Perspectives and Experiences of Youth of Sexual and Reproductive Health Services in Lindelani Township.

Masters Dissertation by

NOMTHETHO DEBBIE NGCOBO

213508372

Supervisor: Professor Pranitha Maharaj

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DECLARATION

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"I Can Do All Things Through Christ Who Strengthens" - Philippians 4:13

ABSTRACT

Sexual and reproductive health (SRH) is an essential part of life for every human being. Many countries have worked in solidarity to maintain barrier-free SRH services worldwide. However, young people continue to face many SRH challenges. Several initiatives have been implemented to reduce these challenges, but remains a range of prevalent issues relating to SRH services. Prioritizing young people's health has been significant in many countries, and the goal is to provide comprehensive education and youth-friendly SRH services. Among the consequential SRH challenges that youth faces are the high rates of HIV and unintended pregnancies, which strain the country's economy and further lead to premature death due to unsafe abortion.

Adolescents and youth constitute a sizeable proportion of the world's population, and they are more prone to experiencing SRH problems. Several studies have highlighted the essential need for SRH services directed at youth, yet the barriers continue to grow. There is a lack of information on the fundamental reasons leading to minimal SRH service use, leading to increased health problems. This study aims to explore the availability and accessibility of SRH services for youth by documenting their experiences. The study was conducted among youth in Lindelani Township who had their SRH services experiences from the health facility located in the area. The study's overall goal was to explore the SRH services perspectives and experiences of young people in Lindelani Township. This study further examined SRH services available to young people, their expectations of SRH facilities, their experiences, and the barriers they face when they need to access SRH services.

The study relied on a qualitative approach. For the study, semi-structured, face-to-face interviews were conducted with 16 young people, of which eight were females, and eight were males aged between 18 and 30 years. Participants were aware of the importance of SRH, and each of them has had SRH issues which led to seeking services at a health facility. During their visit to the health facility, the participants experienced numerous challenges such as the shortage of contraceptives and medication and the negative attitudes of health providers. Some male participants complained that SRH services catered more for females, and they felt that STI and HIV testing, counselling, and treatment were the only services available to them. Participants expressed concerns about their poorly equipped health facility, lack of

professionalism, and lack of information. These have been significant concerns hindering young people from returning to the facility since their needs are partially met.

Providing young people with easy access to SRH services and comprehensive sexual education from an early age will reduce the increasing numbers of unintended pregnancies, unsafe abortions, and HIV prevalence. Based on the findings, the study highlights the need for barrier-free SRH services, comprehensive information provision, and youth-friendly services.

Acronyms

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
ASRH	Adolescent Sexual and Reproductive Health
BV	Bacterial Vaginosis
CHC	Community Health Centres
GBD	Global Burden of Diseases
GBV	Gender-Based Violence
HBCT	Home-Based Counselling and Testing
HCT	HIV counseling and testing
HIV	Human Immune Virus
HPCSA	Health Professions Council of South Africa
HSV	herpes simplex virus type 2
IDU	Injection Drug Users
IHME	Institute for Health Metrics and Evaluation
KP	key populations
LARC	long-acting reversible contraception
LGBT	Lesbian, Gay, Bisexual, and Transgender
LMIC	Low and Middle-Income Countries
MSM	Males who have Sex with Males
NAFCI	National Adolescent Friendly Clinic Initiative
NYDA	National Youth Development Agency
NYP	National Youth Policy
PICT	Provider-Initiated Counselling and Testing
PID	Pelvic Inflammatory Disease
PITC	Provider-Initiated Testing and Counselling
PWID	People Who Inject Drugs
SAYC	South African Youth Council
SRH	Sexual and Reproductive Health

SRHR	Sexual and Reproductive Health Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SW	Sex Workers
TG	Transgender people
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UN	United Nations
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Sexual and reproductive health (SRH) is an essential yet broad and complex part of every individual's life. According to Edwards and Coleman (2004, p.2), "sexual health is a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity." This indicates that it does not mean the person may not have any diseases but that regardless of all, they still take care of themselves and their health. Furthermore, health-related problems tend to arise when people ignore and neglect signs of ill-health that might impact their lives if not given medical attention. For instance, a female might have a strange discharge from her vagina and think it is normal not knowing that this might be a sign of a severe infection that requires medical attention as it may impact her sexual and reproductive life.

Sexual health problems among young men and women often arise from the early sexual debut and lack of information. According to Bengesai et al. (2018, p. 9) in a study conducted in South Africa it is revealed that the normative age at first sex was between 15 to 17 years. This is the age where youth are not well-informed. Moreover, the South Africa's National Youth Policy, National Youth Commission Act, and Integrated Youth Development Strategy (draft 1 and 2), defined youth as individuals who are aged between 14 to 35 years (NYP, 2009; NYDA, 2008; SAYC, 2010). However, for this study, individuals between the ages of 18 and 30 years were selected, which are the ages where no parental consent is needed, and most SRH problems are extremely high. Among this age group, individuals are already sexually active and engaging in sexual activities. According to Bearinger et al. (2007), it is stated that a third of unmarried adolescent girls have had sexual intercourse in most countries. This suggests that once youth have reached puberty, they become more prone to sexual involvement. Additionally, scholars like Agranovich et al. (2006) revealed that Russian youth engaged in sexual activities as early as their teenage years, which was several years younger than their parents. This data highlights that SRH services are crucial and need to be provided to youth.

Also in South Africa young women engage in sexual activities from as early as 18 years and 14% are likely to fall pregnant before they even reach the age of 18 years (Nacosa, 2018). Furthermore the most important part of SRH is to improve access to comprehensive information, which will reduce illness and positively impact young people's overall health and

well-being (Rogers and Dantas, 2017). Adolescents and young people (10–24 years) constitute 18% to 26% of the world's population, and this is generally the age at which sexual debut begins (Godia et al., 2014). Thus, it is crucial that before young people experiment sexually, they are aware of the necessary precautions and preventative measures. The first step to ensuring a healthy sexual and reproductive life is to avoid contracting sexually transmitted infections (STIs) and experiencing an unintended pregnancy. Condoms offer dual-protection and are adequate to prevent unintended pregnancy, as well as the transmission of STIs, including HIV (WHO, 2020). Condoms are an effective contraceptive method; however, most young people find themselves experiencing a range of challenges due to incorrect and inconsistent use (Thatte, 2016). Among these challenges are unintended pregnancy and contracting STIs.

Some people in sexual relationships display responsibleness by ensuring transparency within the partnership, such as informing each other about their HIV and STI status. They also depend on family planning methods to prevent pregnancy. According to Starbird et al. (2016, p.2), "family planning supports the rights of the girl child to remain unmarried and childless, until she is physically, psychologically, and economically ready, and desires to bear children." Moreover, family planning methods also allow men and women to space, delay, or stop childbearing. There are numerous contraceptives or family planning methods available, including oral contraceptive pills, implants, injectables, patches, vaginal rings, intrauterine devices, condoms, male and female sterilization, lactational amenorrhea methods, withdrawal, and fertility awareness-based methods (WHO, 2020). The use of these methods allows men and women to plan their future better, improve their educational prospects, enhance their wealth, and help save money to better take care of the children and those on the way (Gates, 2019).

The absence of family planning methods and contraception during penetrative sexual intercourse may lead to unintended pregnancy, HIV, and STI transmission. According to Groenewald et al. (2018, p. 5) it is reported that South African adolescents are at high risk of HIV and this risk is bigger among young women and girls aged 15 - 24 years, who are over 4 times at higher risk than their male counterparts. These girls are usually in high school around this age, and they have little to no comprehensive sexual education on SRH issues preventative measures like safe sexual practice, contraceptives and family planning methods. According to

WHO (2020), contraception contributes to the reduction of infant mortality. When births are separated by less than two years, the infant mortality rate is 45% higher than two to three years apart and 60% higher than four or more years apart (WHO, 2020). This outcome may be because after giving birth, the body needs time to recover, and when deprived, it becomes hard for the foetus to survive full gestation or for the infant to live longer. In the absence of contraception, some women find themselves in situations where abortion is their only option. According to Thatte et al. (2016), unplanned pregnancy among young people often results in unsafe abortion, which can cause severe complications and even death. These complications may arise from the use of illegal facilities due to desperation, lack of support from elders, and fear of being judged or stigmatized.

WHO (2014b) states that one of the critical concerns globally is the SRH of adolescents, especially in developing countries and regions like Sub-Saharan Africa, where the most significant number of deaths are HIV and AIDS. In the adolescent stage, sexual desires occur due to physical and emotional changes, increasing the risk of unsafe behaviour and elevating vulnerability to HIV and other STIs. Ramjee and Daniels (2013) further explain that women have greater exposure to HIV and STI due to several biological, behavioural, socioeconomic, cultural, and structural influences. For example, biologically, women are more susceptible to contracting STIs than men; culture teaches women to be submissive towards a male partner. Some have relationships for financial gain, thus depriving them of the opportunity to negotiate safe sex. Moreover, SRH services and information are made available to ensure an individual's safe and healthy well-being and prevent adverse SRH outcomes.

Several barriers prevent adolescents and youth from easily accessing and utilizing SRH services and information from healthcare facilities. WHO (2020) mentions that the lack of public awareness, comprehensive SRH information, inadequate training of health workers, and widespread stigma about STIs remain barriers to effective use of these interventions. According to Nkosi et al. (2019, p. 2), "the utilisation of healthcare services is not based on a single decision but multiple actions occurring over time and access is continually negotiated, subsequently, an individuals' beliefs about their health condition affects whether they use formal healthcare services." In making a decision to visit the healthare facility, these factors come into play and influences the final decision made by a person in need of service. Nkosi et al. (2019, p. 1) further stated that in South African studies on health service utilisation among adolescents and young people, the likelihood of HIV stigmatization at the facility continues to

create challenges and prevent uptake of health services. Stigmatization has been and is still the biggest constraint among young people trying to access the SRH services mainly because of all the judgmental comments and behaviours attached to these services blocking free utilization. Because of all this, the study aimed to close this gap by collecting data on the fundamental reasons for minimal utilization of SRH services by youth, thus increasing SRH problems.

1.1.1 What is Sexual and Reproductive Health?

SRH is a complex phenomenon with distinct definitions that keep changing over time. Good SRH is a state of complete physical, mental, and social well-being in all matters relating to the reproductive system (UNFPA, 2016). SRH services are services found in health facilities available to both males and females. Amongst definitions from other authors, Rogers and Dantas (2017, p.3) mentioned that "SRH information is a broad term and has been used to encompass the provision of information, education, and counselling relating to reproductive health, such as fertility, prevention of unintended pregnancies, contraception methods and use; sexual health advice, including information on abortion, hygiene, and STI/HIV." Access to SRH information shapes youth's perspectives and experiences towards the practice of safe SRH for both males and females. SRH facilities provide services that consist of contraceptive availability (injectable, pills, implants, IUDs, patch, etc.), male circumcision, pap smear, sexually transmitted infections and HIV treatment, maternal care during and after pregnancy, and abortion (Bearinger et al., 2007; Chandra-Mouli et al., 2015; Morris and Rushwan, 2015). Females primarily use most SRH facilities, probably because there are more services available for women.

In a study conducted by Alli et al. (2013), it is stated that health providers knew that they had to provide a full complement of services with all the necessary information, but because of limited time and pressure, they focused on the curative aspects of services. Nonetheless, patients' rights are essential and should be taken into consideration. Every person visiting a health facility has the right to be given helpful information on any diseases or infection they have; thus, this is the only way to ensure that illnesses can be prevented or reduced.

Sexual and reproductive health rights (SRHR) are not limited to health facilities' information and services. Still, it also consists of the right to control one's body, desires, and experiences concerning sexuality. According to Amnesty International (2008, p.1), it is also argued that

“sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health, enshrined in the Universal Declaration of Human Rights and other international human rights conventions, declarations, and consensus agreements.” SRHR caters to all individuals, especially those who are already engaging in sexual activity even when they are under legal age.

According to Strode and Essack (2017), the Sexual Offences Act states that the age of consent to sex in South Africa is 16 years; however, it also says that adolescents aged 12 - 15 years may engage in consensual sex with peers in the same age category without criminal sanction. This law acknowledges that sexual behaviour does not begin at 16 years but earlier than that. An example is given in Bhamjee et al. (2016), who observed that a person (“A”) who commits an act of sexual penetration with a child (“B”) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration with a child. By law, a child cannot consent to sexual intercourse with an older person since they can be easily manipulated into doing things they do not intend to do.

In any country’s rules and regulations, everyone abides by the laws of not violating other people’s rights under any circumstances while exercising theirs freely. According to WHO (2014a, p.16), sexual and reproductive health and rights includes measures to eradicate preventable maternal and neonatal mortality and morbidity, to ensure high quality sexual and reproductive health services, including contraceptive services, and to diagnose and treat sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and protect the sexual and reproductive health needs of young people. Men also have SRH rights, but the emphasis is more on women and adolescents because they are more vulnerable and experience more significant threats regarding their SRH than men. According to Kumar et al. (2015), both men and women need to have access to SRH information and services, achieving the highest attainable standard for health, including respecting, protecting, and fulfilling all individuals' human rights.

1.2 Motivation for the study

In South Africa, the number of pregnancies among 15- to 19-year-olds has increased and every year about 16 million girls around this age and some 1 million under this age give birth

(Statistics South Africa, 2018). The increase in the number of pregnancies in this age group may reflect the lack of necessary information to equip young people to protect them against unplanned pregnancy. The increase in unplanned pregnancy rates shows that there is still not enough education about SRH among youth, thus increasing their vulnerability to adverse sexual and reproductive outcomes (Nacosa, 2018). In a multi-country study, it is shown that the median age at first sex for some countries among women aged 20-24 years ranged from as low as 16 years in Chad, Mali, and Mozambique; 19.6 years in Senegal; and the rest of Sub-Saharan Africa being 18.5 years in comparison, to men who were as low as 16.9 years in Mozambique and 19.6 years in Ghana (Hindin and Fatusi, 2009). In the middle to low-income countries, teenagers are more prone to sexual intercourse involvement due to limited SRH education and services.

Moreover, this may be the reason behind the changing statistics in teenage pregnancy. Additionally, WHO (2014) suggested that health services need to go beyond SRH and respond to the range of adolescents' health problems and health-related behaviours. Adolescents are challenged with several health-related issues most of the time and have a need for comprehensive information to be able to face these issues and deal with them. According to the Statistics South Africa (2019) teenage pregnancy numbers have been fluctuating over the years; in 2011 it was 8.1%, 6.6% in 2015, and 8% in 2018. As they transition to adulthood, they experience body changes, puberty, and risky behaviours, making them more vulnerable to a range of SRH problems.

Addressing the global concern of youth SRH problems by reducing them also helps reduce the number of fertility rates and HIV-related deaths. Moreover, the dangers of contracting STIs, especially HIV, being uninformed, not going for regular check-ups, or avoiding treatment, have devastating health-related consequences, including sterility, cervical cancer, and death (Galati, 2015). This is mainly because an individual becomes weak and prone to many infections and other health-related issues, leading to death. According to WHO (2018), there are 12.8 million births among adolescent girls aged 15-19 years annually, representing 44 births per 1000 in this age category. The higher the number of adolescents giving birth every year, the increased number of adolescents engaging in unprotected sexual activities, whether voluntarily (through consent) or involuntarily (through rape), thereby putting themselves at elevated risk of contracting sexually transmitted infections.

It is not only sexually active people who become infected with STIs but also those who no longer engage in sex or have never engaged in sex that find themselves in situations where they become infected. A study conducted in Sydney showed a rising number of Neisseria gonorrhoea (sexually transmitted infection), which Dayan (2004) undoubtedly believed children acquired through autoinoculation while using a toilet in a crowded aeroplane. As much as sexually active individuals usually contract STIs, everyone is at risk of contracting them even through nonsexual encounters. Dayan (2004) further explains that doctors managed to conclude that children were suffering from gonorrhoea (found on a toilet seat) because of the unusual onset of symptoms like vaginal discharge, which had developed suddenly, prompting concerns that the young girl was raped.

STIs can be very dangerous for everyone who is exposed to them. Those who engage in unprotected sex become more vulnerable to all of them, including HIV, and if pregnant, the baby might be harmed (Mbizvo and Zaidi, 2010). This information suggests that low- and middle-income countries have more teenagers engaging in just sex but unprotected sex, thus increasing their chances of having SRH problems. Additionally, Shisana et al. (2014, p.156) stated that the level of HIV infections among female youth aged 15–24 years was more than four times higher than males in this age group. This means that the female counterparts are more vulnerable to HIV since more HIV new infections are recorded for them than males.

The escalating numbers of sexually transmitted infections and pregnancies in developing nations may have been due to insufficient SRH services (Beksinska, 2014). Depending on location, accessibility, and availability, SRH services are still an issue, and consequently, in some places, young people encounter hindrances when trying to access services. Therefore, the purpose of this study is to share insights into the experiences and barriers faced by youth in Lindelani Township when seeking and accessing SRH services. The aim is to explore the perspectives and experiences of male and female youth aged 18-30 years in Lindelani Township. This will help better understand the SRH services available to youth and whether the problem is on the service usage, availability, or accessibility.

1.3 Objectives of the study

The study’s overall objective is to explore youth's perspectives and experiences of sexual and reproductive health services in Lindelani Township.

The specific objectives are:

- To explore the SRH services available to young people.
- To understand the expectations and experiences of young people in accessing SRH services.
- To explore the barriers youth face when accessing SRH services.

To address the specific objectives, the study was interested in the following key questions:

- What are the SRH services available to the youth?
- What are the youth's expectations and experiences when accessing the SRH services?
- What are the barriers youth face when accessing the SRH services?

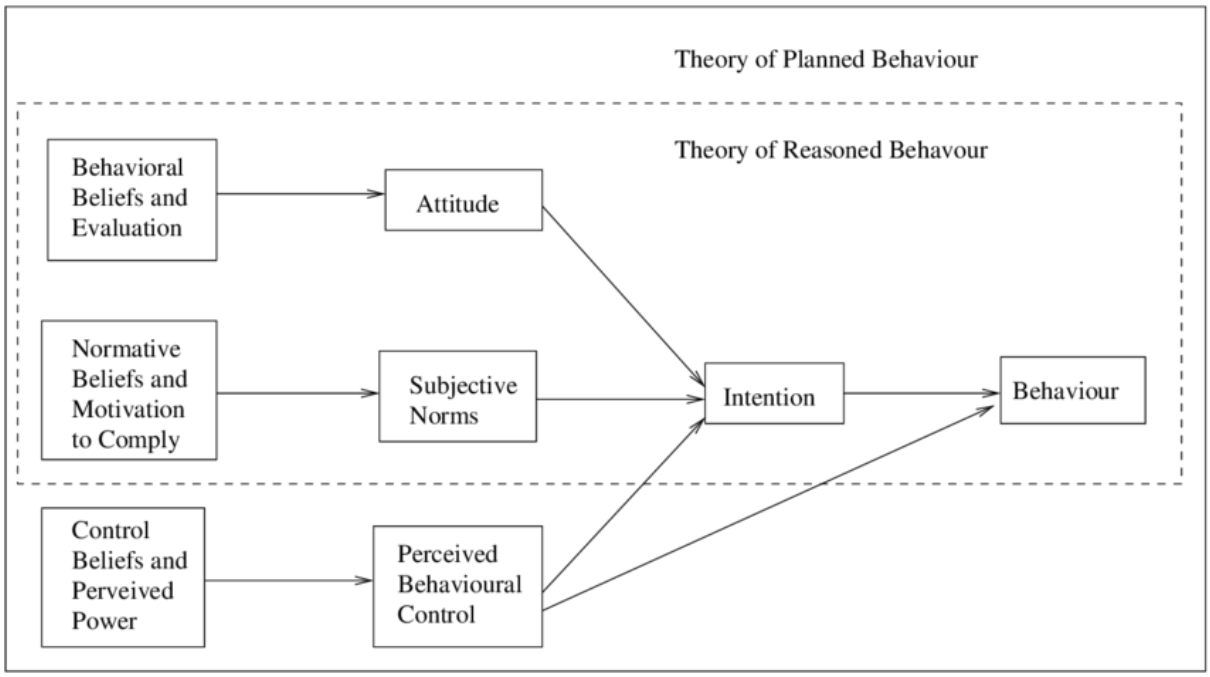
1.4 Theoretical framework

For the past two decades, social psychology theories have been widely used to predict and understand social behaviours in different domains (Godin and Kok, 1996). The theory of planned behaviour defines the interaction among people where one's action or behaviour towards the other influences their future behaviour. For example, how the nurse treats the patient seeking SRH services influences their future behaviour (deciding to return or get assistance elsewhere). The components of the theory used to guide this study are displayed in Figure 1.1 below.

The theory of planned behaviour (TPB) is a theory extended or developed from the theory of reasoned action (TRA), which Ajzen and Fishbein first introduced in 1975, and the TPB includes an additional construct: perceived control over the performance of the behaviour (Chang, 1998; Ajzen et al., 1980). This theory is more applicable when the probability of success and actual control over a behaviour's performance is at the best possible level. Montano and Kasprzyk (2015) argue that both theories focus on theoretical constructs that deal with individual motivational factors as the main determinants of the likelihood of performing the particular behaviour. In addition to attitudes and subjective norms, which comprise the theory of reasoned action, the TPB's essential contribution is the concept of perceived behavioural control, defined as an individual's perception of the ease or difficulty of performing the behaviour (Ajzen; 1987, 2002). The behaviour rises when the individual sees the action as accessible or challenging to perform regardless of the situation.

The level individual tries engaging in a behaviour and the level of control they have over the behaviour influences their decision to engage in the action. TRA and TPB have been used successfully to predict and explain a wide range of health behaviours and intentions, including smoking, drinking, health services utilization, exercise, sun protection, breastfeeding, substance use, HIV and STI-prevention behaviours, and use of contraceptives, safety helmets, and seatbelts (Montano and Kasprzyk, 2015). Moreover, this theory is used to predict the participants' behaviour through their expectations of the SRH facilities and explain their future intentions through their experiences in seeking SRH services. According to Montano and Kasprzyk (2015, p.76), a fundamental assumption of TRA is that "individuals are rational actors who process information and that underlying reasons determine motivation to perform a behaviour." For example, a person would sit and think since they have started engaging in sexual activities, the results would be pregnancy or STI if 'negligent,' so that alone is enough motivation to seek preventative measures like family planning methods and condoms.

Figure 1.1: Theory of Planned behaviour



Source: Gangwal and Bansal (2016)

Behavioural belief is the subjective probability that the behaviour will produce a given outcome or experience. This is when a person believes that there will be a particular outcome from their actions. If the attitude towards the behaviour is favourable or positively evaluated, the

behavioural intention becomes stronger, and then the chances of performing that behaviour becomes more prominent. On the contrary, believing that 'nurses are judgemental, scary, not doing their 'job' would produce adverse outcomes, including failure to go to a health facility to seek SRH services and suffering the consequences.

Normative beliefs are an individual's beliefs about the extent to which other people who are essential to the individual think they should or should not perform a behaviour. The individual is concerned about what these people around him or her feel, thus putting pressure on them. A person's belief that people will agree or approve of the behaviour creates a stronger intention and increases behavioural performance likelihood, as Gangwal and Bansal argued (2016). For example, the determinant of action will be friends' attitudes towards visiting the clinic, condom usage, testing for HIV, and circumcision.

Perceived behavioural control refers to the control one has over one internal state, behaviours, place, people, things, feelings, or activities (Ajzen, 2002). This is an individual's control over their behaviour, their decision to follow what other people say or do. When an individual's behavioural control is effortless, then the intention to perform action becomes strong (high possibility of performance). When the behavioural control is difficult, the intention becomes weak (lower chance of understanding) (Miller, 2017). For example, no matter how many people or SRH advocacy campaigns encourage contraceptive use to prevent unplanned pregnancy and STIs, if one's intentions of performing that behaviour is weak, then performing the behaviour becomes hard.

Attitudes and subjective norms can also influence a person's behavioural intention and perceived control combined. The more favourable a person's attitude is toward the behaviour and personal criteria, the stronger the perceived behavioural control and the stronger it will be to act on that attitude. Moreover, given enough actual control over the behaviour, people will be expected to carry out their intentions when the opportunity arises (Ajzen, 2002). Thus, an individual with positive attitudes about always using condoms during vaginal or anal intercourse, who perceive social support for these behaviours from essential critical referent others and who has the conviction that he or she can carry out these behaviours effectively, will likely take consistent HIV preventive actions (Fisher, 1997). The model emphasizes the necessary skills for performing the behaviour, environmental factors, and experience (Ajzen and Madden, 1986). For example, a person considers all the contributing factors when deciding

to go to the clinic, such as if the weather is good on the day, they want to visit the clinic, how they were treated the last time they went there, and what their friends and family think or will say about them going to the clinic.

The TRA and TPB explain all the factors contributing to the performed action of individuals. They are in line with the objectives and will help answer the research questions of the study. Therefore, it is best suited for the research study as it will highlight the individual's intentions, motivations, and attitudes towards seeking SRH services.

1.5 Organization of the Dissertation

The dissertation is divided into five chapters. Chapter one provides background information on SRH. It also introduces the study and outlines the study's objectives and the theoretical framework used to guide this study. Chapter two reviews relevant literature on factors promoting and inhibiting the use of SRH services. Chapter three focuses on the primary tool of data collection. It also provides information on the ethical considerations and limitations of the study. In chapter four, the main findings from the interviews are provided. The concluding chapter, which is chapter five, provides an in-depth discussion of the research findings; highlighting recommendations; and citing the overall relevance of the study in terms of the research objectives

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

"We cannot always build the future for our youth, but we can build our youth for the future."

Franklin D. Roosevelt (Big Think, 2015).

Nurturing young people through education guarantees that they will become the world's most incredible resource in the future (Bekker et al., 2015). Essentially education is needed about SRH, especially for the youth. The youth constitute the bulk of the global population; therefore, investment in them will benefit a country's economic and social development (Godia et al., 2014). They engage in risky behaviours and encounter many obstacles that influence their decision-making and affect their SRH. UNFPA (2016) also highlights that youth are also highly vulnerable, often facing SRH information and care barriers.

This chapter explores arguments from various scholars around issues of SRH and services available to the youth, considering their reasons for SRH use, factors promoting the use of SRH services, perceptions of risk of pregnancy, and sexually transmitted infections, including HIV and AIDS. This chapter also presents literature associated with the challenges of accessing SRH services.

2.2 Reasons for accessing services

2.2.1 Risky sexual behaviours

Correct and consistent condom use is an effective means of protection against the consequences of risky sexual behaviours such as unintended pregnancy and the transmission of HIV and other STI's. The constant use of male latex condoms provides an 85% protective effect (WHO, 2020). However, most youths engage in sex at younger ages, and their first sexual encounter is not entirely voluntary, often influenced by peers or the media, or is through rape. Nearly half of American youth have engaged in sexual activity before high school completion, and engagement usually begins around 16 years (Khurana and Cooksey, 2012). The early onset of sexual engagement results in SRH problems experienced sooner. The beginning of sexual engagement among young people differs; however, they begin sexual activities in their mid-teenage years in most cases. According to Richter et al. (2015, p.2), the median age of sexual debut is 16 years for females and 15 years for males in South Africa. Females become more

susceptible to SRH challenges than males. However, evidence provided by Richter (2015) suggests that males start engaging in risky sexual behaviours before females.

According to Alzate et al. (2018) (as cited in Cahyaningtyasa et al., 2020), service providers say that parents avoid talking about sexuality and limit conversations on issues such as pregnancy, sexually transmitted infections, or HIV, as many parents expect and wait to sign forms for schools to talk about sexuality. Therefore, parents hope that schools would take this responsibility. The majority of elders have always avoided topics on SRH. A review by Tangmunkongvorakul et al. (2005) mentioned that parents and teachers denied adolescent girls from accessing sex education programs delivered by NGOs because they were confident that there is no need for this information, and some were afraid that such knowledge would stimulate fornication. Parents' lack of information on SRH is the reason for their denial of sex education and believing that it influences their children to engage in sexual intercourse.

In most cases, parents often tend to underestimate adolescent sexual involvement, and as a result, 60% of mothers of sexually experienced youth mistakenly testified that their children are virgins (Khurana and Cooksey, 2012). These false perceptions held by parents indirectly force children to rely on their peers for information, even though peers do not always give or have proper advice regarding sex-related issues. Peers are not always influential in young people engaging in sexual activity. Some young people do so for financial gain; thus, they get involved in transactional relationships. According to Nacosa (2018, p.1), "poverty can lead to transactional relationships and age-disparate relationships (where young women are having sex with men 5-8 years older than themselves) and both are also well-known risk factors for HIV."

Young girls engage in transactional relationships for gifts or money. As a result, they have little or no negotiating power in these relationships, especially condom usage. This situation may result in unintended pregnancy or an elevated risk of contracting STIs, including HIV and AIDS (Mchunu et al., 2012). Practising safe sex, which includes condom use in this relationship, becomes difficult and usually depends on the person with more power. According to Thatte et al. (2016), correct and consistent condom use among youth continues to be elusive, and condom use at last sex among 15-24-year-olds is substantially lower than 50% worldwide. Youths are likely to engage in sexually risky behaviours where there is an imbalance in condom use among the two sexes. According to Avert (2020), evidence found among young people aged 15-24 years suggest that 68% of young men with multiple partners reported using a

condom the last time they had sex, compared to 47% of young women. Most of the time, adolescents and youth engage in risky sexual behaviours through their friends' influences or wanting to experiment with what they see on media platforms (Hilliard, 2019).

2.2.2 The influence of the media

The media has a powerful influence to play in encouraging young people to seek SRH services. The youth's experimental nature also plays a role in their exposure to reproductive health risks, including abuse. The use of the internet and media can lead to addictive behaviour like sexting (Mitchell et al., 2012). Sexting is generally referred to as sending sexual images or pictures of yourself to someone and sometimes sexual texts via cell phones and other electronic devices where they are undressed or nearly undressed (Mitchell et al., 2012; Ybarra and Mitchell, 2014). Sexting is described as speaking or being asked to talk about sex in a sexually provocative manner, giving personal sexual information, or doing something sexual when one does not want to, using the internet (Ybarra et al., 2012).

Young people have always experimented with drugs and alcohol, but social networking sites offer dangerous opportunities for adolescents to be exposed to drugs (Hilliard, 2019). For example, drug users (IDU) share injections with others unaware of their HIV status, which increases their likelihood of becoming infected. Hilliard (2019) further states that social media such as Instagram, Facebook, and Snapchat offer a setting where young people are exposed to famous and ordinary people alike engaging in risky behaviours involving drug and alcohol use. Furthermore, engaging in these risky behaviours at a young age leads to uncontrolled behaviour when intoxicated, including risky behaviours such as unprotected sex.

In many cases, youth engage in alcohol and drug use in schools, clubs, and other social areas (Hilliard, 2019). When an individual is under the influence of drugs or alcohol, their action may result in significant health consequences like injuries, rape, unprotected sex, leading to unintended pregnancy or contraction of HIV and other STIs. A study conducted among university students revealed that students are heavily influenced by their peers and described that the campus culture encourages partying and risky behaviours, such as alcohol and drug use, casual sex, and inconsistent condom use (Cassidy et al., 2018). Students and other young people feel that they want to be part of a group and engage in risky behaviours to fit in. Hilliard (2019) also mentions that these dangerous behavioural factors contribute to the high disease burden and why SRH facilities always have patients seeking services.

2.3 Factors promoting availability and accessibility of service

2.3.1 Communication

Communicating, guiding, and supporting young people about SRH encourages them to seek these services when they experience any challenges. Parents often do not share information about SRH with their children (Alzate et al., 2018). Additionally, if communication were made a norm, it would help prevent youth from engaging in risky sexual behaviours. Fortenberry (2013) argued that in late adolescence, which is 16-19 years, physical and sexual maturity is complete, identity is significantly developed, and abstract thinking is well developed. Fortenberry (2013) suggests that adolescents are consciously aware of the sexual decisions, and their sexual behaviour is a significant determinant of their SRH.

Youth trust and prefer their parents to be their source of information, but older people become hesitant to share such information when it comes to information about sexual intercourse. It is not easy for parents to have such conversations, and they fear that if they do, their children will engage in sexual activity (Khurana and Cooksey, 2012). As much as sex is a taboo topic**,** it should be openly discussed. Khurana and Cooksey (2012) explain that parents should acknowledge that equipping their children with information will enable them to make better decisions. Lince-Deroche et al. (2015) argue that health providers think it is the parent's responsibility to discuss SRH with their children. In contrast, parents, on the other hand, become aggressive and defensive when the topic is mentioned. Consequently, the lack of access to necessary information leads to a range of reproductive health problems, including unintended pregnancy, abortion, contracting sexually transmitted infections, and other SRH complications (Morris and Rushwan, 2015). When young people have little to no information on SRH, it is easy for them to experience negative consequences.

A study conducted by Dapaah et al. (2015) evaluated active referral systems in Nigeria revealed significant improvements in condom use, knowledge of STIs, and reduced sexually transmitted disease symptoms; result from in-school interventions. The information indicates that providing young people with information, communicating with them, supporting, and teaching them about SRH services yields positive outcomes that contribute to better health outcomes. Moreover, Cassidy et al. (2018) suggest that easy access to SRH information and services at university is advantageous for youth, especially since they are more likely to be sexually exploring and experimenting.

Parental attitudes can influence the timing, nature, and extent of parent-teen sexual communication and how it is perceived by adolescents (Khurana and Cooksey, 2012). Parents should try to practice open communication and transparency towards their children, especially when it comes to crucial aspects that would influence their lives positively and prevent them from making decisions that will have a negative impact. Nevertheless, societal, cultural, and religious elements discourage people from discussing adolescent SRH as many communities disapprove of adolescent sexual activity. This is often demonstrated through the stigmatization of sexual health concerns (Morris and Rushwan, 2015). Due to these reasons, it is crucial to provide sexual education to everyone, especially young people who need it the most.

2.3.2 Sexuality education

One of the popular misconceptions about sex education is that it teaches children how to engage in sex, and it has a significant influence on the onset of sexual activity. However, according to Breuner et al. (2016, p.1), "sexuality education is defined as teaching about human sexuality, including intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, sexual orientation, gender identity, abstinence, contraception, and reproductive rights and responsibilities." Providing sexual education from an early age will allow young people to become informed and make better decisions. Education provision is vital to help young people make informed decisions concerning their sexuality and build awareness and understanding of sexual relations because it is crucial for their sexual development (Robinson et al., 2017). This awareness is key to developing healthy decision-making and non-conformity and recognizing negative behaviour influenced by peers.

Barriers to providing comprehensive sex education in schools include high drop-out rates, a shortage of teacher training, and resistance in schools because of the subject matter's perceived sensitive nature (Avert, 2020). Though sexuality education has been vital for young people and may lead to better behavioural control, some parents do not approve of it (Robinson et al., 2017). A study conducted in Australia found that parents feared that if their children accessed certain information about sex and sexuality before they were 'mature,' they would have too much information at an early age and that they would not be able to handle this knowledge appropriately (Robinson et al., 2017). Another study conducted in Iran found that families thought it is disgraceful to give their female children information about SRH issues (Kohan et al., 2017). Parents and families against teaching sex education to their children think that this places their children more at risk of engaging in sexual activity sooner.

Another significant barrier is the cultural and religious beliefs of parents, teachers, and health providers. According to Glover and Macleod (2016, p.5), "teachers are invested in their moralities, cultures and normative expectations of gender and sexualities which infiltrate into the classroom context." Just like health providers, teachers do not realize that it is best to provide information. Another study conducted with Muslim women revealed that few women displayed negative attitudes when it came to SRH teachings and saw no need for it since they believed that their religion offered them enough protection against STIs (Alomair et al., 2020). Irrespective of beliefs, culture, and religious practices, young people still deserve to be given information to encourage safer practices.

Consequently, cultural and religious beliefs severely compromise complete and correct sexuality education for children, thus strengthening the idea that sexuality conversations between children and adults are off-limits (Robinson et al., 2017). According to Alomair et al. (2020), women held the common belief that it is essential to learn about SRH, with some stating their preference of being taught in a structured manner by a trained professional. The main concern is that it should be conducted by people trained to do so. Moreover, Kohan et al. (2017) added that it is crucial for children to be taught in school alone and for their parents to communicate with them accordingly on these issues.

2.3.3 Contraception

Condoms and hormonal contraception together are essential and can be well recommended for adolescents for dual protection, and long-acting reversible contraception (LARC), including both intrauterine contraception and implants, are safe, highly effective, and thus well suited for adolescents (Apter, 2018). For contraceptives to be considered adequate or to make better use of them, young people need to be taught how to use them and make informed decisions. Sexual health for adolescents includes recognizing sexual rights, sexuality education and counselling, and confidential, high-quality services where adolescents get appropriate counselling and provide a wider choice of methods, including long-term strategies (Mbizvo and Zaidi, 2010).

Hindin and Fatusi (2009) argue that young people may engage in unprotected sex (not use contraceptives) for several reasons, including fear of contraceptive side effects, misinformation about pregnancy risk and STIs, or concerns about the safety of condoms. These reasons suggest that young people lack basic information to reduce the unmet need for contraception, prevent

SRH issues, and engage in safe sexual activity due to misinformation. Olawale and Ifeanyi (2016) found that young girls complained that their boyfriends did not like using condoms because it reduced sexual pleasure during intercourse. Therefore, to prove their commitment and love, condoms are no longer seen as necessary between partners.

Contraception is defined as "the use of various devices, drugs, agents, sexual practices, or surgical procedures to prevent conception or impregnation that plays a vital role in eradicating extreme poverty" (Olawale and Ifeanyi, 2016, p.2). For example, adolescent pregnancies are more likely to occur in disadvantaged communities, commonly driven by poverty and lack of education and employment opportunities (WHO, 2020). According to Olawale and Ifeanyi (2016), contraception eradicates extreme poverty to control the number of children that people have and take care of. Prevention methods or contraceptives are birth control measures, namely the implant, IUD, birth control pills, emergency contraception, patch, injection, vasectomy, tying ovary tubes and a patch; and those that prevent both pregnancy and sexually transmitted infections like condoms (male or female type) (Galati, 2015; Apter, 2018). Additionally, dual protection is highly recommended and includes the use of more than one method simultaneously. In Rwanda, Farmer et al. (2015) found that biological processes such as withdrawal, cycle beads, and the traditional calendar method were shared among participants whose religious beliefs prevented them from using modern contraceptive methods. Though there are various contraceptives and family planning methods for both men and women, some prefer these natural methods.

However, lack of information and misunderstanding about the side effects and usefulness of family planning methods significantly impact the consistency of use among women (Alomair et al., 2020). Since women's bodies are biologically and genetically diverse, contraceptives do not react the same in every person. That is why it is vital to be given complete information and alternatives before complications occur due to the chosen method. According to Sedgh et al. (2015, p.57), fear of side effects and health risks have become more common explanations for non-use in the majority of countries in this analysis, possibly because more women have experienced the side effects of contraceptive methods or misconceptions about the problems associated with use. These fears are primarily created by misinformation from peers or any other uninformed individuals, thus exacerbating the unmet need for contraception.

2.3.4 Youth-friendly services

Adolescent and youth-friendly services (AYFS) are geared towards attracting young people to healthcare facilities and SRH services. Many SRH issues, including high levels of unintended pregnancies and high HIV rates, are prevalent among young people. The term 'adolescent-friendly means that the clinic should create a safe, comfortable, and welcoming space for young people seeking assistance. Nath and Garg (2008) explain that adolescent-friendly health services (AFHS) offer various options from protective, promotive, and medicinal services under one umbrella to guarantee better-quality, easy access, and convenient use of health services. In agreement with Nath and Garg (2008), Bearinger et al. (2007) mention that young people need access to quality youth-friendly services responsive to this population. Any healthcare provider can offer assistance, but those trained to work with young people provide better adolescent and youth-friendly facilities.

According to Dapaah et al. (2015, p.2), "the demand for youth-friendly services is informed by its ability to effectively attract the youth, meet their needs comfortably and responsively and succeed in retaining these young clients for continuing care." Achievement in the implementation of barrier-free youth-friendly services in healthcare facilities means young people will benefit. Also, since girls and women are the dominant users of SRH services, as mentioned by WHO (2012), health departments must guarantee that girls and women's agency and choice are promoted by making available a wide range of HIV prevention commodities, ranging from Prep and microbicides to user-friendly condoms. Thus, ensuring youth-friendly service provision to young people would reduce unintended pregnancy and HIV/STI infection risks.

2.4 Perception on the risk of pregnancy

According to Darroch et al. (2016) (as cited in WHO, 2020), an estimated 21 million girls between 15–19 years in developing counties fall pregnant, and approximately 12 million of them give birth every year. These statistics show that out of all the adolescents who get pregnant every year, slightly more than half of them manage to carry their babies till birth, thus increasing the need for intervention. Mbizvo and Zaidi (2010) emphasized that some measures reduce the risk of unintended pregnancies, including removing barriers to accessing contraception and reducing the need to opt for unsafe abortion to make safe abortion services

more widely available. Moreover, lifting the barriers to contraception will reduce unintended pregnancies, which will prevent the escalating number of unsafe abortions.

Young people face various consequences when they find themselves experiencing an unintended pregnancy. Children born to adolescent mothers are more likely to live in poverty, have difficulty in school, and suffer from abuse and neglect (Aspy et al., 2012). Also, adolescent pregnancy and childbearing often result in school dropout; although efforts are underway to enable them to return to school after childbirth, this can jeopardize their future education and employment opportunities (WHO, 2015). According to Thatte et al. (2016), it is also revealed that unplanned pregnancy among young people increases the risk of unsafe abortion, which can lead to severe complications and even death. Adolescents often lack support, information, and source of advice, and this often leads to the high burden of SRH.

2.5 Burden of Sexual and Reproductive Health

According to Lopez (2005, p.1), the concept of burden of disease was developed in the 1990s by the Harvard School of Public Health, the World Bank, and the World Health Organization (WHO) to describe death and loss of health due to diseases, injuries, and risk factors. The leading causes of the global burden of diseases are HIV/AIDS, STIs, preterm birth complications, and neonatal infections (WHO, 2008; Lopez et al., 2006; IHME, 2018). In Sub-Saharan Africa, these complications or burden of disease are likely to put added pressure on healthcare providers. Educational information on the burden of disease would play a significant role in understanding what they should do to keep themselves safe. The burden of disease does not depend on age, sex, and geographical area but is influenced by it; for example, when people grow up, they are more exposed to diseases and are more susceptible to risk factors relating to SRH. Due to geographical influence, when men grow up, they tend to make bad lifestyle choices leading to injuries.

2.5.1 Pregnancy Infirmities

Pregnancies are normal and only considered a burden to reproductive health when they come with illnesses, threatening life difficulties, and even death. According to Mbizvo and Zaidi (2010), it is revealed that nearly 90% of the 16 million births to adolescent girls occur in low resource countries. Data showed that approximately 30% of teenagers (aged 13 - 19 years) in South Africa report ever being pregnant in 2013 (Strode and Essack, 2017), and 99 000 school-

going adolescent girls were pregnant in the same year (Stats SA, 2017). One study found that one of the many reasons making teenagers vulnerable to pregnancy is that young people do not want to assume any responsibility for birth control, and "some girls are seeking love, and naively believe a baby can give them the affection they seek" (Olawale and Ifeanyi, 2016, p.2). For these reasons, young girls find themselves experiencing pregnancies that were not planned nor intended, and as a result, they opt for an abortion.

Due to desperation, these young girls opt for unsafe pregnancy termination, which puts their lives at risk. According to Singh and Maddow-Zimet (2012) (as cited in WHO, 2020), about 7 million women in developing countries had had unsafe abortions that landed them in hospital. Furthermore, women with no access to safe abortion services are exposed to unsafe abortion, and if the procedure is done at a later gestation stage, they are more likely to die or be injured.

2.5.2 HIV Burden on SRH

HIV is one of the highest burdens of disease and continues to be a significant global public health issue, having claimed almost 33 million lives so far (WHO, 2020). This disease has made many people suffer throughout the world, and many elders have died, leaving behind children. According to Avert (2020), South Africa has the highest HIV occurrence, with an estimated 7.7 million infected people; among its provinces, KwaZulu-Natal has the highest prevalence rate of HIV, estimated at 27%.

According to Statistic South Africa (2018, p.10), the total number of persons living with HIV increased from 4.25 million in 2002 to 7.52 million in 2018, and the HIV occurrence among the youth aged 15–24 years declined from 6.7% to 5.5%. This data shows that the number of people living with HIV increases over the years despite the health sector's improvement. Furthermore, in the same year, 2018, 4.7 million women were found living with HIV than 2.8 million men (Avert, 2020). However, between 2000 and 2019, new HIV infections fell by 39%, and HIV-related deaths fell by 51%, with 15.3 million lives saved due to ART (WHO, 2020). Antiretroviral treatment has helped fight and reduce HIV prevalence, but still, there were barriers towards use.

Barriers preventing access to HIV testing and antiretroviral therapy (ART) for youth remain a concern globally among young people (Bekker et al., 2015; Kurth et al., 2015). Barrier-free services and essential HIV education would benefit many by limiting the increasing number of

deaths among adolescents. This increase has occurred predominantly in the African region, resulting in AIDS being the leading cause of death among adolescents. It is also the second leading cause of death for adolescents worldwide (Bekker et al., 2015). In Kenya, an estimated 100,000 new HIV infections occurred in 2013, girls and key populations were excessively affected (Kurth et al., 2015). Adolescent girls become infected with HIV in large numbers every year compared to teenage boys (Avert, 2020).

HIV and other STIs are more prevalent among young people. Aspy et al. (2012) revealed that young women aged 15-19 years have higher rates of chlamydia and gonorrhoea than women in other age groups, and HIV is a significant cause of morbidity and mortality among young people. Key populations are more vulnerable to HIV. Female adolescents are the most susceptible and are among the key populations (KPs), including males who have sex with males (MSM), people who inject drugs (PWID), transgender people (TG), and sex workers (SW). Access to HIV testing among these groups is even more challenging due to marginalization and stigma (Kurth et al., 2015). Effective responses to the HIV epidemic require more prevention programs with information and services aimed at these groups to reduce infection rates.

Data indicates that in South Africa, the number of people living with HIV increased by 3 million in 16 years (Statistics SA, 2018)**.** As previously mentioned, women suffer more STI complications, thus increasing their chances of contracting HIV; consequently, the statistics reveal many infected women, especially in the reproductive ages, compared to men. Barriers to access to HIV testing and antiretroviral therapy (ART) for youth remain a concern globally (Bekker et al., 2015; Kurth et al., 2015).

2.5.3 STIs impact on SRH

According to Unemo (2017), sexually transmitted infections often affect sexual organs and are transmitted through sexual engagements, vaginal sex, anal sex, or even oral sex. Each year, an estimated 376 million new STIs constitute chlamydia, gonorrhoea, syphilis, and trichomoniasis (Rowley et al., 2016; WHO, 2018). Chlamydia is one of the most common STIs affecting both men and women worldwide, and WHO projected that in 2012 between the ages 15 to 49 years, 4.2% of women and 2.7% of men of the 131 million population globally were newly infected (Unemo et al., 2017). These statistics indicate that women are more likely to suffer more consequences of STIs compared to men.

Many studies have defined and researched STIs. Some mentioned that STIs and bacterial vaginosis (BV) fall under the most critical conditions globally and are linked with increased transmission of HIV and poor reproductive and sexual health (Francis et al., 2018; Unemo et al., 2017). According to Francis et al. (2018), most STIs are asymptomatic and go unnoticed and untreated, which can cause morbidity, including pregnancy complications and other health-related concerns. Due to symptoms not been visible, people continue to engage in unprotected sex without knowing the risks and continually transmitting the infection to their sexual partners. The World Health Organization (2020) outlines that in some cases, STIs can have serious reproductive health consequences beyond the direct impact of the infection itself (e.g., infertility or mother-to-child transmission).

When untreated, STIs are dangerous and could result in various complications. For example, the difficulties of curable STIs include, among others, pelvic inflammatory disease (PID), ectopic pregnancy, infertility, neurological and cardiovascular diseases; fetal or neonatal death, premature delivery, neonatal encephalitis, eye infections, and pneumonia; and STIs increase the infectiousness of and susceptibility to HIV (Unemo et al., 2017). Young people who are more sexually active and engage in risky behaviour experience these difficulties. A study conducted by Francis et al. (2018, p.4) found that in sub-Saharan Africa, STI prevalence was higher among young women than among older women except for those with herpes simplex virus type 2 (HSV-2).

Rotermann (2012) also states that individuals aged 15 to 24 years have the highest STI prevalence rates. This information suggests that youth are more likely to make poor decisions regarding their SRH through recklessness, negligence, or lack of knowledge (Morris and Rushwan, 2015). Moreover, those adolescents who have concerned parents are informed about contraceptives and safe sexual behaviour to prevent pregnancy and STIs, including HIV. However, some parents do not want to assume the responsibility but shift it to health providers and teachers who are viewed as experienced and able to deal with or teach about such things (Lince-Deroche, 2015). Yet if parents and healthcare providers can assume their roles, providing guidance and information, many young people's SRH risks would be controlled or reduced.

2.6 Factors inhibiting the use of SRH services

For some people, accessing a health facility is a challenge because of financial constraints, long-distance transportation, and fear that they may be stigmatized and discriminated against (WHO, 2020). In most cases, youth issues arise from lack of education, parental guidance and communication, and peer influence. Youth have expectations of health providers in SRH facilities which are not always met. Some individuals believe that gaining information or assistance from the health providers will be easy, but there are challenges such as the judgmental attitudes of health providers (Lince-Deroche et al., 2015).

2.6.1 Lack of information

Health providers' misconception and myths hinder their work-related opinions; for example, some providers still believe and feel that engaging in sex from an early age is perpetuated by easy access to contraceptives in clinics (Chilinda et al., 2014). Depriving young people of information and access to necessary contraceptives and other SRH information exposes them to adverse SRH outcomes. In some cases, adolescents have misconceptions about the immediate and long-term side effects of contraceptive methods. These concerns are central to their health and their future ability to bear children, and because of these fears adolescents often experience, they then consider other methods such as withdrawal and traditional methods (Rotermann, 2012). The effectiveness of these methods is low, and adolescents cannot use them properly. In a study by Avert (2020), a responsible and concerned parent expressed the desire to receive more information at home and school about risky sexual behaviour and encourages non-judgemental, direct conversations with young people about relationships with older men. Accessing information is a big challenge, especially for the youth; however, some parents try to provide information to their children.

Misinformed individuals have the perception that condom use is associated with unfaithfulness in long-term relationships. According to Lince-Deroche et al. (2015), though condoms are easily accessible and inexpensive, consistent service tends to decrease over time within stable partnerships. They are associated with being 'unfaithful' or as 'not trusting.' Furthermore, the lack of helpful information results in misuse or inconsistency of preventative measures in place by the health officials. Poor understanding of how contraceptive methods work leads to inconsistent, incorrect, and resistance to condom use, despite awareness of potential STI

exposure (Chandra-Mouli et al., 2014; Apter, 2018). This habit of not using contraceptives consistently to protect against STIs results in increased HIV incidence.

Providing comprehensive SRH information helps prevent issues that arise from misinformation, myths, and stigma associated with SRH. It enables people to make informed decisions regarding their lives and others' lives, such as their sexual partners. Mbizvo and Zaidi (2010) mentioned that some adolescents do not use contraceptives because they claim they are complicated to use. Nacosa (2018) observed several factors contribute to the risk, including limited access to information about sex, sexuality, pregnancy prevention, inadequate access to SRH services, especially in rural or isolated communities, and substance abuse. When insufficient information, stigma, and judgment are prevalent in health facilities, there will be no adverse interest in seeking such services.

2.6.2 Fear of stigma and discrimination

There are many reasons why young people do not want to seek help in public healthcare facilities, and among those reasons is fear of being stigmatized and discriminated against. There are beliefs that sex is meant to occur between older, married people, and it is morally wrong for young people to engage in sex before marriage. Thus, it becomes difficult for young people to seek help when they encounter sexual problems. In their research, Robinson et al. (2017) argue that socio-cultural and religious customs that view sex as immoral and problematic lead to subsequent shame, mistreatment, and stigma among sexually active women. This makes it difficult for these young people to face senior health professionals to discuss sex-related issues. A study conducted by Thatte et al. (2016) in Ghana discovered that fear of stigma was a significant barrier to HIV and STI testing.

People and adolescents fear their families finding out that they seek SRH services since sexual behaviour is labelled as shameful and immoral. Farmer et al. (2015) also added that young and unmarried women often face stigma when accessing family planning services because of these expectations. This plays a role in increasing HIV-related deaths and pregnancies. A study conducted in Kenya on HIV women seeking SRH services reveals that fear of stigma acts as a barrier to disclosing status, negatively impacts breastfeeding practices, and adheres to ARV treatment more difficult (Farmer, 2015).

2.6.3 Attitudes of health providers

Young people experience difficulties when seeking assistance, especially in the SRH sector, where nurses judge, stigmatize and leave their needs unmet. Young people cannot bear the undesirable attitudes imposed by the health providers towards them, which is a massive constraint in seeking SRH services (Alli et al., 2013). Such behaviour is against a health provider's job description and role. They are expected to provide non-judgmental, stigma-free, and youth-friendly services, but sometimes they fail to do so. The adverse treatment that youth receive from health providers is demotivating and often perpetuates risky behaviour. A study in Vietnam found that health staff would scold patients and make them cry, making them feel like they had done something wrong (Hoang et al., 2018). This leaves young people confused and hurt when they receive this kind of treatment from professionals. The staff expressed that they also face constraints, including working under pressure because of the shortage of human resources, lack of infrastructure, and high caseloads, which may explain their behaviour (Alli et al., 2013). Due to these work-related pressures, some staff members end up taking out their frustrations on patients. As a result, patients may not want to return to the facility.

Most people, including some health providers, believe that sexual intercourse should only be between married individuals, and in cases when young people are having sex, it is considered a disgrace (Nath and Garg, 2008). This serves as a barrier towards receiving friendly services. In many poor communities of low and middle-income countries (LMIC), contraceptives methods are not available to adolescents, and even when the methods are available, laws and policies prevent their provision to unmarried adolescents or those under a certain age (Chandra-Mouli et al., 2014). It is reported by Low (2009), in a study in India, that sexually active young or unmarried people are not permitted to obtain contraceptives. These discriminatory actions by government policies and providers contribute to the excessive increase in pregnancy, abortion, and HIV rates (Thatte et al., 2016). It is these types of behaviours and attitudes towards young people that limit their access to SRH services.

Personal beliefs continue to be a barrier between health providers and their job fulfillment, which poses a challenge. In Senegal, a study found that health providers offered contraceptives only if the client met specific age requirements irrespective of marital status (Thatte et al., 2016, p.2). Health providers compromise others' needs due to their personal beliefs; thus, many young people are deprived of services that they require. Some people are prohibited from using contraceptive methods because of general practices of early marriage and motherhood (Morris

and Rushwan, 2015). Restrictive policies, cultural and religious constraints contribute to adverse SRH outcomes and do not prevent young people from engaging in risky behaviours.

Even where there are no legal restrictions, some health workers refuse to provide unmarried adolescents with contraceptive information and services because they disapprove of premarital sexual activity (Low, 2009; Chandra-Mouli et al., 2014; Galati, 2015; Woog et al., 2015). Unethical behaviour occurs when they disregard their duties as health providers towards every individual in need of services and then start imposing their beliefs onto the young. Moreover, providers often tend to have biases or preferences for particular methods and promote those they perceive to be the best option for clients. As a result, this limits young people's access to a range of methods.

2.6.4 Inaccessibility of services

Morris and Rushwan (2015) suggest that current contraceptive use prevents approximately 272 000 maternal mortalities per year, and if current family planning needs were met, another 104 000 lives would not be lost, many of which would be that of adolescents. Adolescents are vulnerable to death and diseases, and due to lack of accessibility to services, they may experience unintended pregnancy and unsafe abortion; therefore, increasing access would save more lives. Their involvement in unprotected sexual intercourse can have life-altering consequences for youth and their families, making it especially important to identify ways to encourage adolescents to practice responsible sexual behaviours (Khurana and Cooksey, 2012). A study conducted in Nepal by Maharjan et al. (2019) with married adolescents revealed that some women use a contraception method secretly, especially if their husbands or family-in-laws did not approve of contraception.

Finances also become a hindrance for some young people. According to Svanemyr et al. (2015), not everyone has access to SRH services as there are many barriers like financial and economic constraints. Occasionally, the inconsistency in the use of contraceptives arises from the inaccessibility and lack of cost-effective measures, making it difficult to access them, especially for those who want to use them but cannot afford them. One of the significant barriers or hindrances to the usage of contraceptives is the cost of family planning and other reproductive health services, and some countries will find it challenging to meet these needs financially, putting pressure on the governments due to economic instability (Hoang et al.,

2018). These financial constraints may be due to more significant numbers of people in need of contraceptives and lack of availability from donors or the government.

As Chandra-Mouli et al. (2014) suggested, even when adolescents can obtain contraception, social pressure may prevent their use; for example, unmarried women feel the pressure of bearing children to satisfy their partners. This causes young people to make decisions out of fear that their partner will leave them if they do not get pregnant. Moreover, because of young people's dependence on parents and other elderly family members, they do not access the SRH services, fearing exposure to being sexually active. This negatively influences their capability to decide contraception (Kohan et al., 2017; Maharjan et al., 2019). Therefore, all these restrictions and barriers result in the unmet need for adolescent and youth SRH services.

2.7 Summary

Having free and available access to SRH information, treatment, and preventative measures contributes to a higher life expectancy. One of the issues mentioned is that many young people become sexually active before the age of 20 and may struggle with unplanned pregnancies, unsafe abortions, sexually transmitted infections, maternal deaths, and injuries. Both married and unmarried women had limited decision-making interventions, freedom of mobility, and financial resources. Poor SRH is likely to increase morbidity, mortality, gender inequality and slow their development.

CHAPTER 3: METHODOLOGY

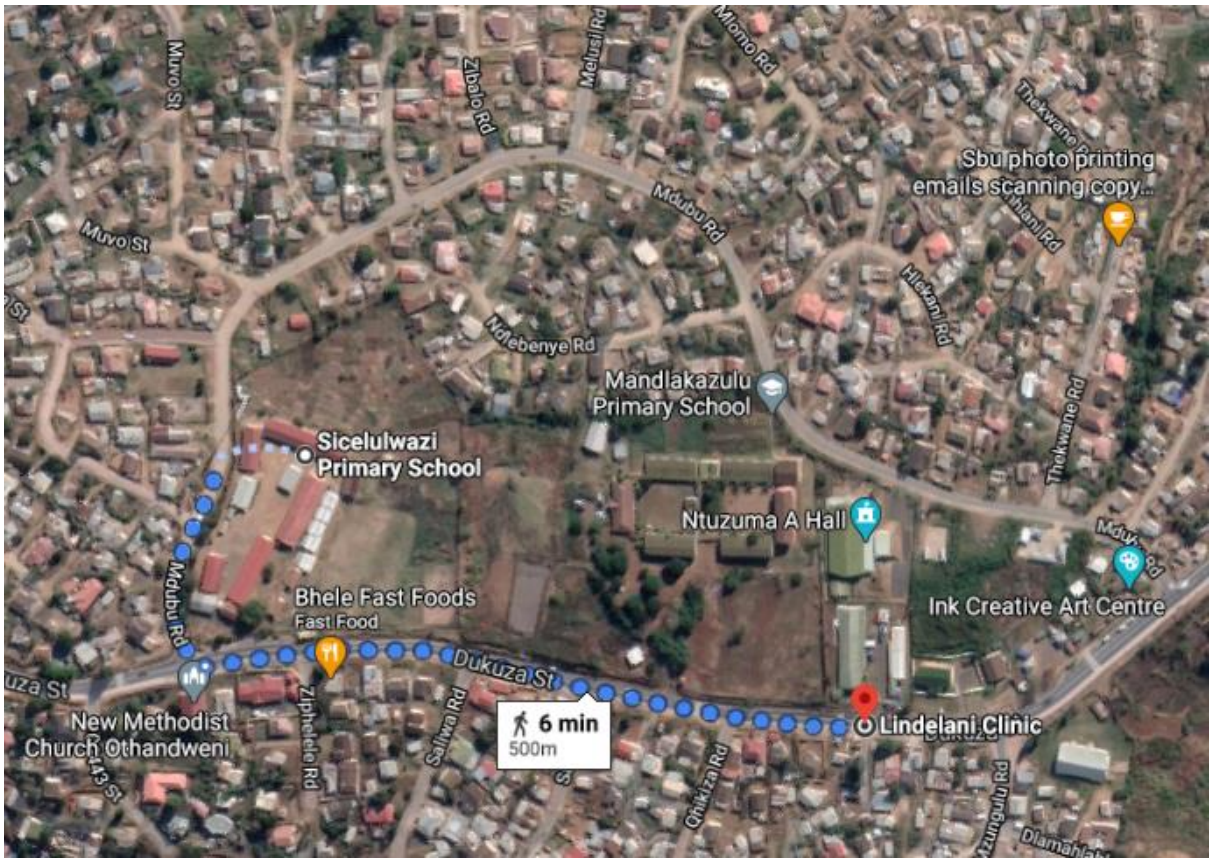
3.1 Introduction

SRH has been an important issue globally. Given that there is a copious number of young people worldwide and rising STIs, HIV, and unplanned pregnancies, SRH mandates immediate attention. This study aims to explore the perspective and experiences of youth who access SRH services. This chapter details the research methodology that was used in data collection and analysis for this study. The first part of the chapter focuses on providing insights into the study context. After that, the study design and sampling methods are discussed. The chapter also highlights the technique of data analysis that was used. The latter part of the chapter presents ethical considerations and the limitations of the study.

3.2 Study Setting

The study was conducted in Ntuzuma, a town situated in the province Kwa-Zulu Natal, South Africa. Ntuzuma is about 25 kilometers north of Durban's city (Statistics South Africa, 2013). It is referred to as the youngest of the four “PINK” program townships and was built by the eThekwini municipality during the 1970s. According to Statistics South Africa (2017), KwaZulu-Natal is the second most populated province, with an estimated 11.1 million people. Ntuzuma has a total population of 125 394 people living in 29 988 households, comprising 64 898 females and 60 496 males. The majority of the people are Black Africans containing 124 719 inhabitants (Statistics South Africa 2013). About 95% of residents speak isiZulu as a first language. An estimated 70% of the population is under the age of 35 years. Ntuzuma consists of nine sub-places, including Lindelani Township (Ntuzuma A), the study's focus area. Ntuzuma has two clinics, and the number of patients per nurse per day is 32.4 (Statistics South Africa, 2013). The clinics are always full, and there are many patients. A map of Lindelani Township is displayed in Figure 3.1 below.

Figure 3.1: Map of Lindelani Township (Ntuzuma A)



Source: Google Maps (2019)

3.3 Research Design

A research design is a plan or a mind map showing how the research will be conducted and which steps will be followed. It includes details of how data was collected, which instruments were used in the data collection process, and methods used to analyse the data collected (Brink et al., 2012). For this research, a qualitative research design was used to understand the research topic from the perspective of the youth being investigated. The research design was the best fit for the study because it allowed the researcher to engage with the participants and gather the information based on their experiences and feelings about the health facility. Since decades ago, qualitative research has always been effective, especially in gathering information about a specific study population; their values, culture, opinions, behaviour, and social influences (Mack, 2005). This was the main reason this type of research design was chosen for this study as it required direct engagement between the researcher and participants, including building rapport.

Phenomenology as a type of qualitative research was used to describe the participants' experiences of SRH services as an essential part of their life events (Astalin, 2013). Doing so enabled the people involved in the study to offer increased insight into the phenomena studied. Many authors have similarly discussed phenomenological research; for example, Finlay (2012, p.3) stated that "phenomenology involves both detailed descriptions of the lifeworld or lived experience." Moreover, the researcher's feelings were detached, and the researcher did not judge whatever the participants provided information.

3.4 Sampling Method

Doing a study with a specific population in mind that will be useful for the research is essential. The researcher chose to use the non-probability sampling techniques, a qualitative method that provides the most reliable representation of the study population (Walliman, 2015). Selecting the study sample that better serves the research purpose saves time for both the researcher conducting the research and the participants involved in the research. Purposive sampling is used, which is also known as the judgmental technique, which, according to Newman (2014), is a valuable sampling type for special situations used in exploratory research or field research and selects cases with a specific purpose. This study's specific goal was to gather information about the experiences and perspectives of SRH services among the youth. Only participants aged between 18-30 years, both males and females, who have sought SRH services in the area, were included in the study. This age category was selected because it does not require parental consent and most participants found were either 30 years or below. The first few participants were recruited outside the healthcare facility in the area, then participants referred the researcher to others. Participants who had experience using SRH services outside of Lindelani Township were excluded from the study.

Purposive and snowballing sampling were used together to select and recruit participants needed for the study. Snowballing is referred to as purposive sampling, where current participants recruit future subjects from among their friends (Newman, 2014). Furthermore, the researcher identified participants with SRH experience who usually visit or have once visited the health facility specifically for SRH. The researcher also selected the participants who had children because it is expected that they would need SRH services such as HIV testing, pregnancy testing, and family planning. The researcher explained that all the services included in SRH and the study's primary purpose are the participants. The recruited

participants then referred the researcher to others they knew were suitable for the study. The research aimed at exploring the experiences of both females and males visiting the clinic and the barriers they encounter preventing their easy access to services. The study included 16 participants (eight males and eight females), allowing the researcher to get several different perspectives and experiences.

3.5 Data collection methods and process

For the research, interviews were used as a form of collecting data. As Gill et al. (2008) mentioned, a research interview aims to explore individuals' perspectives, experiences, attitudes, and motivations. This data collection method enabled the researcher to interact with the participants to get their direct views and experiences of accessing SRH services. During the face-to-face interviews, the researcher used the semi-structured in-depth interview guide, not limiting the participants to a 'yes and no' answer but allowing them to share as much information as they can. This was beneficial as it allowed the researcher to gather detailed information and to probe where possible. The open-ended questions that were part of the questionnaire could evoke meaningful and socially relevant responses to the participant, unexpected by the researcher, which is rich and explanatory (Mack, 2005). The researcher asked a series of questions, using a polite tone, to elicit honest responses from participants.

The face-to-face interviews were conducted in a place chosen by participants and where the researcher was able to maintain eye contact to help build a trustworthy relationship. The interview setting was mainly in the participants' homes, a place they are familiar with, where privacy was guaranteed. Once the participant understood the study's purpose, it became easy for them to share their ideas and feelings on the phenomena at hand and not hesitate to answer questions honestly and openly. Interviews can be carried out in various locations: in the home, at work, outdoors, on the move (e.g., while traveling) and can be used to interview people both individually and in groups (Walliman, 2010). All interviews were audio-recorded, which allowed the researcher to focus on the discussion rather than writing notes, which can distract both the participant and the researcher. The interviews lasted approximately 15-30 minutes in duration.

Upon reviewing some of the transcripts, the researcher saw the need to do follow-up interviews with a few participants. As per the ethics protocol, the follow-up interviews were also recorded,

with additional questions probed. It is also highlighted by Mack (2005) that in-depth interviews are best for data collection to get more insights into people's past, views, and understandings, on a specific topic being explored. The discussions were audiotaped with the permission of participants and then transcribed before they are analyzed.

3.6 Data Analysis methods

A qualitative method was used to gather data from the participants, and semi-structured face-to-face interviews were transcribed and analyzed thematically. Pseudonyms were used to protect the identities of the participant and to maintain their confidentiality. For this study, thematic analysis was used to identify the key themes that emerged from the interviews. According to Braun and Clarke (2006, p.6), thematic investigation is referred to as "a method for identifying, analysing, organizing, describing, and reporting themes found within a data set." This was the best qualitative data analysis approach for this research allowed for eradicating errors throughout the study. Moreover, no software was used to analyse data.

Since the interviews were recorded, the researcher spent time going through each recording, transcribing, and translating from the local language (Isizulu) to English. The researcher became familiar with the data by reading it repeatedly. The researcher manually generated initial codes from the data found to be more relevant to the study. The researcher searched for the themes by selecting the most frequent and relevant codes. The researcher reviewed themes and refined them. The researcher defined and sorted themes for the final output. The researcher then consolidated the findings of the study in the results chapter.

3.7 Ethical Considerations

The researcher addressed the fundamental principles that need to be considered for research ethics (Boddy et al., 2010). The University of KwaZulu-Natal's Human and Social Sciences Research Ethics Committee (HSSREC) reviewed the research to ensure the research study's quality and integrity. Once ethical approval was granted, then data collection commenced. The participants were informed about the purpose of the study, methods, and possible uses. Then they were required to sign the informed consent form as an agreement of participation in the research study. Confidentiality was respected and maintained by the non-revelation of the participant's information, and responses and anonymity were ensured by using pseudonyms. Moreover, the researcher did this to avoid reputational damage and the risk of upsetting participants. The participants were told that their participation in the study is voluntary, and no

rewards will be given for their participation. The participants were also notified of their right to withdraw from the study without any implications for them.

Before collecting data, permission to conduct the study in the community was granted by the Lindelani Ward Counsellor. The ethics committee permitted the University of KwaZulu-Natal (Protocol Reference Number: HSSREC/00000043/2019). The research objectives were made clear, no misleading information was provided, and appointments were made depending on the participants' availability. Furthermore, the researcher communicated with the participants honestly and transparently, avoided deception and did not exaggerate the research objectives. Lastly, the researcher remained as objective as possible throughout the research interviews with the participants. Any work used by other authors was acknowledged using references and paraphrasing.

3.8 Limitations of the study

The study was conducted in Lindelani Township in Ntuzuma and specifically those who had sought services at an SRH facility. The participants may not have honestly answered the questions because the research topic required personal and sensitive information. Many of the questions were qualitatively structured and tested the perceptions and experiences of youth, and the study results cannot be verified since they are person-centred.

Identifying participants who met the sampling criteria was challenging, especially since the study required not just anyone with SRH services experiences but those specifically who used a facility in Lindelani Township. This is a limitation since other people may also have beneficial information for the study. Altogether, the study results will not be generalized to the whole population because of the limited sample size for statistical measurement and the study's qualitative nature. Participants who had time constraints had difficulty providing detailed information. Lastly, for the participants that decided to withdraw in the middle of the study, the researcher had to find replacement participants, which was a time-consuming process.

3.9 Summary

The methodology chapter outlined the methods and procedures that the researcher followed in gathering data for this research. For this study, a qualitative approach was used to gather information on participants' experiences, perceptions, and barriers to SRH services. The

participants were purposively sampled, and data was collected using face-to-face in-depth interviews. The data collected was then analyzed thematically, where themes and codes were generated to inform the research findings.

CHAPTER 4: RESULTS

4.1 Introduction

Globally, barrier-free and youth-friendly SRH services have been a necessity to fight SRH risk factors. Therefore, it is essential to examine youth's experiences to determine if health facilities have met their needs. The study explores the perspectives and experiences of youth who have accessed SRH facilities in Lindelani Township. In this study, qualitative semi-structured interviews were conducted with young men and women. The aim of using semi-structured interviews was to make sure that participants were given a chance to explain their responses and are not limited to one-word answers. This chapter represents the results from the participants who shared their service experiences and the type of treatment they received, including the challenges they encountered when they visited SRH facilities. This chapter begins by presenting the study sample's characteristics, and after that, the major themes are presented.

4.2 Characteristics of the study sample

Interviews were conducted with a total of 16 participants comprising eight males and eight females. The participants' targeted age range was 18 to 30 years, and the ages of the sample ranged from 22-30 years (see Table 4.1). All the participants interviewed were single and have never been married. Their educational level was high, with most reporting secondary level of education. More than half of the study participants (10 of 16) reported having at least one child. Only two of those who reported having children indicated that their children did not share the same mother or father.

Table 4.1: Demographic characteristics of Participants

DEMOGRAPHIC TABLE						
Participants no.	**Pseudonym**	**Gender**	**Age in Years**	**Marital Status**	**Highest Educational level**	**Number of children**
1	Tanzania	Female	25	Single	Post-secondary	None
2	Rio	Male	29	Single	Post-secondary	One
3	Morocco	Male	27	Single	Post-secondary	None
4	Zaria	Female	30	Single	Grade 11	Two
5	Sierra Leone	Female	26	Single	Grade 11	Two
6	Benin	Male	28	Single	Post-secondary	None
7	Cameroon	Female	28	Single	Matric	One
8	Nairobi	Female	24	Single	Post-secondary	None
9	Tokyo	Female	27	Single	Matric	Three
10	Moscow	Male	24	Single	Matric	Two
11	Cairo	Male	24	Single	Post-secondary	None
12	Niger	Male	22	Single	Post-secondary	One
13	Chad	Male	24	Single	Post-secondary	One
14	Togo	Male	24	Single	Post-secondary	One
15	Libya	Female	24	Single	Post-secondary	One
16	Paris	Female	26	Single	Matric	None

4.3 Youth's perspective of SRH services

4.3.1 Participant's thoughts on SRH

Participants were asked to define and identify the SRH services available at their nearest facility based on their understanding and experiences. In the interviews, it was clear that most of them understood SRH. They articulated some of the core aspects of SRH regarding family planning, pregnancy, STI, and HIV services. The participants were aware of SRH, and they were able to demonstrate an adequate understanding of the critical tenets of SRH based on their understandings and experiences.

"The first thing that pops up in my mind is knowing your health status whether you are HIV positive or negative; have STIs or STDs; use contraceptives…pap smear if you have cervical issues as a woman." (Female, age 25, Tanzania)

"What comes to mind is family planning and HIV and AIDS prevention or treatment. So, family planning is very dominant." (Male, age 27, Morocco)

"I think it is health-related for different sexualities. Reproductive health is for mothers or girls getting things like pap smears or contraceptives. Things that have to do with reproduction meaning one's vagina or penis and family planning, different sexualities (LGBTs)." (Male, age 22, Niger)

The participants provided the information based on their experiences or observations at the clinic when they went to access services. The information presented by the participants suggests that they are aware of the services provided or offered by healthcare facilities. Most people have certain expectations of what they assume they will find in the healthcare facilities or their treatment. One of the participants, Niger, seems to think that SRH services mainly cater to females; therefore, he felt that males have limited services. This thought may have been driven by the fact that most common SRH services, especially in the clinics, are used by females, such as pregnancy services and family planning. Thus, when people go to healthcare facilities, they already have a list of services they expect to receive.

4.3.2 Expectations on healthcare facilities and health providers

Most of the time, people's expectations of health facilities vary, arising from past experiences. In most cases, people expect only the best service from their trusted healthcare service providers. The participants' expectations of positive services and treatment become a motivator for seeking assistance from facilities. Most of the respondents had high expectations of their local health facility, and this suggested that they were aware of the roles and responsibilities health providers should play and what a health facility should be comprised of.

"I was expecting the service to be quick even though it cannot be that quick but at least considerate of others. For nurses to be sympathetic in the service, they give and not for people to find themselves in near-death or critical situations while at the clinic." (Female, age 25, Tanzania)

Tanzania's response suggests that she expected health providers to work at a quicker pace and be kind to patients; however, the actual services received at the health facility did not meet her expectations. The participants expected health providers to be professional, cautious, and provide exceptional services to every patient, especially to the terminally ill, so they would not die at the facility due to staff negligence. The participant's responses also show that she was very concerned with the lack of professionalism and ill-treatment she received at the clinic. She was worried that patients' lives continued to be at risk, even in a place where they should be getting help.

> *"As a patient, I expect to be treated with care. The health providers should be welcoming and communicate well with patients so that one will not be scared to say everything because when you get there and find them with no time, so you end up lying." (Female, age 28, Cameroon)*

> *"I expected a better quality of service as nurses are trained to provide and I also expected to be treated right as a community member." (Male, age 24, Cairo)*

> *"I expected to be treated right, get healthcare workers that will make me feel welcomed not discriminated because sometimes it happens you find judgmental staff."(Female, 24, Libya)*

Being treated respectfully, with care, and given quality service was important for many participants; however, those expectations were unmet. The health providers were always busy and rarely had time to give their full attention to patients. As a result, participants then found themselves in situations where they were not honest about the reason for their visit to the facility. When participants do not provide the real reason for their visit, this prevents them from getting the appropriate treatment. Moreover, patients need to be open about their problems to any health provider, and they need to trust them with their concerns. Doing so will aid in attaining proper treatment. If healthcare providers do not encourage open communication with patients, they are likely to be scared to share or fully disclose their needs.

Based on other people's negative experiences of the healthcare facility, two participants said they expected to have negative experiences as well. There is a tendency for most healthcare workers to mistreat young people by giving them less than satisfactory service. Many young

people reported that they heard that health workers do not treat the youth with respect and are particularly judgmental towards them. The participants claim that:

> *"I have heard stories saying the nurses do not treat people well, especially when you are young and have sexually related problems."(Male, age 24, Togo)*

> *"I expected to be shouted at even though I knew they would help at the end of the day, and they did shout by the way."(Male, age 24, Chad)*

These two participants expected the worst from the healthcare providers due to what they heard from others. Being shouted at by a healthcare professional instills fear in many young people and may result in them suffering rather than seeking assistance. Moreover, contracting an STI is a significant concern for young people, and they avoid seeking help because of the fear of been judged by healthcare providers.

4.3.3 Unmet expectations and unsatisfactory services

The way participants viewed the health facility, and the health providers was dependent on their services. Some expectations were very high, and the healthcare providers could not meet those expectations. The interviews revealed that only one participant had her expectations partly met, mainly because she did get help as expected, but she also received a judgment from nurses because she did not look her age. She stated that:

> *"I can say 50% [of expectations] were met, and the other 50% I did not quite see. As much as I did get help, but because I looked a bit younger, the nurses were judgmental." (Female, 24, Libya)*

This shows that some nurses are judgmental and based their treatment of patients on their age; hence, young people generally suffer. These attitudes towards young people seeking SRH assistance might prevent them from returning if they need assistance because of the fear of being mistreated. Other participants mentioned that:

> *"So, when I got there, the service was slow, and things were not going as expected." (Male, age 24, Cairo)*

> *"If you get there just before they take the tea break, they just keep delaying on purpose until they go for a break."(Female, age 26, Paris)*

The participants had hoped that they would get good service provision from health professionals. Unfortunately, things did not go as expected, and the unmet expectations of most participants were due to the poor quality of services given by the health providers at the facility.

The amount of time it took for each patient to get assistance was long, and as a result, this heightened participant's lack of satisfaction concerning service delivery. They felt that they were forced to wait in a long queue, which did not bother the nurses since their working pace was slow. The participants were concerned that the healthcare providers did not seem bothered by the facility's high volume. Even on days with few patients, the pace at which they worked did not change; since they generally kept themselves distracted while patients waited for assistance.

> *"I am not sure whether they are lazy to work because whether you get to the clinic early or late, it is the same thing; the queues do not move. You sit there for hours and then see them taking tea breaks."(Female, age 24, Nairobi)*

> *"The lines become very long, but we end up getting help, and the health providers take ridiculously long hours while we wait there sick."(Male, age 23, Moscow)*

All the participants agree that the healthcare professional's treatment was unacceptable, and the services provided were inadequate at the healthcare facility. Participants are aware of how healthcare facilities are supposed to be operating and the type of service they should be receiving from the facility, but they experienced unsatisfactory outcomes. One of the participants highlighted that HIV patients are separated from other patients, and in this way, it reveals their reasons for coming to the health facility.

> *"Besides the judgmental part, I also notice that people who take HIV medication are separated from those who take other treatment, and that causes stigma."(Female, age 24, Libya)*

People living with HIV are judged and stigmatized because of the belief that HIV is a disgrace or is contagious. Segregating HIV patients from other SRH patients in healthcare facilities violates their privacy and may result in them discontinuing treatment. Moreover, the high level

of stigma associated with HIV and AIDS in healthcare facilities and the communities is likely to affect willingness to seek HIV treatment. Therefore, as revealed by Integra Initiative (2015), it is crucial to integrate SRH and HIV services to reduce stigma by offering a facility that provides a range of services. This will allow all patients to blend in, and there will be no assumptions or distinctions made as to which treatment they may be getting at the facility.

4.4 Reasons for SRH difficulties

4.4.1 Risky sexual behaviour

Risky sexual behaviours are defined as acts that increase the exposure of the sexually active individual to contract a sexually transmitted infection, or fall pregnant, or impregnate a partner, and this behaviour is more common in young people. The information provided by the study participants indicated that they engaged in risky behaviours. Eleven participants reported that they have had multiple sexual partnerships before. Moreover, only one participant mentioned that they consistently used condoms. One of the female participants shared her experiences:

> *"I was dating a Ben 10 and had broken up with the father of my children but did have sex with both of them regardless."(Female, age 30, Zaria)*

This participant was not ashamed of stating that she had two sexual partners and that she had sexual encounters with both the father of her children and another man who was younger than her. Besides having more than one sexual partner, most participants reported the inconsistent practice of safer sex which puts them at a higher risk of contracting HIV and other sexually transmitted infections. The women were exposed to infectious diseases when practicing unsafe sex and were at risk of an unplanned pregnancy. One participant mentioned that she had two sexual partners and experienced an unplanned pregnancy. She wanted to abort the baby because she was unsure of the biological father of the child.

> *"I did not know who the baby's father was, and I could not carry a child whose father is very young compared to me; that is why I wanted to abort."(Female, age 30, Zaria)*

Zaria engaged in risky behaviour, had unprotected sex with two men and conceived a baby she did not know who the father was. Even after she had gone through the stressful experience of being pregnant and not knowing the child's father, she further mentions other risky behaviours

that she was involved in. When she was asked if she wanted to have other children in the future, she said that she did not as she felt that she still wanted to enjoy her life. Zaria complains about her children being a barrier when she wants to have fun and drink.

> *"No, I struggle when I want to go out, to have fun and drink, the children are there, and when my mother looks after the children for me, I must pay her R50 per child for the night. So, never! I do not want other children."(Female, age 30, Zaria)*

Alcohol use is likely to lead to risky behaviours which increases the risk of engaging in unprotected sex and experiencing an unplanned pregnancy or contracting STIs.

4.4.2 Need for access to information and communication

Communication is vital for young people to make informed decisions regarding their life and health. Three participants felt comfortable speaking to health providers because they felt that they would not listen and advise only but will also provide the necessary help for their SRH related issue. One of them says that:

> *"They are in the health department so they will give me the help I need, unlike when I tell someone at home. After I tell them they will say I must go to the clinic to get help." (Female, age 28, Cameroon)*

As much as barriers and hindrances prevent access to health services, health providers are and should be the most informed about SRH services. One male participant mentioned that he was comfortable discussing his SRH problems with his mother merely because she was a health provider and is well informed about health issues. He reported that:

> *"My mom used to work in the health department, so she is understanding and advises me on these things. She made me trust her and made me believe that I can talk to her about anything regarding these sexual things."(Male, age 29, Rio)*

This participant's mother used her experience as a healthcare provider to her advantage and built a close and trustworthy relationship with her son. This shows the importance of being knowledgeable about such matters as a parent so that it would be easier to pass on reliable information to children. The participants point out that they would feel most comfortable with

health providers with a range of characteristics, including those that are not-judgmental, friendly, respectful, assuring them of privacy and confidentiality, and trustworthy. Even though health providers can also counsel, less than half of the participants trusted them enough to confide in them. However, as mentioned by most of the participants the health providers in the clinic may be lacking the qualities required to make young people feel comfortable.

4.5 Factors leading to pregnancy

4.5.1 Contraceptive failure

When participants with children were asked if they had planned on having children, most of them said they did not intend to and that it was just a consequence of unsafe sex sometimes rising from poor access to contaceptives or poor contraceptive information in addition to contraceptive failure. One of the participants reported using contraceptives to prevent unplanned pregnancy, but unfortunately, she did fall pregnant. She explains that:

> *"None of the children were planned. I fell pregnant with the second child while I had a loop (IUD), and with the third one, I was on contraceptive pills. With the first child, I was still young I was not on any family planning method, now I do not know what to do since these methods do not work on me."(Female, age 27, Tokyo)*

From the participant's response it was clear that after she had the first child, she learned from her mistake and opted for contraceptives to help her prevent pregnancy. However, she fell pregnant twice while using contraceptives. The participant expressed feelings of hopelessness regarding contraceptives since she had tried both long and short-term methods, but they were not effective. However, factors contributing to unplanned pregnancy are not limited to contraceptive failure but also unavailability of preferred contraceptives, and discontinuation of the method also play a role in contributing to pregnancy.

4.5.2 Contraceptive availability

There are many contraceptives available for men and women to prevent STIs, and prevent or delay pregnancy. However, according to the participants, the methods available at health facilities are limited. The local health facilities only offer condoms to men to prevent both pregnancies and STIs, including HIV. There are a range of contraceptive methods for women but sometimes there is a problem of supply. Condoms, injectable, implants, and pills were the

most common contraceptives mentioned by participants. Women often face challenges when accessing methods, and one participant explained that:

> *"I asked the nurse the difference between contraceptives, but she looked as if she did not want to explain and seemed as if she had personal problems. I ended up taking the pills because I had no choice despite not given an informed chance to choose." (Female, age 27, Tokyo)*

At times, health providers do not provide adequate information about the different contraceptive methods, usage, and side effects to help participants make informed choices. In this case, the participant felt the pressure of having no choice and decided to take the available method (pill) without the necessary information. Females may feel the pressure to use any method available to them to avoid getting pregnant; however, others just choose to discontinue the method.

4.5.3 Contraceptive discontinuation

Some women discontinue the use of contraceptive methods for various reasons. Generally, when women discontinue contraceptives there is an underlying factor leading to that reason. For some people, experiencing side effects may lead to the decision to stop using the method. One of the participants' reasons for contraceptive discontinuation was the type of method used and the side effects. One participant mentioned that:

> *"I used depo Provera (a 3-month injection) …Yes, I lost weight, and there was a time where I never had my periods for three years, and then after that, I went non-stop for three months. So that is when I was forced to go to the doctor because I was running out of blood and the doctor advised me to stop, then I did."(Female, age 26, Sierra Leone)*

> *"I now use condoms, and I also have pills to clean my womb if I had unprotected sex." (Female, age 26, Sierra Leone).*

The information reported by the participant suggests that as much as contraceptives have significant benefits, they do pose dangers. The side effects of contraceptives instil fear among those with limited information about the different types of contraceptives. Some participants mentioned that they suffered some weight loss due to the contraceptive method. One participant

revealed that her periods stopped for three years and then began again continuously. Due to the extreme side effects caused by the contraceptive method used, the participant chose to discontinue the method and depend on condoms. Furthermore, the participant also spoke about certain pills she uses to clean her womb after having sex without the protection and those pills are not contraceptive pills.

The injectable contraception mentioned above is not the only contraceptive associated with excessive bleeding, which is one of the side effects discouraging women from using it. The implant also has similar side effects. The participant stated that:

> *"I used an implant...I usually had my periods for four days a month on my normal cycle, but when I first had the implant, I bled for four months non-stop. Non-stop every day, and if it is not blood coming out, it would be this smelly brownish discharge; I even did not know how I was going to do things with my boyfriend."(Female, age 24, Libya)*

The side effects caused by contraceptives scare those who are considering using the method and those who are currently using them. One of the participants mentioned that healthcare providers do not provide any information on contraceptives or explain much, which contributes to discontinuation of contraception and the risk of falling pregnant. Moreover, if the providers described the use, side effects, and what to expect from the chosen contraceptive method, participants would have known that they can change to another method rather than discontinue if they were to encounter challenges.

4.7 HIV and STI experiences

4.7.1 HIV voluntary counseling and testing

It is necessary for everyone to get tested and know their status, but it is a responsibility that requires voluntary action. People get tested for HIV for various reasons of which most of the time it is done voluntarily. The carelessness of people having unprotected sexual intercourse contributes to elevated levels of HIV infection. Some participants mentioned that the lack of trust in their partner and non-use of condoms was the primary reason for them testing.

> *"I had unprotected sex, so I wanted to know if I am safe because these guys can never be trusted."(Female, age 24, Nairobi)*

"I sometimes do not use a condom. I need to know if I am still okay, so when things go wrong, then I would start treatment as soon as possible."(Female, age 28, Cameroon)

"I do an HIV test when I find out that my partner is cheating."(Female, age 27, Tokyo)

The participants acknowledged that testing was about knowing their status. They knew what the outcome of unprotected sex could be, and despite not trusting their sexual partners, they still did not practice safer sex. Two participants spoke of the importance of knowing their status which will enable them to start treatment soon after testing if they are positive. However, they fail to use condoms consistently.

Some participants went for testing because they were sick, and the health providers needed to know their HIV status first before proceeding. Also, health providers do an HIV test when one has a STI to check and monitor the risk of HIV infection. The participants reported that:

"I expected to be HIV positive and to get help. I was shocked when I found that I am negative, but I guess my sickness was nothing sexually related."(Male, age 29, Rio)

"I was sick, and they said I must test before they check what was wrong with me." (Female, age 30, Zaria)

"I had an STI."(Male, age 24, Chad)

One of the above participants expected to test HIV positive when he was sick. These expectations may have risen from the kind of sickness that he had experienced and his engagement in unsafe sexual practices. Some participants had to do an HIV test because it was a new clinic procedure that everyone had to follow when coming for contraceptives or when pregnant. Participants reported that:

"There is a new procedure that each time you go for contraceptives you test first and when you are found positive you start with the treatment right away."(Female, age 27, Tokyo)

"At first, it was just my friends and I after we spoke and encouraged each other. The second time was after my baby mama found out she was pregnant and tested at the clinic. She said I must test as well."(Male, age 22, Niger)

The new testing procedure may have negative and positive outcomes. Some patients are encouraged to know their status whereas others are discouraged from taking contraceptives because they have to test before receiving any method. Testing the father of the child when a woman is pregnant is very important, especially if they are still in a relationship, as it might put the child at risk of becoming infected if both parents do not know their statuses or if the father were to infect the mother because he is unaware that he is sick. Therefore, doing an HIV or STI test is very important so that treatment can begin as soon as possible.

4.7.2 STIs and HIV treatment

Having an STI or rather HIV and going for treatment is not an issue as it shows bravery that one can acknowledge this and seek help. The challenge begins when patients receive unsatisfactory treatment, which makes them feel ashamed. People do not realize that their behaviour of judging, stigmatizing, and ill-treating HIV patients, or people with STIs have harmful consequences.

> *"The treatment helped cure the STI, but the shouting and insults from the nurses do not help. So, if I happen to have the same STI again, I will not go back."(Male, age 24, Chad)*

> *"The time I went to the clinic, the nurse once told me that it is important that the man gets treated as well when a female is found with an STI because if the man does not, he will keep re-infecting the woman."(Female, age 24, Nairobi)*

Chad indicates that he was not treated with respect by the health provider, which made him conclude that he would not come back to the facility if he were to have the same problem. On the contrary, the other participant was attended to professionally by the health provider, who provided treatment and advice to prevent the same problem from occurring in the future. This is evidence that some providers do their job well and provide a safe space for the patients visiting the facility.

4.8 Factors inhibiting the use of SRH services

4.8.1 Challenges getting information or assistance

Challenges accessing SRH health information or assistance has been a global concern for some time, especially in disadvantaged areas. The participants' challenges of accessing their nearest

facility, services, and information were not personal (i.e., distance, money, fear, or partner refusal), but they were mostly challenges that originated because of health providers and the facility. One participant stated that:

> *"I had a sexually related problem because something grew in my vagina, I do not know the name, even on the card the handwriting was unclear, and the nurses just do not say."(Female, age 24, Nairobi)*

This participant had a vaginal growth, and the healthcare provider did not explain any details to her about it. When one visits a health facility, they should be correctly diagnosed and then given appropriate information and treatment for the illness. When a health provider offers information on treatment and prevention to the patient, it benefits the patient. It helps save the health providers' time, as the patient would not come back for the same problem that could be prevented in the future. Another participant explains that:

> *"I asked the nurse what the difference between all contraceptives is, but she looked as if she did not want to explain and seemed as if she had personal problems. I ended up taking the pills because I had no choice despite not given an informed chance to choose."(Female, age 27, Tokyo)*

It is within a patient's right to be given information on how to use the service and essentially be given a chance to choose service or treatment (HPCSA, 2008). Here, the participant's rights were violated which is the right to information and the right to make an informed choice. The health provider, in this case, did not follow the health service protocol.

4.8.2 Denied services

None of the patients thought they would be denied access to service or treatment when they go to a healthcare facility since it is in their right to access them. According to the National Patients' Rights Charter by the Health Professions Council of South Africa (HPCSA, 2008, p. 5), everyone has the right to access healthcare, including treatment, rehabilitation, counselling etc. Some participants find themselves in situations where they were deprived of this right to services on their arrival at the health facility. Some of the participants complained that they were denied access to services.

"The other nurse said they deal with emergency cases and that the nurse that said I must come back did not say I must come at night. Therefore, she sent me back home even after explaining that I work during the day."(Female, age 24, Nairobi)

The health facility should be accommodative of everyone and consider all in need. The nurse could have given the participant help and advised her not to return at night instead of denying her the service. Some patients work during the day which means they also should receive service even when their cases are not considered an emergency. This information raises questions like "what is the role of these health providers in the community if patients are denied the help they need?"

4.8.3 Mistreatment of patients by staff

Those who cannot afford private healthcare facilities have no other choice but to settle for whatever treatment they get from health providers. Even if in the process of getting help, they feel dehumanized, discriminated upon, and ill-treated. The participants mentioned several forms of poor treatment by health providers. The participants said that:

"This other time, the community was once striking against the maltreatment of patients in the clinic by the staff and not doing their job. So out of all that, I think the health department is negligent."(Female, age 24, Nairobi)

"The complaint boxes that are put there are useless because the nurses themselves remove and destroy the complaints before they even reach the right people. In the clinic, when they know their head of department is coming, they work, and the pace is fast, and you see that all the other days, they are just abusing the sick."(Female, age 26, Sierra Leone)

Participants feel that even the Department of Health is failing them and not taking their complaints seriously even after resorting to protest action. Additionally, the health providers are portrayed as people who seem to acknowledge that the ill-treatment is wrong since they do not behave the same way when one of the superiors come to monitor and check the facility operations. This behaviour may be deceiving to the health department personnel, resulting in them not attending to any matters. Others say:

"There was a person behind me in a stretcher who came with the ambulance which was not attended to and ended up dying."(Female, age 25, Tanzania)

"Sometimes people even die there because of their negligence and carelessness." (Female, age 30, Zaria)

"Another thing is that they do not like their jobs, you would be sitting on a bench for long hours, and when people die, they start asking why people did not say the deceased was critical, like as if a person would just visit the clinic for fun." (Female, age 26, Sierra Leone)

Usually, when a person is brought by an ambulance to the health facility, they need urgent help, and from the participants observation, that was not the case. A participant reported that a patient had died while waiting in the queue to get help, and this shows how negligent and careless health providers can be, as one of the participants had suggested. Another participant also commented on the death of patients in the health facility, and health providers were complaining and blaming the other patients for not reporting to them when the patient is terminally ill. This type of behaviour from health professionals is unacceptable since every patient at the facility deserves to be attended to and given the help needed.

The death of a patient in the health facility due to staff carelessness and negligence is unethical. Many nurses in the health facility appear as individuals who do not value their jobs or even care about people's lives. The way they treat patients needs more scrutiny, and necessary measures need to be taken to keep the health facility safe for patients. Participants also complained about stigma towards STI and AIDS patients.

"I think one of my major concerns is a stigma towards HIV treatment and prevention." (Male, age 27, Morocco)

"So, when you go there, you are more likely to be told how stupid and careless you are. The treatment helps cure the STI, but the shouting and insults from the nurses do not help. So, if I happen to have the same STI again, I will not go back"(Male, age 24, Chad)

Lack of information often drive stigma, usually where people react negatively to things, they are not aware of and feel threatened by. According to the participants' report, they are not treated appropriately in the healthcare facility and treatment of HIV patients is particularly disturbing because of the stigma attached to them. People living with HIV do not feel

welcomed at the health facility. Furthermore, the rudeness of health providers is a major constraint to the use of services. These types of behaviours result in patients becoming scared, and they refuse to return to the facility.

> *"The type of counselling is not the one I hoped for because the nurse was just lecturing me because she mentioned things like 'you young people do not take care of yourselves, you are becoming sexual predators, what are you going to do if you find out that you are positive'"(Male, age 22, Niger)*

This participant is concerned that the counselling session turned into a judgmental lecture from the health provider. Health providers should know that young people become sexually active from a young age, and all they need is guidance, accurate information, and encouragement to practise safe sex to prevent diseases. When they are shouted at and judged by providers, they get scared and avoid seeking help.

However, one of the main points that the participants highlighted about the healthcare providers' mistreatment was the need for healthcare providers to assume a professional role. This was a focal point for almost all the participants, and examples of some of their responses included:

> *"Maybe educate the current nurses to separate their parenthood from work, when at work they should assume a work responsibility and not be a parent to younger patients" (Male, age 22, Niger)*

> *"Their moral values do not matter, and what they believe in, it is not like they should be robots, but they should mind their own business and do their job"(Male, age 24, Chad)*

> *"There is a need for major improvement in terms of nurses' professionalism, loving their work because it seems as if they chose a nursing career for money and not because of their passion for it."(Female, age 24, Nairobi)*

Participants emphasized the need for healthcare providers to be professionals who prioritize their role. It is suggested that healthcare providers often assume a parental role whereas they should be objective. Their job is solely to help those in need without judging or discriminating

regardless of their own beliefs. They should not deter patients, especially young people who often visit health facilities out of desperation. They should not be exposed to judgments, stigmas, and discrimination.

4.8.4 Privacy and confidentiality

When people find themselves in situations where they contract sexually related diseases or infections, it raises concern and they become anxious. When they finally decide to seek help at health facilities, they expect to receive treatment for their illness.

> *"They [SRH facilities] are very men-cantered; men are given the privilege of privacy which women do not have. For example, when we go to test for STIs, we do not urinate in those glasses, which are dehumanizing for women since they must walk in front of everyone with that from the toilet to the nurse."(Male, age 24, Chad)*

Privacy is a primary concern, especially for women. One participant says that there are no measures to protect the dignity of women. Their right to privacy is violated, especially for those ordered to give urine samples, as everyone can see and could easily assume why this was requested.

It is within every patient's right when attending any health facility for their privacy and confidentiality to be assured. Though this is important and is known by any health providers however, there are some hindrances that prevent the fulfilment of these patients' needs, such as the facility not having enough private rooms. Below the study, participants explain their experiences and the issues they faced regarding privacy and confidentiality.

> *"The problem is all of the people coming for the injection a nurse would just call them all in one room and inject them one by one in front of one another"(Female, age 27, Tokyo)*

> *"They even announce in the waiting room with everyone present that those who came for this type of contraceptive we do not have it, go and come back some other time. Whereas clinics and nurses should protect a person's privacy at all times"(Female, age 26, Sierra Leone)*

These two participants' experiences show that the health providers breached their privacy and confidentiality at the health facility. Even though patients come for the same service at the clinic, it does not make it suitable for the health provider to serve them in one room simultaneously, as each one of them should be treated in private. In the second incident, the participant stated that the health provider announced in front of everyone in the waiting room when they ran out of a particular type of contraceptive, violating their right to confidentiality. Those who did not want people to know or see them coming for contraceptives were now exposed. This might have raised stigma and judgment towards those portrayed as too young to be engaging in sexual activity and using contraceptives.

> *"The nurses shout at us for no reason, there is no privacy involved. You try telling a nurse what is wrong, and she just yells for everyone to hear."(Male, age 28, Benin)*

> *"You see, the nurses are very rude at the clinic, so if you try to whisper your problem to them so that people will not hear because they do not have offices, they just bluntly say it out loud."(Male, age 23, Moscow)*

This concern illustrated by these two participants shows the ill-treatment and rudeness of health providers, which violates privacy. The fact that two different people spoke about the same problem shows that it was a common occurrence. As much as health facilities have a shortage of consultation rooms, they must try to maintain confidential and private service delivery with every patient that they see.

> *"Their queues separate people and through this people are exposed to stigma and judgement, for example when you are seen in an HIV queue everyone will know that you have it." (Male, age 23, Moscow)*

> *"Everyone sees and assumes that now that you are going to the VCT (voluntary counselling and testing) section, it means you are sick and collecting your treatment." (Female, age 26, Sierra Leone)*

One of the most stigmatized and judged diseases is HIV and AIDS, which is a concern for many people. Participants expressed concerns regarding the exposure of HIV patients at the healthcare facility. Their status is now revealed because they have joined a certain queue. If

everyone seeking SRH services are placed in the same queue, then this might eliminate the assumptions that people make about patients standing in those queues. Public healthcare facilities usually operate under strenuous conditions where they do not have enough resources to help the patients seeking services in the facility.

4.8.5 Lack of resources at the facility

There are issues that patients encounter beyond those experienced because of health providers. It is most common in public facilities and usually in informal settlements like townships and rural areas. The study participants mentioned the issues they faced in the facility that are resource-based.

> *"The last time I went, I had a problem. I kept going, and they would say they do not have contraceptive pills, so I was then forced to opt for the injection."(Female, age 27, Tokyo)*

Contraceptive methods are essential to every female who wants to stop or delay childbearing, therefore going to the health facility and finding out that the methods are unavailable might be discouraging. One participant spoke about returning to the health facility a couple of times to check if the contraceptive pills that she was using were available. It was not available at the health facility and therefore she had to use the injection. Since she did not want to have an unplanned pregnancy, she had no other choice but to take a contraceptive that was available during her visit to the health facility. Other participants reported that:

> *"If you come for the flu, they say there is no medication, go buy this and that and so you end up giving up and leaving without even getting the medication."(Female, age 26, Sierra Leone)*

> *"The treatment at times is just not there, and after waiting in the queue for a very long time, they tell you they do not have treatment."(Male, age 27, Morocco)*

When patients are sick and go to the health facility, they expect to be given help and treatment for the illness that they have, but upon arrival at the facility, they find out that there is no treatment. After waiting in long queues some patients are told that treatment or medication that they need is not available which is discouraging. Some patients cannot afford any other options

however, they are still given a list of medication that they can purchase to treat their symptoms because the facility does not have any supplies to distribute.

4.9 Summary

In this chapter, the main findings from the interviews are presented, which revealed the perceptions and experiences of SRH services of youth in Lindelani Township. The average age of all the participants was 26 years for both males and females combined. The results suggest that female participants had more experience visiting SRH facilities while male participants felt that not many services are offered to them in the health facility. There seems to be a contradiction between the types of service the participants expected to receive in comparison to what they received. The results indicate that a common barrier to accessing the facility's SRH services was the health providers and their negative attitudes. Thus, negative experiences meant that participants were not willing to return.

The findings also indicate that there is still a significant need for comprehensive information, youth-friendly services, and accessibility to a range of contraceptive methods. Participants complained about spending long hours in the facility, short-staffed facilities, and the need for younger providers with whom they can comfortably discuss their SRH issues. Participants were also engaged in risky behaviours. Inconsistent condom use and discontinuation of family planning methods were reported, putting the participants at risk of contracting HIV, STIs, and experiencing an unplanned pregnancy.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

5.1 Introduction

SRH issues resulting from risky behaviours lead to higher HIV prevalence rates, unplanned pregnancies, and unsafe abortions among adolescents and youth, and this has been a burden globally, especially in underdeveloped and developing countries. Due to these problems, adolescent youth-friendly services are meant to reduce service delivery barriers by accommodating young people or providing education and counselling materials to youth (Thatte et al., 2016). However, only a few health facilities cater to the youth with little to no barriers. Other facilities do not provide youth-friendly services due to various reasons, which in turn minimize service utilization. The study explored the perspectives and experiences of youth of SRH services in Lindelani Township. This chapter is a discussion of the main findings from the interviews. It also presents recommendations based on the findings of the study.

5.2 Discussion

The study was conducted in the participant's preferred location where they were comfortable enough to give out detailed information on their experiences. They identified several barriers they encounter when accessing SRH services in their nearest health facility. Like other disadvantaged communities, Lindelani youth also experience challenges with service delivery from their health facility and a lack of youth-friendly services. Adolescent sexual and reproductive health (ASRH) has been overlooked historically despite the high risks' countries face. Large numbers of adolescents and youth across the world engage in unprotected sexual activity and thereafter face the consequences. The consequences faced include unintended pregnancy, unmet need for contraception and unsafe abortion, school drop-out, vulnerability to GBV, exploitation, pregnancy-related mortality and morbidity, and high rates of HIV and other STIs (Hindin and Fatusi, 2009; Low, 2009; Mbizvo and Zaidi, 2010; Svanemyr et al., 2015; Chandra-Mouli et al., 2014; Morris and Rushwan, 2015). These challenges are recurring, and females face more difficulties or suffer the most compared to males.

The male participants encountered challenges with HIV and STIs, while females mentioned challenges central to pregnancy and contraceptives. The interviews revealed that young people engage in risky sexual behaviour which increases their risk of developing these SRH challenges. Most participants in the study engaged in risky sexual behaviours where they had

experiences with multiple sexual partners and did not use condoms consistently. Even with the availability of free condoms in facilities, the use is still inconsistent. According to Thatte et al. (2016), there is less than 50% of young people that are correctly and consistently using condoms globally. The non-use or inconsistent use of condoms during any sexual encounter results from negative attitudes about safe sexual practices, leading to adverse SRH outcomes.

Moreover, in his theory explanation, Fisher (1997) outlined that individuals with positive attitudes about consistent and safe sex practice, who receive social support for these behaviours from others and who assume he or she can carry out these behaviours effectively, will likely take consistent HIV preventive actions. From what the participants have revealed, it seems like risky sexual behaviour is the norm among youth in this township, and it appears complex for them to control their behaviour, thus showing weak intentions towards performing action perceived as reducing risk like consistent, safe sexual practices and detachment from risky behaviours. According to Bhana et al, (2019, p. 362) it is argued that "most education interventions continue to emphasise 'risk' over 'desire' and 'shame' over 'pleasure'. Thus, they run the risk of speaking to no-one: not to the adults who have failed to escape these constraints, nor to the young people whose bodies and experiences tell them differently." This has been the constraint between successfully intervening and trying to reduce the risky behaviours faced by young people when it comes to SRH issues. As much as many intervention programmes have been around yet little change has occurred thus far, is because the approach on the issues is not entirely wrong but could be done differently.

The study participants did not receive comprehensive sexuality education since they reported that health providers do not communicate with them adequately. Contrary to the study results, Kaidbey and Engelman (2017) suggested that exposure to sexuality education contributes to a decline in risky behaviour, delays in sexual debut, reduces the number of sexual partners, and increases condom and contraception use. However, most of the study participants mentioned the opposite. It was uncomfortable for them to speak to health providers since they did not have enough time to provide them with relevant information. The age difference restricted them from freely asking for information. Robinson et al. (2017) supports the study findings by suggesting that the barriers youth encounter make it difficult for them to communicate with adults; therefore, these conversations are avoided. Additionally, one of the study participants mentioned that due to fear of what the health providers might say, they lie about their primary reason for visiting the facility. The belief among the elderly that young people should not be

having sex before marriage, leads to negative attitudes towards those engaging in such activities, and as a result their intention of disclosing that to elderly providers becomes hard or impossible.

When such discussions are off-limits, it becomes difficult for youth to seek advice from health providers even though they are experts in the field of SRH. For example, for contraceptives to be considered adequate or to measure better use, young people need to be taught how to use them correctly and consistently. Nevertheless, as evidenced by the study, this was not the case; that is, the study participants mentioned that the healthcare providers in their facility did not give them comprehensive information about contraceptives to make an informed choice. In such situations, young people often rely on the information they get from peers, which is sometime inaccurate and misunderstood. Alomair et al. (2020) also supported this, highlighting that misunderstandings about the side effects and usefulness of family planning methods significantly impact the consistency of use among women. Consequently, some study participants reported discontinuation of the contraceptive methods due to excessive side effects, which puts them in health risks and experiencing an unplanned pregnancy.

Many women in the study who are using or have once used modern contraceptives have experienced different types of side effects where some are manageable, but some are severe. A survey conducted by Farmer et al. (2015) reveals that a range of side effects experienced by participants was related to the hormonal contraceptive methods, which resulted in excessive bleeding, losing, and gaining weight, headaches, and backaches, no longer have periods, and vaginal dryness. As much as contraceptives are beneficial to women, the side effects often lead to inconsistent use or discontinuation. Contraceptives discontinuation was identified in the study where participants stated their reasons being related to side effects experienced.

Other than side effects and contraceptive discontinuation, other female participants highlighted the shortage of contraceptives during their frequent visits to the facility. One of participants said she was given an alternative method without an explanation on how this method was differenct from her primary method. She further stated that there was no freedom of choice of method. Often, patients who needed the contraceptive injection were placed in the same room and given the injection at the same time, hence violating patient privacy. In line with the findings of this study, Woog et al. (2015) states that in some cases, even if the health facilities exist, there is not enough trained staff to provide the needed services and the supply of

medication and contraceptives are often lacking. The participants of this study also felt that health providers still need more training. More trained individuals are required to ease the workload, and more resources are required to improve service delivery.

This suggests that there is still a need for comprehensive SRH information and service in some health facilities worldwide (WHO, 2015). Some of these services were available at the participants' nearest health facility; however, participants complained about the unfriendliness of the health providers. This was not what participants expected and that made their visits to the facility uncomfortable. Other studies also stated that unfriendly behaviour from health care providers attending to pregnant adolescents had been found in many countries, yet all adolescents need access to quality youth-friendly services provided by clinicians trained to work with this population (Bearinger et al., 2007; Maharjan et al., 2019). Participants encountered challenges regarding the friendliness of the health facility and not being treated with respect by the providers and they reported that this influenced their utilization of services in the facility and the challenges resulted in high possibility of them actually utilising it, hence they opted to visit other facilities.

Other study participants reported unprofessionalism and non-integration of services in the facility that they consider unfriendly to them. They complained that separating HIV-related services from other SRH services creates stigma and they receive judgments from other people and therefore they become hesitant to seek services, even if it is just HIV testing. As explained by Dapaah et al. (2015), the strength of youth-friendly services is its ability to positively attract youth to come in large numbers to a space that is safe, non-discriminatory, and empathetic. On the contrary, the participants reported that the health facility in the Lindelani area did not positively attract them. Those who sought help there did not have any other options, and the treatment received was not welcoming. Participants shared more complaints and concerns regarding the service in the facility than satisfaction. According to Nkosi et al. (2019, p. 1), "young people's life context and their relationships with healthcare providers shape their health seeking behaviours and the extent to which they prioritise their health." Whether they access the health care facilities even if it is in their favour but if the relationship with the health provider is unfavourable their chances of prioritizing their health becomes jeopardized. Moreover, many participants reported ill-treatment by the health providers at the facility and no interest in going back to the facility seeking SRH services.

One of the study participants mentioned that they experienced contraceptive failure, and as a result, they voluntarily used natural methods to prevent an unplanned pregnancy. However, the findings are different from a study conducted in Rwanda by Farmer et al. (2015), who suggests the use of natural family planning methods as alternatives because of religious beliefs which prohibited modern contraception. As much as traditional or natural methods have no side effects and have no financial implications, they are unreliable. Nacosa (2018) reported that the critical first step in reducing the teenage pregnancy rate would be meeting their need to access easy-going, youth-friendly information on SRH, including modern contraception methods. Contraceptives prevent unplanned pregnancy, but contraceptives like condoms also help prevent the spread of STIs and HIV, but barriers always hinder full access to these services.

Some study participants were unhappy with the treatment they received from health providers when they needed treatment for an infection. Unemo et al. (2017) outlined the complications of curable STIs, mentioning that they increase the infectiousness and susceptibility to HIV. Thus, this is the type of information that study participants required so that they can protect themselves. Almost all the study participants tested for HIV, and their experiences of counselling differed where some were satisfied whereas others were not. The participants go for regular HIV tests however, they also reported inconsistent condom use and some had multiple partners. Mohlabane et al. (2016) stated that HIV counselling and testing (HCT) enables people who find themselves positive to start treatment early, reduce the risk of further transmission of the virus, and encourage those who test negative to practice safe sex to maintain their negative status. The majority of participants had regular HIV tests but still did not practice safe sex to maintain their negative status. Likewise, this diminishes the purpose of testing since their behaviour puts them at a greater risk of becoming exposed to sexual infections.

Furthermore, Ajzen (2002), in the theory of planned behaviour, speaks of a given degree of actual control over behaviour; however, the study participants' intention of safe sex was not necessary even though they had complete control over action to protect themselves from HIV, STIs and unplanned pregnancy. Many barriers that young people face when accessing SRH services and almost all of the ones reported in the study are health provider related. Providers in the health facility showed little to no care for the patients, especially the younger patients. Participants felt like the providers take on a parent role and do not respect their privacy and confidentiality. These findings are supported by other studies that highlight young people's SRH needs being underserved where lack of privacy and confidentiality leads to negative

emotions and jeopardizes their satisfaction and likelihood of returning to the facility (Cassidy et al., 2018; Odo et al., 2018). This kind of treatment in the health facility entails that patients feel unwelcomed and thus reduces the number of young people accessing the services' available at facilities.

5.3 Recommendations

Adolescent and youth's SRH remains a public health concern and priority. There is a need to train health care providers to provide integrated youth friendly SRH services and meet the youth's needs, thus creating a harmonious relationship. According to Woog et al. (2015), one approach is to integrate and link HIV and STI services with other reproductive health services. This can be achieved by implementing health provider training, where they are trained to provide comprehensive SRH services so that there would not be a need for separate queues. This will help promote patient privacy and confidentiality of service during their visit to the health facility. As a result, many youth and other patients will visit the clinic more frequently when they are not concerned about others knowing the reason for their visit.

An important finding that has emerged from the study is the need to have a variety of sexual and reproductive services combined with information and education to guide the sexual choices of young people. In support of the above statement, Woog et al. (2015, p.17) stated that "efforts to increase knowledge that condom use is an effective method for preventing STIs are critical to HIV prevention". Furthermore, this opportunity can be used to train health providers to stop stigmatizing, judging, and discriminating against youth seeking SRH services as this remains a hindrance to SRH access. This can be done through regular workshops where health providers invite youth to attend and, in return, receive comprehensive SRH information, which will encourage youth to attend health facilities more regularly and practice safe sexual practices.

Furthermore, schools and clinics should also provide information, education, and counselling to adolescents regarding growth and development, and maturation. As such, adolescents will be knowledgeable about sexual health and hence make informed choices. Good quality sexuality education can be a vital resource to provide young people with knowledge and information to address sexual and reproductive health and to prevent adverse social, health and educational outcomes (Bhana et al., 2019). Furthermore, it is essential to promote awareness of the importance of early access to SRH services through appropriate community forums.

Behaviour change interventions such as abstinence and condom use should be emphasized. These interventions can then assist in preventing the youth from contracting STIs and HIV and AIDS thus leading to a healthy generation.

Lastly, the government should always make sure that every health facility is well-equipped. There should be adequate resources to provide continuation for service provision and attend to the needs of every patient. One of the reasons discouraging youth from going to a health facility is the ongoing shortage of resources. Additionally, health providers should be sent for frequent training to keep them updated on information about the SRH services, new initiatives, and improved service provision. This will enable the creation of a welcoming and comfortable space for the youth, thus promoting youth-friendly services.

5.4 Limitations

Findings from the study should be considered in light of the several limitations. SRH is a very sensitive issue to deal with in general. One of the major hurdles was that some participants were reluctant to share all the experiences that they regard as personal information. This resulted in some participants withdrawing from the study due to discomfort from the particular questions asked during the interview. As stated in the participant's consent form as part of the ethical procedure, all participants have the right to withdraw from the study if they feel uncomfortable or do not want to participate any further. The withdrawal of participants prolonged the study as the researcher needed more time to find new participants who will replace those who withdrew during the data collection process. In some cases, the researcher found that other males opted to seek assistance in private facilities. Therefore, this automatically disqualified them from participating in the study.

Furthermore, the interviews conducted in the research excluded those who did not visit the health facility in Lindelani Township. Hence this is a problem since participants could have given reasons for non-use of the clinic's SRH services. Translating the interviews from a local language into English may have affected the integrity of the data collected. Besides, one participant was unreachable during the follow-up interviews, and their participation would have also contributed to the study. However, since the research is qualitative and not statistically representative, the researcher used the available information, which did not affect the study's overall results.

5.5 Conclusion

This study explored youth's perspectives and experiences of SRH services in Lindelani Township. Despite the limitations, the study contributes to the body of knowledge by providing an in-depth overview of the experiences of youth and their challenges which causes minimal use of SRH services. The study outlined challenges that need government attention in finding resolutions leading to better implementation of youth-friendly services, especially in disadvantaged areas like Lindelani Township. The achievement and manageability of youth-friendly services depend not just on the provision of services but also the government should make it a goal to implement programs in health facilities that include youth and health providers to create a trustworthy relationship between both stakeholders. This could result in a lower disease burden, like HIV reduction and a decline in risky behaviour which results in unintended pregnancy and unsafe abortion.

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APPENDIX 1: INTERVIEW GUIDE

Interview Schedule

Good day, my name is ***Nomthetho Ngcobo*** from the University of KwaZulu-Natal in the School of Built Environment and Development Studies. I would appreciate your participation in this study that I am conducting. This study aims to explore the perspectives and experiences of youth on sexual and reproductive health services/facilities. I will ask you questions about your expectations of the sexual and reproductive health services, experiences you have had when visiting these facilities, the barriers you came across when accessing these services in the facilities. The information you provide will be kept confidential. You will not be identified in any of the output that will be produced. Please note that you are free to withdraw from this survey at any point in time should you wish to do so. The interview will last approximately 20-30 minutes.

Please tell me about yourself:

1. How old are you?
2. What is your marital status?
3. What is your highest educational level?
4. Do you have children?
    - If yes, how many children do you have?
    - Do they share the same mother/father?
    - How old were you when you had your first child?
    - Was the baby planned or unplanned?
    - When you first found out that you were pregnant/ impregnated someone, how did you feel?
    - Are there any challenges you have come across because of having a child?

Now I would like to know about your knowledge and expectations on SRH services

5. What do you understand about sexual and reproductive health?
    - What are the services available?

6. Have you ever sought sexual and reproductive health services in your nearest health facility?
    - What were your expectations?
    - Were your expectations met?
    - If not, what do you think should be done differently?

Now I would like to know about your overall experiences on SRH services

7. Have you had more than one sexual partner at the same time?
8. Do you use a condom every time you engage in sexual intercourse?
    - Do you use it on every occasion (round)?
9. Researcher: Have you ever went for HIV testing?
    - What was your reason for testing?
    - Did you receive pre- and post-counselling?
10. Do you use any contraceptive method?
    - If yes, which one?
    - Do you experience any side effects due to the type of contraceptive you use?
    - If not, what do you rely on to prevent pregnancy?
11. How often do you need to visit a health facility?
    - How do you travel to a health facility?
    - How long does it take you to get to the health facility?
12. Please describe your experiences of visiting a health care facility.
    - Are you satisfied with the service and treatment you get?
    - Do you think the staff is helpful? If no, why not?

Now I would like to know about your barriers when accessing the SRH services

13. Have you encountered any challenges getting information or assistance from a health provider?
    - If yes, what were those challenges?

14. Who do you feel comfortable talking to about your sexual health problems?

- Why them?

15. What are your concerns regarding the sexual and reproductive health services in your nearest health facility?

- What do you think should be done to rectify these concerns?

16. Is there anything you do not like about the SRH facilities?

- If yes, what is it that you do not like offered by these facilities?

Now I would like to know about your overall thoughts on the SRH services

17. From your observations, who do you think visits the clinic more between the male and female youth?

- Why do you think so?

18. What do you think is the major barrier preventing youth from going to the clinic in numbers?

What do you think should be done to correct this?

APPENDIX 2: ETHICAL CLEARANCE LETTER

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

21 August 2019

Miss Nomthetho Debbie Ngcobo (213508372)
School Of Built Env & Dev Stud
Howard College

Dear Miss Ngcobo,

Protocol reference number: HSSREC/00000043/2019
Project title: Perspectives and experiences of youth in sexual and reproductive health services in Lindelani Township

Full Approval – Expedited Application

This letter serves to notify you that your application received on 07 June 2019 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**

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.

This approval is valid for one year from 21 August 2019.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

Yours sincerely,

[redacted]

Professor Urmilla Bob
University Dean of Research

/dd

APPENDIX 3: INFORMED CONSENT FORM

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Information Sheet and Consent to Participate in Research

Date: Day of 2019

Dear potential participant.

My name is Ngcobo Nomthetho Debbie, a master's student from the School of Built Environment and Development Studies (BEDS), Population Studies, at the University of KwaZulu-Natal Howard College.

You are being invited to consider participating in a study that involves research in the "Perspectives and experiences of youth of sexual and reproductive health services in Lindelani Township". The aim and purpose of this research is to explore the sexual and reproductive health services' availability, accessibility, and barriers. The study is expected to enroll 20 participants (10 males and 10 females) in Lindelani Township in Ntuzuma A. It will involve the following procedure: interviews where participants will be required to answer the research questions. The duration of your participation if you choose to enroll and remain in the study is expected to be about 20-30 minutes. The study has no funding therefore your participation will be completely voluntary.

The study may involve discomforts since some of the questions asked may be personal. We hope that the study will create the following benefits such as provision of sexual and reproductive health information to the youth of Lindelani, providing root for easy access to the SRH facilities and resolutions to the barriers preventing access to these facilities.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher by emailing 213508372@stu.ukzn.ac.za or call 0740329948 or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Your participation in this research is completely voluntary, there will be no financial benefits, and withdrawal can be done at any time due to any reason.

In the event of refusal/withdrawal from participation in the research, there will be no penalties nor consequences to the participant for withdrawal from the study.

Please note that all the information that you share during the interview will be kept confidential by the researcher and the research supervisor.

Your names and identity will remain confidential, pseudonyms (false names) will be used in research report. The interview transcripts will be stored in secure storage and destroyed after five years.

CONSENT FORM

I……have been informed about the study entitled "Youth perspectives and experiences of sexual and reproductive health services in Lindelani Township" by Nomthetho Debbie Ngcobo.

I understand the purpose and procedures of the study.
I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.
I declare that my participation in this study is entirely voluntary and that I may withdraw from the study at any time.
If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 213508372@stu.ukzn.ac.za or call 0740329948.
If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

I hereby provide consent to: Audio-record my interview YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**