%) strongly agreed and (n=10, 6%) disagreed. The mean was 3.14. The majority of the youth respondents agreed that they have overall satisfaction with the environment at the health facility, (n=76, 45%) agreed, (n=47, 28%) strongly agreed and (n=45, 27%) disagreed. The mean was 3.01. The majority of the respondents further agreed when asked whether visual and auditory consultations are maintained during consultation and other procedures, (n=133, 79%) agreed, (n=30, 18%) strongly agreed and (n=5, 3%) disagreed. The mean was 3.14.

Table 4.5 The environment and facility characteristics of the CHC setting

Item	Strongly disagree		Disagree		Agree		Strongly agree		Mean
	n	%	n	%	n	%	n	%	
Sexual and reproductive health is provided at convenient hours for youth	8	5	13	8	118	70	29	17	3.0

Decoration and surroundings are inviting to youth patients (non-medical)	0	0	32	19	109	65	27	16	2.97
The location of the youth-friendly health facility is close to public transport	0	0	30	18	108	64	30	18	2.99
The location of the youth-friendly health facility is far away from places where adults spend most of their time	0	0	24	14	126	75	18	11	2.98
The location of the youth-friendly health facility is close to places where unmarried youth spend their time (e.g. schools, video centres and recreation centres)	0	0	50	20	98	58	20	12	2.82
The location of the youth-friendly health facility is close to the place where the general public is often found.	0	0	14	8	134	80	20	12	3.04
Counselling and consultation rooms ensure privacy for youth patients	0	0	12	7	108	64	48	29	3.21
Separate space or time is used for the consultation of youth patients	0	0	8	5	101	60	59	35	3.21
Educational materials are displayed and available to youth patients	0	0	10	6	123	73	35	21	3.14
Youth patients show overall satisfaction with the environment at the health facility	0	0	45	27	76	45	47	28	3.01
Visual and auditory privacy are maintained during consultation and other procedures	0	0	5	3	133	79	30	18	3.14

Table 4.6 The relationship between educational level and whether sexual and reproductive health is provided at convenient hours for youth

	Sexual and reproductive health is provided at convenient hours for youth patients					Total	Chi-square	Df	p-value
		Strongly Disagree	Disagree	Agree	Strongly agree				
Educational Level	High School	0	13	32	0	45	○	○	○
	Matriculated but not studying	0	0	15	11	26	○	○	○

	Tertiary	0	0	61	36	97	○	○	○
Total		0	13	108	47	168	○	○	○

4.6.1 The relationship between educational level and whether sexual and reproductive health is provided at convenient hours for youth patients

The chi-square test was performed to test the relationship between educational level and whether sexual and reproductive health is provided at convenient hours for youth patients. The chi-square test value was 53.458 with df 4, p-value is 0.000, (two-sided) which is statistically significant. Thus there is a relationship between educational level and whether sexual and reproductive health is provided at convenient hours for youth patients.

Table 4.7 The relationship between educational level and whether youth show overall satisfaction with the environment at the health facility

	Youth show overall satisfaction with the environment at the health facility						Chi-square	Df	p-value
		Strongly Disagree	Disagree	Agree	Strongly agree	Total	81.225	4	0.000
Educational Level	High School	0	34	11	0	45	○		○
	Matriculated but not studying	0	0	11	15	26	○		○
	Tertiary	0	12	53	32	97	○		○
Total		0	46	75	47	168	○		○

4.6.2 The relationship between educational level and whether youth show overall satisfaction with the environment at the health facility

The chi-square test was performed to test the relationship between educational level and whether youth show overall satisfaction with the environment at the health facility. The chi-square test value was 81.225 with df 4, p-value is 0.000, (2-sided) which is statistically significant. Thus there is a relationship between educational level and whether youth show overall satisfaction with the environment at the health facility.

Table 4.8: Cross tabulation of educational level and whether sexual and reproductive healthcare is provided at convenient hours for youth patients

Educational level		Frequency of provision of sexual and reproductive health at convenient hours for youth patients		Total
		Strongly Agree	Agree	
High School	n	0	32	32
	%	0.00%	100.0%	100.0%
Matriculated but not studying	n	11	15	26
	%	42.3%	57.7%	100.0%
Tertiary	n	36	61	97
	%	37.1%	62.9%	100.0%
Total	n	47	108	155
	%	30.3%	69.7%	100.0%

4.6.3 Cross tabulation of educational level and whether sexual and reproductive health is provided at convenient hours for youth patients

The results displayed in Table 4.7 show that more youth patients agreed compared those who strongly agreed that sexual and reproductive health is provided at convenient hours for youth at the selected health facility, 69.7% (n=108) agreed and 30.3% (n=47) strongly agreed.

4.7 Exploring services rendered to adolescents regarding youth-friendly sexual and reproductive health services

The respondents were requested to respond to some statements referring to the services which are rendered to adolescents regarding youth-friendly sexual and reproductive health services using a four-point Likert scale ranging from strongly disagree to strongly agree. The results are displayed in Table 4.4.

When asked whether counselling services are available for youth, the majority of the respondents agreed, (n=91, 54%) agreed and (n=77, 46%) strongly agreed. The mean was 3.46. the majority of the respondents that contraceptive methods such as the condom, the pill and the injectables are always available for youth, (n=104, 62%) agreed, (n=50, 30%) strongly agreed and (n=14, 8%) disagreed. The mean was 3.23. The majority of the respondents agreed that contraceptives are always available, (n=126, 75%) agreed, (n=29, 17%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.10. Most of the respondents disagreed that the IUD is readily available at the health facility, (n=155, 92%) disagreed and (n=13, 8%) agreed. The mean was 2.08. The majority of the respondents agreed that premarital counselling is available for youth, (n=155, 92%) agreed and (n=13, 8%) strongly agreed. The mean was 3.08. Most of the respondents agreed that STI treatment for youth is always available, (n=106, 63%) agreed, (n=50, 30%) strongly agreed and (n=12, 7%) disagreed. The mean was 3.24.

Most of the respondents agreed that both male and female adolescents are welcomed and served at the selected health facility, (n=118, 70%) agreed and (n=50, 30%) strongly agreed. The mean was 3.30. Most of the respondents agreed that unmarried adolescents are welcomed and served at the health facility, (n=119, 71%) agreed and (n=49, 29%) strongly agreed. The mean was 3.29. The majority of the respondents agreed that there is no discrimination in service provision for both married and unmarried youth (n=73, 44%) agreed, (n=55, 33%) strongly agreed and (n=39, 23%) disagreed. The mean was 3.10. Most of the respondents agreed that individualised care is promoted, (n=131, 78%) agreed, (n=24, 14%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.07. The majority of the respondents further agreed that youth are involved in decision making regarding their care after the provision of adequate information of different options of treatment/methods, (n=109, 65%) agreed, (n=22, 13%) disagreed and (n=37, 22%) strongly disagreed. The mean was 2.43.

The majority of the respondents agreed that youth are given their preferred treatment/methods (contraceptive), (n=121, 72%) agreed, and (n=47, 28%) strongly agreed. The mean was 3.28. Most of the respondents disagreed that the healthcare providers force youth to use particular method/treatment, (n=96, 57%) disagreed, (n=18, 11%) strongly disagreed and (n=54, 32%) agreed. The mean was 2.21. Most of the respondents disagreed that medical procedures such as pelvic examinations and blood tests are delayed for youth, (n=100, 60%) disagreed, (n=7, 4%) strongly disagreed, (n=49, 29%) agreed and (n=12, 7%) strongly agreed. The mean was 2.38. The majority of the respondents agreed that the healthcare providers emphasise the importance of adolescents partners if they have STIs, (n=128, 76%) agreed, and (n=40, 24%) strongly agreed. The mean was 3.24.

Most of the respondents agreed that agreed that referral services are available for youth when necessary, (n=125, 74%) agreed, (n=30, 18%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.11. The majority of the respondents agreed that healthcare providers identify and make plans for people who require special support for e.g. a young woman whose partner is opposed to the use of contraceptives, (n=73, 43%) agreed, (n=45, 27%) strongly agreed and (n=50, 30%) disagreed. The mean was 2.98. Most of the respondents agreed that healthcare providers identify and make plans for identifying sexual violence, (n=121, 72%) agreed, (n=19, 11%) strongly agreed, (n=13, 8%) disagreed and (n=15, 9%) strongly disagreed. The mean was 2.84. The majority of the respondents agreed that youth who are first time users at the health facility receive a friendly welcome, (n=123, 73%) agreed, (n=32, 19%) strongly agreed and (n=13, 8%) disagreed. The mean was 3.11.

Most of the respondents agreed that youth who are first time users at the healthcare facility are orientated, and educational services are provided, (n=126, 75%) agreed, (n=17, 10%) strongly agreed and (n=25, 15%) disagreed. The mean was 2.95. The majority of the respondents agreed that youth who are first time users at the health facility are provided with education on their rights to use the services, (n=114, 68%) agreed, (n=29, 17%) strongly agreed and (n=25, 15%) disagreed. The mean was 3.02. Most of the respondents agreed that youth are provided with the assurance of confidentiality at their first visit, (n=134, 80%) agreed and (n=34, 20%) strongly agreed. The mean was 3.20. The majority of the respondents agreed that youth are provided with

operational times of the facility at their first visit, (n=122, 73%) agreed, (n=12, 7%) strongly agreed and (n=34, 20%) disagreed. The mean was 2.87.

The majority of the respondents disagreed that first time users are provided with leaflets on sexual and reproductive health and youth-friendly services, (n=77, 46%), (n=8, 5%) strongly disagreed, (n=76, 45%) agreed and (n=7, 4%) strongly agreed. The mean was 2.48. Most of the respondents agreed that provision of services to youth involves their decision-making regarding treatment, (n=126, 75%) agreed, (n=17, 10%) strongly agreed and (n=25, 15%) disagreed. The mean was 2.94. The majority of the respondents agreed that youth are provided with encouragement of continuity and arrangement of follow-up care, (n=109, 65%) agreed, (n=22, 13%) strongly agreed (n=12, 7%) disagreed and (n=25, 15%) strongly disagreed. The mean was 2.76. Most of the respondents again agreed that youth who are regular users of the health facility always receive a friendly welcome, (n=153, 91%) agreed, (n=2, 1%) strongly agreed and (n=13, 8%) disagreed. The mean was 2.93. The majority of the respondents agreed that youth who are regular users of the health facility receive follow up care, (n=123, 73%) agreed, (n=12, 7%) strongly agreed, (n=25, 15%) disagreed and (n=8, 5%) strongly disagreed. The mean was 2.69. Most of the respondents agreed that regular youth users of the health facility are provided with an assessment of current needs and counselling and education, (n=86, 51%) agreed, (n=19, 11%) strongly agreed, (n=55, 33%) disagreed and (n=8, 5%) strongly disagreed. The mean was 2.83. Most of the respondents agreed that when youth patients are managed they are asked about their sexual history, (n=87, 52%) agreed, (n=2, 1%) strongly agreed, (n=71, 42%) disagreed and (n=8, 5%) strongly agreed. The mean was 2.50. The majority of the respondents further agreed that when youth patients are managed they are motivated to change their sexual behaviour, (n=125, 74%) agree, (n=35, 21%) disagreed and (n=8, 5%) strongly disagreed. The mean was 2.70. The majority of the respondents also agreed that when youth patients are managed they are advised on prevention measures, (n=144, 86%) agreed, (n=2, 1%) strongly agreed, (n=14, 8%) disagreed and (n=8, 5%) strongly disagreed. The mean was 2.84.

Table 4.9 Exploring services rendered to adolescents regarding youth-friendly sexual and reproductive healthcare services

Item	Strongly disagree		Disagree		Agree		Strongly agree		Mean
	n	%	n	%	n	%	n	%	
Counselling services are available for youth	0	0	0	0	91	54	77	46	3.46
Contraceptive methods such as the condom, the pill and the injectables are always available for youth	0	0	14	8	104	62	50	30	3.23
Emergency contraceptives are always available	0	0	13	8	126	75	29	17	3.10
The IUD is readily available	0	0	155	92	13	8	0	0	2.08
Pre-marital counselling is available for youth	0	0	0	0	155	92	13	8	3.08
STI treatment for youth is always available	0	0	12	7	106	63	50	30	3.24
Both male and female adolescents are welcome and served	0	0	0	0	118	70	50	30	3.30
Unmarried adolescents are welcomed and served	0	0	0	0	119	71	49	29	3.29
There is no discrimination in service provision for both married and unmarried youth	0	0	39	23	74	44	55	33	3.10
Individualised care is provided and promoted	0	0	13	8	131	78	24	14	3.07
Youth are involved in decision making regarding their care after the provision of adequate information of different options of different options of treatment/methods	37	22	22	13	109	65	0	0	2.43
Youth are given their preferred treatment/methods (contraceptive)	0	0	121	72	47	28	0	0	3.28
The healthcare provider forces youth to use particular method/treatment	18	11	96	57	54	32	0	0	2.21
Medical procedures such as pelvic examinations and blood tests are delayed for youth	7	4	100	60	49	29	12	7	2.38
The Healthcare provider emphasises the importance of adolescents partners if they have STIs	0	0	0	0	128	76	40	24	3.24
Referral services are available for youth when necessary	0	0	13	8	125	74	30	18	3.11

Healthcare providers identify and make plans for people who require special support for e.g. a young woman whose partner is opposed to the use of contraceptives	0	0	50	30	73	43	45	27	2.98
Healthcare providers identify and make plans for identifying sexual violence	15	9	13	8	121	72	19	11	2.84
Youth who are first time users at the health facility receive a friendly welcome	0	0	13	8	123	73	32	19	3.11
Youth who are first-time users are orientated and education and services are provided	0	0	25	15	126	75	17	10	2.95
Youth who are first-time users are provided with education on their rights to use their services	0	0	25	15	114	68	29	17	3.02
Youth are provided with assurance of confidentiality at their first visit	0	0	0	0	134	80	34	20	3.20
Youth are provided with the operational times of the facility at their first visit	0	0	34	20	122	73	12	7	2.87
First time users are provided with leaflets on sexual and reproductive health and youth-friendly services	8	5	77	46	76	45	7	4	2.48
Provision of services to youth involves their decision-making regarding treatment	0	0	25	15	126	75	17	10	2.94
Youth are provided with encouragement of continuity and arrangement of follow-up care	25	15	12	7	109	65	22	13	2.76
Youth who are regular users of the health facility always receive a friendly welcome	0	0	13	8	153	91	2	1	2.93
Youth who are regular users of the health facility receive follow-up care	8	5	25	15	123	73	12	7	2.69
Regular youth users of the health facility are provided with an assessment of current needs and counselling and education	8	5	55	33	86	51	19	11	2.83
When youth patients are managed they are asked about their sexual history	8	5	71	42	87	52	2	1	2.50
When youth patients are managed they are motivated to change their sexual behaviour	8	5	35	21	125	74	0	0	2.70

When youth patients are managed they are advised on prevention measures	8	5	14	8	144	86	2	1	2.84
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Table 4.10 The relationship between educational level and whether the provision of services to youth involves their decision-making

	Provision of services to youth involves their decision-making						Chi-sqaure	Df	p-value
		Strongly Disagree	Disagree	Agree	Strongly agree	Total	92.327	4	0.000
Educational Level	High School	0	26	19	0	45	○		○
	Matriculated but not studying	0	0	26	0	26	○		○
	Tertiary	0	0	81	16	97	○		○
Total		0	26	126	16	168	○		○

4.7.1 The relationship between educational level and whether the provision of services involves their decision-making

The chi-square test was performed to test the relationship between educational levels and whether provision of services to youth involves their decision-making. The chi-square test value was 92.327 with df 4, p-value is 0.000, (2-sided) which is statistically significant. Thus there is a relationship between educational levels and whether provision of services to youth involves their decision-making.

Table 4.11 The relationship between age and whether the healthcare provider forces youth to use a particular method/treatment

	The Healthcare provider forces youth to use a particular method/treatment						Chi-sqaure	Df	p-value
		Strongly Disagree	Disagree	Agree	Strongly agree	Total	13.381	6	0.037
What is your age?	18	3	19	11	0	33	○	○	○
	19	0	14	14	0	28	○	○	○
	20	6	32	21	0	59	○	○	○
	21	9	31	8	0	48	○	○	○
Total		18	96	54	0	168	○	○	○

4.7.2 The relationship between age and whether the healthcare provider forces youth to use a particular method/treatment

The chi-square test was performed to test the relationship between age and whether the healthcare provider forces youth to use a particular method/treatment. The chi-square test value was 13.381 with df 6, p-value is 0.037, (2-sided) which is statistically significant. Thus there is a relationship between age and whether the healthcare provider forces youth to use a particular method/treatment.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1 Introduction

This chapter presents the discussion of the recommendations and conclusion findings of this research study. The purpose of this study was to explore adolescent's perception regarding youth-friendly sexual and reproductive health services in a selected CHC in uMgungundlovu District. The research objectives were to: a) to explore the attitudes of staff towards giving sexual and reproductive health services to youths, b) to explore the implementation of the sexual and reproductive health youth-friendly policies, c) to describe the environment and facility characteristics of the CHC settings, and d) to explore services rendered to adolescents with regard to youth-friendly sexual and reproductive health services.

The findings are discussed in relation to the research objectives and the conceptual framework used in this study as well as the relevant literature reviewed. In this study, a quantitative exploration and descriptive design was used to conduct the research. A questionnaire was used as a data collection tool. Utilising the survey for its exploratory purpose allowed the researcher to obtain information relating to the perceptions of adolescents regarding youth-friendly sexual and reproductive health services in a selected CHC in uMgungundlovu District. A non-probability convenient sampling technique was used to obtain a sample of 168 youth patients attending sexual and reproductive health services in a selected CHC in the uMgungundlovu District. Only 168 out of 169 in the sample returned with complete questionnaires. All the respondents were females.

5.2 Discussion of the findings

The major themes that are discussed in this chapter are staff attitudes towards rendering sexual and reproductive healthcare services to youths, the implementation of sexual and reproductive health youth-friendly policies, the environment and facility characteristics of the CHC setting,

and services rendered to adolescents regarding youth-friendly sexual and reproductive healthcare services.

5.2.1 Staff attitudes towards rendering sexual and reproductive health services to youths

The findings indicated that staff is friendly and responsive to youth patients. When asked whether staff is friendly and responsive, most of the respondents agreed. This is opposed to what was discovered in the study conducted by (Pozo et al., 2015) where it was found that one of the key barriers to adolescents access to contraception is that they do not trust in the confidentiality of staff in the healthcare facilities and worried about being negatively judged for being sexually active. This particularly applied to young adolescent girls (Córdova-Pozo et al., 2015).

Most of the respondents agreed that staff respect and ensure that their privacy as youth patients is maintained. This is similar to what was discovered by (Kennedy E et al., 2011): some of the factors which prevented adolescents from accessing healthcare services were the judgmental attitudes of the services providers, the lack of confidentiality and privacy and adolescent's lack of SRH knowledge were some important barriers which prevented adolescents from accessing services.

The majority of the respondents agreed that health staff is knowledgeable about youth health concerns and needs. This is similar to what was discovered in the study conducted by (Kim Jonas et al., 2017). They found that healthcare workers may influence the utilisation of SRH services by adolescents through the quality of care they provide and the behaviours or attitudes they hold. The study showed that negative behaviours and attitudes of healthcare workers together with other personal determinants such as poor knowledge and skills of SRH services and other factors like the availability of essential drugs and equipment are related to the provision of improper SRH services. The study also indicated that healthcare workers negative behaviours and attitudes are unlikely to encourage women, in general, to access and utilise SRH services, specifically young women (Jonas et al., 2017).

The respondents were further asked if counsellors spend enough time with them, and majority of the respondents agreed. This is similar to the study conducted by (Alfred Meremo et al., 2016) in Tanzania on the barriers to accessibility and utilisation of HIV testing and counselling services. This study showed that 4.09% of the clients reported spending more than two hours at the HTC centre before they were attended. Of those clients who received counselling, 21.8% reported counselling to be done in groups. The findings showed that although the coverage of the HTC was high, long waiting time, and lack of confidentiality impeded its accessibility and utilisation (Alfred Meremo et al., 2016).

The majority of the respondents also agreed that counsellors use language that is understandable to them. This is congruent with what was discovered by (Alfred Meremo et al., 2016) in their study on barriers to accessibility and utilisation of HIV testing, where no language barriers were discovered in the findings between the HIV counsellors and the participants of the study.

When asked whether the nurses are non-judgmental and approachable, most of the respondents agreed. This is opposed to what was discovered by (Andrew G. Onokerhoray and Johnson Egbemudla Dudu, 2017) on the perceptions of adolescents on the attitudes of providers in their access and use of reproductive health services in Nigeria. The results showed that an average of 66.8% of the respondents were not comfortable with the waiting time at the facilities where they went to seek healthcare services and the lack of friendly attitudes by the healthcare providers together with the inadequate duration of consultations, judgmental attitudes of providers, lack of satisfactory services and of confidentiality which puts off adolescents from accessing and using adolescents reproductive health services (ibid).

When asked whether the nurses are non-judgmental and approachable, most of the respondents agreed. This differs from the findings of (Andrew G. Onokerhoray and Johnson Egbemudla Dudu, 2017) where respondents were not comfortable with the long waiting time at the facilities where they went to seek SRH when compared with the little time they spent in the consultation rooms with the healthcare providers.

When asked whether nurses use language that is understandable to youth most of the respondents agreed. This is similar to what was discovered by (Kennedy et al., 2013), where the judgmental attitudes of the service providers, disapproval from parents, lack of confidentiality and privacy,

and adolescents' lack of SRH knowledge were the important barriers preventing adolescents from accessing services. There were no language barriers from the nurses mentioned in the study.

The majority of the respondents agreed that information provided during a consultation is clear and helpful. This is opposed to what was mentioned in the study by (Rebecca Sally Geary et al., 2014) that knowledge about sexuality and reproductive health among youth is limited and that youths "report a need for more information on relationships, pregnancy and STIs. Fear of judgmental attitudes of healthcare workers has been reported as a barrier to young people's use of a range of health services in South Africa"(R. Jewkes et al., 2005) and Alli et al., 2013. Most of the respondents agreed that the information provided for a follow-up visit is clear. This also differs from (Rebecca Sally Geary et al., 2014).

The majority of the respondents agreed that medical providers offer them choices including abstinence, contraception and withdrawal. A study was conducted by (Kim Jonas et al., 2016) to examine the trends in teenage pregnancy and to identify associations with other health risk behaviours in South Africa. The study revealed that girls continue to become pregnant at unacceptably high rates in the country. However, among those who are sexually active pregnancy prevalence rates have increased (Jonas et al., 2016).

5.2.2 Implementation of sexual and reproductive health youth-friendly policies

Most of the respondents disagreed that there is no long waiting time for patients, 52% disagreed and 35% agreed. This is opposed to the findings found in the study conducted by (Andrew G. Onokerhoray and Johnson Egbemudla Dudu, 2017) in Nigeria. The results from the study showed that an average of 66.8% of the respondents were not comfortable with the waiting time at the facilities where they went to seek SRH, this together with the lack of friendly attitudes from the health providers together with the inadequate duration of consultations, the judgmental attitudes of some providers, lack of satisfactory services and lack of confidentiality puts off adolescents from accessing and using adolescents reproductive health services.

When asked whether youth patients are given time to discuss their issues related to sexual and reproductive health, most of the respondents agreed. This is opposed to the study conducted by (Anna Newton-Levinson et al., 2016) examining barriers adolescents that adolescents encounter when seeking appropriate medical care for STI services for youths. Youth reported avoiding the healthcare services or having anxiety relating to confidentiality based on some behaviours of the healthcare providers. The majority of the healthcare providers were described by youth as judgmental or having a poor attitude. Some of the negative behaviours mentioned by youths were rude or unfriendly treatment, blaming, lecturing, or scolding, or yelling at them.

Most of the respondents agreed that services are offered to both male and female youth patients. This is echoed by the study conducted by (Pamela M. Godia et al., 2014) which explored perceptions and experiences of young people in Kenya aged 10 to 24 years regarding their SRH needs and whether these are met by the available healthcare providers. Young people's perceptions were not identical and showed variation between boys and girls as well as the types of service delivery received. Girls that sought antenatal care and family planning services at the health facilities characterised the available services as good and staff being helpful. However, boys that took part in the study perceived the services at the health facilities as designed for women and children and as a result felt uncomfortable in seeking the services

The respondents were further questioned whether the clinic operates at a convenient time for youth, and most of the respondents agreed. This is opposed the study conducted by (Vanessa Woog et al., 2015) on sexual and reproductive health. According to Woog et al. (2015), key structural barriers that often prevent young people from acquiring sexual and reproductive health services include inconvenient location areas and the operational times of the facilities, and not being aware of where the services are provided.

The majority of respondents also agreed that medical supplies and contraceptives are always available at the health facility. This is similar to (Vanessa Woog et al., 2015) who found that key structural barriers that prevent young people from acquiring sexual and reproductive health services include inconvenient location areas and the operational times of the facilities, and not being aware of where the services are provided.

5.2.3 Environment and facility characteristics of the CHC setting

When asked whether sexual and reproductive health is provided at convenient hours for youth, the majority of the respondents agreed. This differs from the study conducted by (Vanessa Woog et al., 2015) on sexual and reproductive health. According to Woog et al. (2015), key structural barriers that usually prevent young people from accessing sexual and reproductive healthcare services include inconvenient location areas, the operational times of the facilities, and not being aware of where the services are provided.

When asked whether the counselling and consultation rooms ensure privacy for youth patients, most of the respondents agreed. This is opposed to the study conducted by (Anna Newton-Levinson et al., 2016) in which youths reported avoiding the healthcare services or having anxiety relating to confidentiality, based on some behaviours of the healthcare providers. The majority of the healthcare providers were described by youths as being judgmental or having a poor attitude. Some of the negative behaviours mentioned by youth were rude or unfriendly treatment, blaming, lecturing, or scolding, or yelling at youths (Newton-Levinson et al., 2016).

The majority of the youth respondents agreed that they have overall satisfaction with the environment at the health facility. This differs from the findings found in the study by Kennedy et al. (2013) regarding the sexual and reproductive health of adolescents in Vanatu, a Pacific island nation. Adolescents' own fear and shame, the judgmental attitudes of the service providers, disapproval from parents, lack of confidentiality and privacy, and adolescent's lack of SRH knowledge were important barriers preventing adolescents from accessing services. These contributed to adolescents' own fear and shame, judgmental attitudes of service providers, and disapproval from parents and community gate-keepers. Lack of confidentiality and privacy, costs, and adolescents' lack of SRH knowledge were also important barriers (Kennedy et al., 2013).

5.2.4 Services rendered to adolescents regarding youth-friendly sexual and reproductive health services

When asked whether counselling services are available for youth, the majority of the respondents agreed. This is congruent with what was discovered by (Alfred Meremo et al., 2016) in the study

on barriers to accessibility and utilisation of HIV testing, counselling services were available for youth. The majority of the respondents agreed that contraceptive methods such as the condom, the pill and the injectables are always available for youth. This is similar to the study by (Vanessa Woog et al., 2015)) which was conducted in various developing countries and which showed that providing universal access to sexual and reproductive healthcare is above the capacity of the country. In some instances the health facilities may exist but there is an inadequate number of trained staff to give the required services and there may be a shortage of drugs and contraceptives.

The majority of the respondents agreed that emergency contraceptives are always available. This is also similar to the research of (Vanessa Woog et al., 2015). Most of the respondents disagreed that IUDs are readily available at the health facility, 92% disagreed and 8% agreed. This is similar to the findings in the study by Tylee et al. (2007) on understanding the sexual and reproductive health needs of adolescents in Uganda which showed that adolescents are usually hesitant to seek sexual and reproductive health services due to barriers such as judgmental healthcare workers, and the lack of supplies, equipment and private consultation rooms.

The majority of the respondents agreed that premarital counselling is available for youths. (N.M. Pritt et al., 2017) found that contraceptive counselling can be understood as a behaviour which is influenced by a number of factors. Included among these factors negatively influencing counselling adolescents about contraceptives are capacities such as inadequate knowledge, an opportunity such as environmental constraints, including the culture of a clinical setting and motivation such as negative attitudes and beliefs.

Most of the respondents agreed that STI treatment for youth is always available. This is also similar to the findings in the study by Tylee et al. (2007) mentioned above.

Most of the respondents agreed that both male and female adolescents are welcomed and served at the selected health facility. This is congruent to what was revealed in the study conducted by (Nadine Crossland et al., 2015) on sexual and reproductive health among Ugandan Youth. In which both male and female adolescents were part of the study on sexual and reproductive health services for youth aged 15 to 24 years of age. Most of the respondents agreed that unmarried adolescents are welcomed and served at the health facility. This is congruent to the study

conducted by (Sushanta K. Banerjee et al., 2015) on young women between the ages of 15 and 24 years regarding sexual and reproductive health knowledge in India, where unmarried adolescents were also welcomed at the health facilities.

The majority of the respondents agreed that there is no discrimination in service provision for both married and unmarried youth. This is similar to the study conducted by (Sushanta K. Banerjee et al., 2015) in which it was found that there was no discrimination at the healthcare facilities between married and unmarried youths.

Most of the respondents agreed that individualised care is promoted. This is congruent with the research by (A. Tylee et al., 2007) from Uganda. Privacy and identity is of importance to them and they desire to make decisions for themselves based on correct information provided. The WHO stipulates that there are various elements that motivate adolescents to seek healthcare. These elements include confidentiality, provision of required information and services, the acceptance of adolescents as they are, allowing them to make their own decision, making sure that adolescents feel welcome and comfortable at the health facilities they present themselves at and the provision of services at times which are convenient for adolescents.

The majority of the respondents further agreed that youth are involved in decision making regarding their care after the provision of adequate information of different options of treatment/methods, 65% agreed, and 22% strongly disagreed. This is similar to the large-scale cluster randomised study done in Tanzania by (Zaina Mchome et al., 2015) to evaluate the state of youth-friendly sexual and reproductive health services. Regarding health worker attitudes to adolescent use of SRH services in various cases in two regions where the study was done, the healthcare workers showed negative attitudes toward adolescent use of SRH services, including verbalising their views that family planning should be reserved for adults especially married couples. This may have come from a familiar perspective that family planning services are mainly meant for child spacing. Knowledge and attitude towards condom use among health workers varied. A number of health workers had positive attitudes to condom use, but others openly discouraged young people from using them ((Zaina Mchome et al., 2015).

The majority of the respondents agreed that youth are given their preferred treatment/methods (contraceptives). This is opposed to what was revealed in the study by (Zaina Mchome et al., 2015) in Tanzania as described above. .

Most of the respondents disagreed that the healthcare providers force youth to use particular method/treatment, 57% disagreed, and 32% agreed. This is similar to what was revealed in the study by (Brittany Schriver et al., 2014). In the study, 25 in-depth interviews were conducted in 2012; the study revealed that knowledge of the YFS was very low. Although the healthcare providers did not force youth to use particular methods/treatment, youth were generally dissatisfied with the current health services in Soweto, and mentioned a lack of resources, long waiting times and poor quality of care (Schriver et al., 2014).

Most of the respondents disagreed that medical procedures such as pelvic examinations and blood tests are delayed for youth, 60% disagreed, and 29% agreed. This is similar to the findings in the study conducted by (Alfred Meremo et al., 2016) on the barriers to accessibility and utilisation of HIV testing and counselling services in Tanzania, which revealed that 4.09% of the clients reported spending more than two hours at the HTC centre before they were attended. The findings showed that although the coverage of the HTC was high, long waiting time, and lack of confidentiality impeded its accessibility and utilisation. Although there were long waiting times there were no specific delays in management of the patients.

The majority of the respondents agreed that healthcare providers identify and make plans for people who require special support, for example, a young woman whose partner is opposed to the use of contraceptives. This is similar to the findings in the study by (Zaina Mchome et al., 2015) on the evaluation of youth-friendly sexual and reproductive health. Regarding health worker attitudes to adolescent use of SRH services in various cases in two regions where the study was done, the health workers showed negative attitudes toward adolescent use of SRH services, including verbalising their views that family planning should be reserved for adults especially married couples. This may have come from a familiar perspective that family planning services are mainly meant for child spacing. Knowledge and attitude towards condom use among health workers varied.

Most of the respondents agreed that healthcare providers identify and make plans for identifying sexual violence. This is similar to the discovery in the study done by (Zaina Mchome et al., 2015) described above.

The majority of the respondents agreed that youths who are first time users at the health facility receive a friendly welcome. This differs from the study conducted by (Anna Newton-Levinson et al., 2016) examining barriers adolescents encounter when seeking appropriate medical care for STI services for youths in 15 countries. Youth reported avoiding the healthcare services or having anxiety relating to confidentiality, based on the some behaviours of the healthcare providers. The majority of the healthcare providers were described by youth as being judgmental or having a poor attitude. Some of the negative behaviours mentioned by youth were rude or unfriendly treatment, blaming, lecturing, or scolding, or yelling at youths (Newton-Levinson et al., 2016).

Most of the respondents agreed that youth who are first time users at the health facility are orientated and educational services are provided, 75% agreed, and 15% disagreed. This also differs from the study conducted by (Anna Newton-Levinson et al., 2016) in which youths reported incidents of shame and stigma as common barriers to seeking care.

The majority of the respondents agreed that youth who are first time users at the health facility are provided with education on their rights to use the services. Most of the respondents agreed that youth are provided with the assurance of their confidentiality at their first visit. This is also opposed to the findings of (Anna Newton-Levinson et al., 2016).

5.3 Recommendations

The recommendations ensuing from this study mainly focus on establishing adolescents' perceptions regarding sexual and reproductive health and youth-friendly healthcare services and empowering youths to stand up for their sexual and reproductive health rights. The findings from this study indicate that healthcare staff have positive attitudes towards rendering sexual and reproductive healthcare services in the selected CHC. Most of the recommendations relate to nursing practice and nursing education and/or the training provider environment. Furthermore, in

line with the findings, the recommendations centre on the promotion of youth-friendly sexual and reproductive healthcare. The recommendations are based on the conclusions and literature review and are given below.

5.3.1 Nursing practice

- The policymakers should consider the formulation of a youth-friendly sexual and reproductive health policy, if one is already formulated, then youth should have an input in its delivery.
- There is a need for CHC personnel to be trained in adolescent friendly SRH and to be updated from time to time.
- There is a need for CHC personnel to be equipped with interpersonal skills.
- There is a need for all personnel to demonstrate respect and concern for young people.
- There is a need for comfortable and conducive surroundings to be created for adolescents.

5.3.2 Nursing education

- Nursing education managers to formulate a curriculum that will address sexual and reproductive health and youth-friendly health services.
- The curriculum should emphasise the importance of the promotion of youth-friendly sexual and reproductive healthcare.

5.2.3 Nursing Research

- A qualitative study on adolescents' perception regarding youth-friendly SRH is recommended as further research.

5.4 Limitations of the study

A limitation of this study is that only female adolescents partook in the study, there were no males that could take part due to the inclusion criteria, the male adolescents that came to the youth centre at the selected health facility were either below 18 years of age, or they were there for minor ailments and not sexual and reproductive health and therefore did not meet the criteria to take part in the study. Furthermore, the researcher had no control over the spoilt questionnaire. Furthermore, the study was only quantitative, focusing on the views provided by the respondents

and they had to choose only those responses that the researcher thought of. A mixed methods approach could have yielded deeper insight into the topic.

5.5 Conclusion

The findings in this research study indicated that healthcare staff generally has positive attitudes towards rendering sexual and reproductive healthcare services in the selected CHC. The study setting was a selected CHC in KwaZulu-Natal and the population included adolescents, which was limited to female adolescents due to male adolescents not meeting the study inclusion criteria. The overall conclusion arising from the study is that adolescents at the selected CHC generally perceive the healthcare staff to have positive attitudes towards rendering sexual and reproductive health services to youths, although there are still some challenges regarding the availability of contraceptives at the facility and the provision of adequate information, as well as a satisfactory environment for youth sexual and reproductive health to be provided.

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ANNEXURE A: QUESTIONNAIRE

Research Title: Exploring adolescents' perception regarding youth-friendly sexual and reproductive health services in a selected CHC in uMgungundlovu District.

Thank you for accepting to participate in this study. Please read the following instructions before completing this questionnaire.

- Please, complete the whole questionnaire
- Read instructions before responding to each section of this questionnaire and use a cross (X) to respond.

SECTION ONE: SOCIO-DEMOGRAPHIC DATA

1. Agein years.

2. Gender: Male 1

Female 2

3 Which level of education are you currently in?

1. High School 1

2. Tertiary 2

3. Matriculated but not studying 3

4. Marital Status: Married 1

Single 2

Divorced 3

5. What is your place of residence?

Rural 1

Township 2

Urban 3

SECTION TWO: EXPLORING STAFF ATTITUDES TOWARDS RENDERING SEXUAL AND REPRODUCTIVE HEALTH SERVICES TO YOUTH

STATEMENT	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
2.1 Staff is friendly and responsive to you as youth patients.				
2.2 Staff respects you and ensures that your privacy is maintained.				
2.3 Health staff is knowledgeable about your concerns and needs.				
2.4 Counselors spend enough time with you.				
2.5 Counselors use language that is understandable to you.				
2.6 Nurses non-judgmental and approachable.				
2.7 Nurses spend enough time with you.				
2.8 Nurses use language that is understandable to you.				
2.9 The information provided to you during a consultation is clear and helpful.				
2.10 The information provided to you for your follow-up visit(s) is clear.				
2.11 Medical providers offer you choices including abstinence, contraception and withdrawal.				
2.12 There is an adequate number of staff available.				

<p>SECTION THREE: THE IMPLEMENTATION OF SEXUAL AND REPRODUCTIVE HEALTH YOUTH FRIENDLY POLICIES</p>

STATEMENT	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
3.1 Youth drop-ins are welcome and accommodated without an appointment.				
3.2 There is no long waiting time for patients.				
3.3 Youth patients are given time to discuss their issues related to sexual and reproductive health.				
3.4 The services are offered to both male and female youth patients.				
3.5 The facility provides information and/or audio-visual materials on reproductive health services and concerns for patients.				
3.6 The facility provides/stocks contraceptive methods that are most popular among youth patients.				
3.7 The sexual and reproductive health services are provided on rights-based approaches.				
3.8 No consent is required for any service.				
3.9 Youth with an STI are forced to bring their partners for them to get treated for a STI.				
3.10 The facility offers a wide range of services.				

3.11 Measures to promote continuity of service utilization are in place.				
3.12 Youth are informed of alternative sources of services in their community.				
3.13 Youth are included in service design and delivery.				
3.14 Clinics operate at a convenient time for youth.				
3.15 The cost of reproductive health services is free of charge.				
3.16 Medical supplies and contraceptives are always available.				
3.17 Policies and strategies for mobilizing youth are in place.				
3.18 Youth friendly SRH services are accessible to youth (with location and distance).				

<p>SECTION FOUR: THE ENVIRONMENT AND FACILITY CHARACTERISTICS OF THE CHC SETTING</p>

STATEMENT	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
4.1 Sexual and reproductive health is provided at convenient hours for youth patients.				
4.2 Decoration and surroundings are inviting to youth patients (non-medical).				
4.3 The location of the youth-friendly				

health facility is close to public transport.				
4.4 The location of the youth-friendly health facility is far away from places where adults spend most of their time.				
4.5 The location of the youth-friendly health facility is close places where unmarried youth spend their time (e.g. schools, video centres and recreation centres).				
4.6 The location of the youth-friendly health facility is close to the place where the general public is often found.				
4.7 Counseling and consultation rooms ensure privacy for youth patients.				
4.8 Separate space or time is used for the consultation of youth patients.				
4.9 Educational materials are displayed and available for youth patients.				
4.10 Youth patients show overall satisfaction with the environment at the health facility.				
4.11 Visual and auditory privacy are maintained during consultation and other procedures.				

SECTION FIVE: EXPLORING SERVICES RENDERED TO ADOLESCENTS REGARDING YOUTH FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES

STATEMENT	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
5.1 Counseling services are available for youth.				
5.2 Contraceptive methods such as the condom, the pill, and the injectables are always available for youth.				
5.3 Emergency contraceptives are always available.				
5.4 The Intra-uterine Device (IUD) is readily available.				
5.5 Pre-marital counseling is available for youth.				
5.6 STI treatment for youth is always available.				
5.7 Both male and female adolescents are welcome and served.				
5.8 Unmarried adolescents are welcomed and served.				
5.9 There is no discrimination in service provision for both married and unmarried youth.				
5.10 Individualised care is provided and promoted.				
5.11 Youth are involved in decision making regarding their care after the provision of adequate information of different options of treatment/methods.				
5.12 Youth are given their preferred treatment/methods (contraceptive).				
5.13 The Healthcare provider forces youth to use particular				

method/treatment.				
5.14 Medical procedures such as pelvic examinations and blood tests are delayed for youth.				
5.15 The Healthcare provider emphasizes the importance of adolescents partners if they have STIs.				
5.16 Referral services are available for youth when necessary.				
5.17 Healthcare providers identify and make plans for people who require special support for e.g. a young woman whose partner is opposed to the use of contraceptives.				
5.18 Healthcare providers identify and make plans for identifying sexual violence.				
5.19 Youth who are first time users at the health facility receive a friendly welcome.				
5.20 Youth who are first time users are orientated and education and services are provided.				
5.21 Youth who are first time users are provided with education on their rights to use their services.				
5.22 Youth are provided with assurance of confidentiality at their first visit.				
5.23 Youth are provided with the operational times of the facility at their first visit.				
5.24 First time users are provided with				

leaflets on sexual and reproductive health and youth-friendly services.				
5.25 Provision of services to youth involves their decision-making regarding treatment.				
5.26 Youth are provided with encouragement of continuity and arrangement of follow-up care.				
5.27 Youth who are regular users of the health facility always receive a friendly welcome.				
5.28 Youth are regular users of the health facility receive follow-up care.				
5.29 Regular youth users of the health facility are provided with an assessment of current needs and counseling and education.				
5.30 When youth patients are managed they are asked about their sexual history.				
5.31 When youth patients are managed they are motivated to change their sexual behavior.				
5.32 When youth patients are managed they are advised on prevention measures.				

Thank-you for your time and participation in the study.

ANNEXURE B: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

25 June 2017

The Nursing Manager
Imbalenhle Community Health Centre
Unit 3 Thwala Road
Imbali
Pietermaritzburg
3201

Dear Sir/Madam,

Re: Request to Conduct a Research Study

I hereby request permission to conduct a research study at your Community Health Centre. I am a Master's Degree student at the University of KwaZulu-Natal, school of Nursing. The title of my study is: **Exploring Adolescents Perception Regarding Youth Friendly Sexual and Reproductive Health Services in Selected CHC's in uMgungundlovu District.**

I would like to commence data collection process by July 2017. This will be done at convenient times as determined by the Nursing Managers at the selected CHC's. The target group for my study is adolescents attending sexual and reproductive health services.

Data collection process will behold confidentiality, anonymity, informed consent and freedom of choice.

Hoping that my request will meet your favorable considerations.

Yours faithfully,

Kwenzile L. Hlatshwayo
Student number: 217063103
Cell No: 073 503 4139
E-mail: klyend1991@gmail.com

ANNEXURE C: LETTER GRANTING PERMISSION TO CONDUCT THE STUDY



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address: 330 Langatbale Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/3165/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Health Research & Knowledge
Management

HRKM Ref: 379/17
NHRD Ref: KZ_201710_015

Date: 11 October 2017
Dear Mrs KL Hlatshwayo

Approval of research

1. The research proposal titled 'Exploring adolescents perception regarding youth friendly sexual and reproductive health Services in selected CHC's in uMgungundlovu District' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at Imbalenhle Community Health Centre.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 12/10/17

ANNEXURE D: LETTER FROM THE ETHICS COMMITTEE



1 November 2017

Mrs Kwenzile Jungile Hlatshwayo 217068103
School of Nursing And Public Health
Howard College Campus

Dear Mrs Hlatshwayo

Protocol Reference Number: HSS/1137/017M

Project title: Exploring adolescents perception regarding youth friendly Sexual and Reproductive Health Services in selected CHC's in uMgungundlovu District

Full Approval – Expedited Application

In response to your application received on 21 August 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and **FULL APPROVAL** for the protocol has been granted.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc: Supervisor: Mrs M Dube
cc: Academic Leader Research: Dr Thandi P Mashamba-Thompson
cc: School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

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Telephone: +27 (0) 31 260 5567/5254/5567 Facsimile: +27 (0) 31 260 4008 Email: ethics@ukzn.ac.za / shenuka@ukzn.ac.za / mohr@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

ANNEXURE E: INFORMATION GIVEN TO PARTICIPANTS

INFORMATION DOCUMENT

Study title: Exploring Adolescents Perception Regarding Youth Friendly Sexual and Reproductive Health Services in Selected CHC's in uMgungundlovu District

Dear Participant

INTRODUCTION

I, Mrs K.L. Hatshwayo, am a student at University of KwaZulu-Natal doing a Masters Degree in Full-Research. As part of my studies at the University I am required to conduct a study in an area of my interest. My study is: **Exploring Adolescents Perception Regarding Youth Friendly Sexual and Reproductive Health Services in Selected CHC's in uMgungundlovu District.**

I am requesting your participation in this study because you meet the criteria of the people who are eligible to participate in the study. The purpose of the study is to explore adolescents' perception regarding youth-friendly sexual and reproductive health services in selected CHC's in the uMgungundlovu District. The study findings may generate a new body of knowledge in nursing and other healthcare staff and to the development of the nursing profession and the way healthcare workers approach adolescents who seek sexual and reproductive healthcare. Findings may also identify the need to revise the current nursing curriculum to include youth-friendly sexual and reproductive healthcare to address the gaps. Please note that there are no incentives for participation.

If you agree to participate, you will be provided with a structured questionnaire and requested to complete it upon your voluntary agreement to participate in the study. Completing the questionnaire will take approximately 20minutes of your time. The information you give will be treated with the utmost confidentiality. Any personal information will not be disclosed unless required by law. Your names will not appear anywhere in the questionnaire or the study findings. You are requested not to put your

names on the questionnaires provided. There are no expenses involved because the study will be conducted during the working times of the Community Health Centre.

Please feel free to ask questions you may have so that you are clear about what is expected of you. You are free to participate or not to participate in this study. You are free to withdraw from the study at any stage without repercussions. There will be no risks attached to your participation. The results of the study will be made available to you on completion of this study.

Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Thank you for your time and cooperation.

Yours sincerely

Mrs K.L. Hatshwayo

Date.....

Contact detail of the researcher-for further information/reporting of study related matters.

Mrs K.L. Haltshwayo

Contact number: 073 503 4139

Email address: klyend1991@gmail.com

Supervisor contact details

Mrs B.M. Dube

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School of Nursing and Public Health

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Email address: dubeb@ukzn.ac.za

Contact number: 031 260 2495

HSSREC Research office: PremlalIMohun

Contact number; 031 260 4557

Email address: MOHUNP@ukzn.ac.za

ANNEXURE F: INFORMED CONSENT FORM

Consent document

Consent to participate in research

Dear Participants

I, Mrs K. L. Hlatshwayo, a student at the University of KwaZulu Natal, as one of the requirements to complete my studies, I am conducting a study through the college of Health Sciences, School of Nursing and Public Health, University of Kwazulu Natal.

The title of the study is: **Exploring Adolescents Perception Regarding Youth Friendly Sexual and Reproductive Health Services in Selected CHC's in uMgungundlovu District**

You have been asked to participate in a research study on: exploring Adolescents Perception Regarding Youth Friendly Sexual and Reproductive Health Services in Selected CHC's in uMgungundlovu District. Findings may contribute to the development of the nursing profession and the way in which nurses and other healthcare workers approach adolescents who seek sexual and reproductive health.

You have been informed about the study by: Mrs K.L. Hlatshwayo contact number 073 503 4139, Email: klyend1991@gmail.com. You may contact me at any time if you have any question about the research.

You may contact the researcher's supervisor- Mrs B.M.Dube contact number 0792198400, Email: dubeb@ukzn.ac.za.

You may contact HSSREC Research office- Premlall Mohun contact number 031-2604557, Email: MOHUNP@ukzn.ac.za

Your participation in this research is voluntary and you will not be penalised if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is written summary of the research.

The research study including the above information has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given opportunity to ask questions that I might have for my participation in the study.

Signature of participant.....

Date.....

ANNEXURE G: LETTER FROM THE EDITOR



Gazelle Editing

Blouberg

Cape Town

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Email: gazelle.english@gmail.com

Website: gazelleediting.com

Co Reg No.: K2013225727

7 December 2017

Re: Editor's Letter

To whom it may concern,

This letter serves to confirm that I, Bronwyn King, chief editor of Gazelle Editing, have edited the thesis by Kwenzile Lungile Hlatshwayo entitled "Exploring Adolescents' Perceptions Regarding Youth-Friendly Sexual and Reproductive Health Services in a Selected CHC in uMgungundlovu District" to the best of my ability in the time given. This included checking for language errors, cross-checking the citations and reference list, and creating a table of contents. A comprehensive editor's report is available on request.

Please contact me using the details above should you require any further information.

Sincerely,

Bronwyn King

A handwritten signature in black ink, appearing to read 'BJK', followed by a long, sweeping horizontal line that curves upwards at the end.