



Understanding Barriers and Facilitators of Sexual and Reproductive Health services uptake among adolescent women and men in semi-rural areas in KwaZulu-Natal, South Africa: A Secondary Analysis

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DECLARATION - PLAGIARISM

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ABSTRACT

Adolescents in South Africa face persistent barriers to accessing sexual and reproductive health (SRH) services, particularly in semi-rural settings where structural limitations, social norms, and service design intersect. This study explored how adolescents in semi-rural KwaZulu-Natal experience and navigate SRH services, and how behavioural, interpersonal, and systemic factors shape their engagement with care. Guided by the COM-B behaviour change model and a healthcare decision framework, the study examined how capability, opportunity, and motivation influence adolescents' health-seeking behaviours.

A qualitative design was employed, incorporating semi-structured interviews and visual elicitation through participant drawings of preferred clinic environments. Thematic analysis identified interconnected barriers related to distance, waiting times, confidentiality concerns, and healthcare worker attitudes, alongside facilitators such as youth-friendly service days, mobile clinics, peer support, and emotionally safe interactions. Findings revealed that adolescents are not passive recipients of care but active agents who critically evaluate services, propose design improvements, and develop strategies to overcome access constraints. Structural inefficiencies were found to carry emotional consequences, often producing embarrassment, anxiety, and disengagement, while respectful communication and predictable service organisation strengthened trust and motivation to return.

The study contributes to existing literature by demonstrating that adolescent SRH access is not solely a logistical issue, but a behavioural and relational phenomenon shaped by symbolic meanings of belonging, dignity, and legitimacy. Effective service delivery, therefore, requires attention not only to infrastructure but to emotional safety, youth participation, and organisational responsiveness. The findings support policy directions that institutionalise adolescent voice in governance, expand youth-friendly service models, and integrate behavioural insights into health system design. Strengthening adolescent-responsive SRH services is essential for advancing equity, autonomy, and sustained engagement in South Africa and comparable contexts.

Keywords

Adolescent health; sexual and reproductive health; youth-friendly services; COM-B model; healthcare access; mobile clinics; behavioural health; South Africa.

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List of Abbreviations

COM-B – Capability, Opportunity, Motivation–Behaviour model

HIV – Human Immunodeficiency Virus

LMIC – Low- and Middle-Income Country

SRH – Sexual and Reproductive Health

SSA – Sub-Saharan Africa

STI – Sexually Transmitted Infection

UNFPA – United Nations Population Fund

WHO – World Health Organization

PHC- Primary Health Care

KZN- KwaZulu-Natal

Definition of Key Terms

To ensure conceptual clarity, the following section defines the key terms used throughout this dissertation. These definitions are grounded in relevant literature and contextualised according to how they apply to adolescents' access to sexual and reproductive health (SRH) services in semi-rural South African settings.

Adolescent – An adolescent refers to an individual between the ages of 10 and 19 years, a developmental stage characterised by rapid physical, emotional, and social change (World Health Organization [WHO], 2022). In this study, the term specifically refers to young people navigating access to sexual and reproductive health services within healthcare systems.

Sexual and Reproductive Health (SRH) – Sexual and reproductive health encompasses a state of physical, emotional, mental, and social well-being in relation to sexuality and reproduction, including access to contraception, HIV testing, STI management, and reproductive healthcare (WHO, 2018). Within this dissertation, SRH services refer to clinic-based and outreach services designed to support adolescents' sexual and reproductive wellbeing.

Barriers – Barriers refer to structural, interpersonal, or psychological factors that obstruct adolescents' ability or willingness to access sexual and reproductive health services. These may include long waiting times, transport costs, stigma, confidentiality concerns, and negative interactions with healthcare workers (Beksinska et al., 2020; Jonas et al., 2018). In this

dissertation and barriers are understood not only as logistical constraints but also as emotional and symbolic obstacles that discourage engagement and weaken adolescents' trust in health systems.

Facilitators – Facilitators are conditions or practices that enable adolescents to access and sustain engagement with sexual and reproductive health services. These include youth-friendly clinic organisation, mobile outreach services, respectful communication, and emotionally safe environments that affirm adolescents' dignity and autonomy (WHO, 2018; Molete et al., 2022). Within this study, facilitators are interpreted as behavioural enablers that expand adolescents' capability, opportunity, and motivation to seek care.

Youth-Friendly Health Services – Youth-friendly health services are healthcare environments designed to be accessible, acceptable, equitable, appropriate, and effective for young people. Such services emphasise confidentiality, respectful communication, and age-appropriate care (WHO, 2012). In the context of this study, youth-friendly services include structural and interpersonal adaptations that reduce barriers to adolescent access.

Healthcare Access – Healthcare access refers to the ability of individuals to obtain appropriate health services when needed, encompassing physical availability, affordability, acceptability, and quality of care (Levesque et al., 2013). In this dissertation, access is examined as a behavioural and relational process shaped by structural, social, and emotional factors.

COM-B Model – The COM-B model conceptualises behaviour as the interaction between Capability, Opportunity, and Motivation, which together influence whether a behaviour occurs (Michie et al., 2011). This framework is used in the study to analyse how adolescents' health-seeking behaviours are shaped by internal knowledge and confidence, social and environmental conditions, and emotional drivers.

Mobile Clinics – Mobile clinics refer to outreach healthcare services delivered through transportable units that bring care directly into communities, particularly in underserved or remote areas. These services are designed to improve accessibility, reduce travel burdens, and minimise stigma associated with fixed facilities (Smith & Chandra-Mouli, 2020).

Summary of Definitions and Relevance to the Dissertation

These terms establish the conceptual foundation for examining adolescents' engagement with sexual and reproductive health services. By grounding the study in clearly defined terminology and established frameworks, the dissertation situates adolescent SRH access within broader behavioural, structural, and social contexts. The definitions support a nuanced understanding of how healthcare systems can either enable or constrain adolescents' wellbeing and agency, and they frame the analysis of barriers, facilitators, and youth-centred service design throughout the study.

CHAPTER 1

1.1 INTRODUCTION

Adolescents represent a significant and growing portion of the global population, with approximately 1.2 billion people aged 10–19 worldwide (UNFPA, 2021). Despite their demographic weight and developmental significance, adolescents continue to face a disproportionate burden of negative sexual and reproductive health (SRH) outcomes. Globally, over 4 million adolescents undergo unsafe abortions annually, and nearly 16 million give birth each year, many under high-risk conditions (WHO, 2022). According to UNAIDS (2022), individuals aged 15–24 account for approximately 27% of all new HIV infections globally, with sub-Saharan Africa (SSA) carrying the highest burden.

In SSA, over 80% of HIV-positive adolescents live in this region, with adolescent girls being three times more likely than boys to acquire HIV (Kharsany & Karim, 2016). In South Africa, the statistics are no less concerning. Adolescent girls and young women (AGYW) account for the majority of new infections, and provinces such as KwaZulu-Natal (KZN) continue to report among the highest rates of HIV and unintended adolescent pregnancies nationally (Cowan & Pettifor, 2009; Melesse et al., 2020). This reality persists despite national SRH policies and increased service availability targeting youth, underscoring a troubling disconnect between policy intention and service uptake.

Adolescence is a transitional period marked by biological, emotional, and social changes, including sexual maturation, identity exploration, and increased risk-taking behaviour (Alimoradi, 2023; Ezumah et al., 2021). These factors, while developmentally normative, interact with multiple external conditions that heighten young people's vulnerability to poor SRH outcomes. Inadequate access to comprehensive sex education, cultural taboos surrounding adolescent sexuality, poverty, limited autonomy, and harmful gender norms all compound the risk, particularly for girls and young women (Janigorban et al., 2022; Melesse et al., 2020).

Although various interventions have been implemented to address these risks, such as peer-led education, digital outreach, school-based health programs, and mobile clinics, many remain inadequate in achieving lasting behavioural change (Denno et al., 2015). Educational approaches, while crucial for knowledge-building, often fail to address structural and psychosocial barriers that shape adolescents' lived experiences (Sidamo, 2024). Factors such as stigma, fear of judgment, low self-efficacy, and concerns about confidentiality continue to discourage adolescents from seeking care, particularly in under-resourced rural and semi-rural areas (Righi et al., 2019; Ayalew et al., 2022).

An emerging body of literature highlights the importance of the physical and social design of health service environments in shaping adolescents' health-seeking behaviour (Chandra-Mouli et al., 2015). Clinics that lack private consultation spaces, youth-specific service areas, or adolescent-friendly staff can inadvertently communicate exclusion, deterring young people from returning for care. Adolescents have reported feeling uncomfortable, judged, or unsafe in clinic settings that are not designed with their needs in mind (Righi et al., 2019). In contrast,

youth-friendly clinics, offering private, respectful, inclusive, and convenient services, are associated with improved service engagement and satisfaction (Yakubu & Salisu, 2018).

This study explores the barriers and facilitators to SRH service uptake among adolescents in semi-rural KwaZulu-Natal, South Africa, with a particular focus on how clinic environments and design influence their access to and use of care. By centring adolescents' voices and perceptions, the study aims to inform the development of youth-responsive SRH services that address not only knowledge gaps but also the environmental and structural conditions shaping health behaviour.

1.2 BACKGROUND OF THE STUDY

The burden of SRH-related illness and inequality among adolescents in SSA continues to raise urgent public health concerns. In Kenya, more than half of new HIV infections in 2015 occurred among individuals aged 15–24 years, with young women accounting for the majority (Cowan & Pettifor, 2009). The 2022 UNAIDS report indicated that adolescent girls and young women (AGYW) in sub-Saharan Africa are disproportionately affected by HIV, with AGYW reported to be approximately three times more likely to acquire HIV than their male peers (UNAIDS, 2022). South Africa mirrors this regional pattern, with adolescent girls in KZN particularly vulnerable due to biological susceptibility, socio-cultural constraints, and limited access to quality SRH services (Kharsany & Karim, 2016; Venketsamy & Kinnear, 2020).

Despite decades of investment in SRH programming, including the Integrated School Health Policy, Youth-Friendly Services (YFS) initiatives, and conditional grants to support adolescent health, the uptake of these services by young people remains suboptimal (Department of Health, 2012). Factors such as inadequate provider training, under-resourced facilities, and lack of adolescent-specific infrastructure contribute to the inefficiency and inaccessibility of these services (Jemmott et al., 2013). These gaps are particularly pronounced in rural and semi-rural areas, where young people must often travel long distances, face transport costs, or contend with long queues and a lack of confidentiality in clinic settings (Ayalew et al., 2022).

Moreover, adolescents in these contexts face heightened socio-cultural barriers, including stigma, judgmental attitudes from adults, and restrictive gender norms that limit young women's autonomy (Meherali, 2023; Mmari & Sabherwal, 2013). For many girls, accessing SRH services requires partner or parental approval, which may not be forthcoming. Even when services are physically available, adolescents report feeling unwelcome, disrespected, or ashamed when seeking care in clinics designed primarily for adults (Righi et al., 2019).

There is growing recognition that the design and layout of clinic environments can either facilitate or obstruct access to SRH services. Youth-friendly design includes not only private consultation areas and welcoming reception spaces but also respectful staff, dedicated adolescent hours, clear signage, and accessible information (Chandra-Mouli et al., 2015). However, in semi-rural South Africa, such design principles are often poorly implemented or entirely absent (Ayalew et al., 2022). This study investigates adolescents' lived experiences within these clinical spaces to better understand how environmental and social design influences access to SRH care.

1.3 STATEMENT OF THE PROBLEM

Adolescents in semi-rural KwaZulu-Natal continue to face disproportionately poor SRH outcomes, despite the increased availability of health services and the adoption of adolescent health policies in South Africa. Existing interventions, including education, peer outreach, and mobile health services, have helped raise awareness but have not adequately addressed persistent barriers to service uptake. These include socio-cultural constraints, economic limitations, psychological deterrents, and service-related challenges such as poor clinic design and inadequate provider sensitivity (Sidamo, 2024; Ayalew et al., 2022).

While previous research has focused on the effectiveness of educational and behaviour change strategies, fewer studies have examined how the physical and social design of clinics influences adolescents' decisions to access or avoid care. Adolescents often encounter healthcare environments that lack privacy, comfort, or a sense of safety, elements that are crucial for youth engagement (Chandra-Mouli et al., 2015). These negative experiences can lead to avoidance or disengagement, contributing to the continuation of preventable health issues.

The disconnect between service provision and adolescent perception represents a critical gap in adolescent health programming. Without understanding how young people experience and interpret clinical spaces, efforts to improve access and outcomes may remain superficial (Tylee et al., 2007). This study responds to that gap by investigating the intersection between clinic design and SRH service uptake in a semi-rural South African setting.

1.4 OBJECTIVES OF THE STUDY

Main Objective:

To explore the barriers and facilitators influencing the uptake of SRH services among adolescents in semi-rural areas of KwaZulu-Natal, with specific attention to how clinic design and service environments affect their healthcare-seeking behaviour.

Specific Objectives:

1. To identify socio-cultural, economic, and structural barriers affecting adolescents' access to SRH services.
2. To explore key facilitators that support adolescents in utilizing available SRH services.
3. To assess adolescents' perceptions of the physical and social design of clinic environments.
4. To generate evidence-based recommendations for improving youth-friendly SRH service spaces.

1.5 RESEARCH QUESTIONS

1. What are the main barriers that prevent adolescents in semi-rural KwaZulu-Natal from accessing SRH services?
2. What factors promote the uptake of SRH services among adolescents in these communities?
3. How do adolescents perceive the physical and social aspects of SRH service environments?
4. What clinic design features do adolescents consider important in facilitating SRH service use?

1.6 SIGNIFICANCE OF THE STUDY

This study advances the field of adolescent sexual and reproductive health (SRH) research by shifting its focus from individual-level interventions to the clinic environment as a critical determinant of service uptake. While prior interventions have prioritized education, peer outreach, and policy reforms, emerging evidence highlights that factors such as privacy, respectful staff behaviour, and accessible layout significantly influence adolescent engagement with SRH services (Sanyang et al., 2025). For example, qualitative synthesis across sub-Saharan Africa underscores adolescents' desire for SRH services delivered in clean, non-judgemental settings by compassionate providers, which aligns with this study's focus on physical and emotional clinic design (Sanyang et al., 2025).

Understanding how the design of clinic spaces affects adolescents' access and comfort has practical implications. Findings could guide facility upgrades, such as creating youth-friendly corners, enhancing confidentiality features, or adjusting waiting area configurations, to foster adolescent trust and increase service use. In KZN, healthcare providers have noted that adequate signage, shorter waiting times, and respectful interactions are essential to service effectiveness, reinforcing the need for design-sensitive improvements (Khuzwayo et al., 2025).

Moreover, the study provides context-specific insights that are especially relevant for provincial and national policymakers. By evidencing the value of investments in adolescent-responsive infrastructure, it supports efforts to implement or refine youth-friendly service models in line with South African health policy goals. In summary, this research not only fills a crucial gap in SRH literature, by centering clinic design, but also offers actionable guidance to improve adolescent engagement and outcomes.

1.7 SCOPE AND LIMITATIONS

This study is situated in semi-rural KwaZulu-Natal, South Africa, and focuses on adolescents aged 14–25 years. The scope is deliberately defined to investigate both perceived and actual barriers to accessing sexual and reproductive health (SRH) services, with a particular emphasis on the influence of clinic environment and design. Specifically, the study examines how features such as clinic layout, privacy, signage, waiting areas, and interpersonal dynamics within healthcare spaces shape adolescents' access to and utilization of SRH services. By concentrating on semi-rural areas, the study aims to provide insights into the intersection between adolescent SRH needs and the environmental design of healthcare services,

contributing to broader discussions on youth-friendly healthcare in resource-constrained contexts (Chandra-Mouli et al., 2015).

Despite its relevance, the study has several limitations that must be acknowledged. First, the findings may not be generalizable beyond semi-rural KwaZulu-Natal. Contextual factors such as clinic infrastructure, staffing patterns, and cultural dynamics differ significantly between rural, semi-rural, and urban settings. This limitation is closely tied to issues of external validity, as results derived from one context cannot always be applied universally (Mitchell & Jolley, 2001).

Second, the study relies heavily on self-reported data from adolescents. Although self-reports provide valuable first-hand insights into young people's experiences and perceptions, they are prone to various biases, including recall inaccuracies, exaggeration, and underreporting, particularly when sensitive issues such as sexual health are involved (Krumpal, 2013). Relatedly, social desirability bias may influence participants to provide responses that align with perceived expectations or socially acceptable norms, potentially limiting the accuracy of the data collected (Krumpal, 2013).

Third, while the study focuses on adolescents' perspectives, it does not incorporate other stakeholders, such as healthcare providers or clinic managers. The absence of triangulation with provider perspectives or observational data may reduce the robustness of findings, as adolescents' perceptions cannot be cross-validated against the experiences and constraints of those responsible for service delivery (Wamoyi et al., 2019). Finally, the findings are context- and time-specific. Changes in national health policy, improvements in clinic infrastructure, or shifts in adolescent attitudes over time may influence the applicability of results in the future.

By acknowledging these limitations, the study demonstrates transparency and academic rigor, ensuring that interpretations of findings remain grounded in the study's contextual and methodological boundaries.

1.8 ORGANISATION OF THE THESIS

This thesis is structured into six chapters. Chapter One introduces the study, outlining its rationale, objectives, and significance. Chapter Two reviews relevant literature on adolescent SRH, barriers to service uptake, and the role of clinic design. Chapter Three describes the research methodology, including the study design, setting, participants, and data collection and analysis procedures. Chapter Four presents the findings, while Chapter Five provides interpretation, discussion, and comparison with existing research. Chapter Six concludes the study and presents recommendations for policy, practice, and future research.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter critically examines existing literature on the uptake of sexual and reproductive health (SRH) services among adolescents, with a specific focus on semi-rural settings in KwaZulu-Natal, South Africa. Building on the foundation laid in Chapter One, the chapter explores how behavioural, social, and environmental factors influence adolescents' engagement with SRH services. The review is guided by the Capability, Opportunity, Motivation – Behaviour (COM-B) model, which provides a comprehensive framework for understanding the determinants of health-related behaviours (Michie et al., 2011). While numerous studies have addressed informational and psychosocial dimensions of adolescent SRH, this chapter foregrounds the role of clinic design, both physical and relational, as a critical structural determinant that can facilitate or hinder service uptake.

Adolescents experience unique vulnerabilities related to sexual and reproductive health, influenced by developmental, social, and contextual factors. Despite the existence of policies and programmes aimed at improving access to SRH services, uptake remains suboptimal, particularly in semi-rural areas where structural and environmental barriers are pronounced (Chandra-Mouli et al., 2015; Toska et al., 2017). These barriers often include long distances to clinics, limited operating hours, overcrowded facilities, and a lack of adolescent-friendly spaces, which intersect with psychosocial concerns such as stigma, fear of judgment, and confidentiality breaches. In such contexts, the environment itself becomes a key determinant of whether adolescents act on their knowledge or intentions (Reddy et al., 2021).

Although alternative behavioural frameworks such as the Health Belief Model or Theory of Planned Behaviour have been widely applied in public health research, the COM-B model is particularly suited to this study. Unlike other models that primarily focus on individual cognition and perception, COM-B integrates both internal (psychological and physical capability, motivation) and external (social and environmental opportunity) factors, providing a more holistic understanding of behaviour within complex service environments (Michie et al., 2011; Cane et al., 2012). This framework allows for a nuanced analysis of how adolescents' health-seeking behaviours are shaped not only by knowledge and attitudes but also by the structural and relational features of the clinics they access (Michie et al., 2011). By situating clinic design as an active behavioural determinant, this chapter examines how environmental modifications can enhance adolescents' capability to navigate services, increase opportunities for safe and confidential care, and reinforce motivation to engage consistently with SRH services.

Overall, this chapter situates the discussion of adolescent SRH within a behavioural and environmental lens, highlighting the importance of integrating physical, social, and policy-level interventions. By applying the COM-B model, the review provides a structured approach for understanding the interplay between adolescent agency and contextual constraints, establishing a foundation for the subsequent conceptual framework and study rationale.

2.2 DECISION FRAMEWORK LOGICAL MODEL

A decision framework logical model is a conceptual tool used to illustrate and explain the factors that influence decision-making and behaviour within a specific context. In health research, logical models are often used to demonstrate how individual, social, structural, and environmental factors interact to shape health behaviours and healthcare utilisation (Kellogg Foundation, 2004). Such frameworks are particularly useful in adolescent sexual and reproductive health (SRH) research because adolescents' healthcare-seeking decisions are influenced by multiple interconnected barriers and facilitators operating at different levels.

In this study, the decision framework logical model was used to provide a conceptual understanding of the factors influencing adolescents' engagement with SRH services and their preferences regarding adolescent-friendly clinic environments. Adolescents' healthcare-seeking decisions are shaped by multiple interacting social, structural, environmental, and individual-level factors that may either facilitate or hinder access to care (World Health Organization [WHO], 2022). The framework therefore provided a useful structure for understanding how adolescents navigate barriers and facilitators when deciding whether to access SRH services.

The framework is conceptually aligned with behavioural and socio-ecological approaches to health behaviour, particularly the Capability, Opportunity, Motivation–Behaviour (COM-B) model, which informed this study (Michie, van Stralen, & West, 2011). The COM-B model proposes that behaviour occurs through the interaction between individuals' capability, opportunity, and motivation. Within the context of adolescent SRH service access, capability refers to adolescents' knowledge, understanding, and confidence in accessing services; opportunity relates to external conditions such as clinic accessibility, transport availability, privacy, and social support; while motivation reflects attitudes, fears, beliefs, and perceptions that influence healthcare-seeking behaviour. The decision framework logical model was relevant to this study because it enabled an exploration of how structural, interpersonal, and environmental factors shaped adolescents' experiences of SRH services and informed their preferences regarding clinic design and service delivery. Previous research has demonstrated that factors such as stigma, concerns regarding confidentiality, long waiting times, inaccessible clinic environments, and negative provider attitudes significantly influence adolescents' willingness to utilise SRH services (Geary et al., 2014; Jonas et al., 2017; WHO, 2022).

The framework further supported the interpretation of adolescents' clinic design preferences by illustrating how healthcare environments can either facilitate or discourage SRH service utilisation. Through this lens, adolescents' recommendations regarding ideal clinic layouts, mobile service delivery models, and adolescent-friendly spaces were understood not merely as design preferences, but as reflections of broader needs related to safety, dignity, confidentiality, accessibility, and equitable healthcare access.

2.3 ADOLESCENCE AS A LIFE STAGE

Adolescence, defined in this study as the period between 14 and 25 years, represents a critical developmental stage characterized by rapid physical, emotional, and cognitive transformations (Ezumah et al., 2021). During this period, individuals experience profound biological changes associated with sexual maturation, including the development of secondary sexual characteristics, hormonal fluctuations, and increased reproductive capacity (Sawyer et al., 2018). These physiological shifts occur alongside cognitive developments, such as improved abstract thinking, planning, and risk assessment, which influence decision-making and behavioural patterns, including those related to sexual and reproductive health (Arnett, 2014).

This stage is also marked by identity formation, increasing autonomy from family structures, and heightened susceptibility to peer influence and societal norms (Ezumah et al., 2021; Steinberg, 2017). Adolescents actively explore and negotiate their emerging independence, often experimenting with behaviours, including sexual activity, in contexts where formal sexual education is inconsistent or absent (Ezumah et al., 2021). In many South African communities, cultural taboos and conservative attitudes toward sexuality further restrict open discussion and limit adolescents' access to reliable SRH information (Alimoradi, 2023; Mavedzenge et al., 2011). In addition to these developmental and sociocultural factors, structural inequities exacerbate vulnerabilities. Poverty, gender-based discrimination, and constrained access to youth-friendly health services create environments where adolescents are more likely to encounter adverse SRH outcomes, including unintended pregnancies, sexually transmitted infections (STIs), and HIV (UNFPA, 2021; Richter et al., 2018). Adolescents in semi-rural settings face additional challenges, such as long distances to clinics, limited transportation, and heightened visibility within close-knit communities, which can amplify stigma and inhibit service use (Reddy et al., 2021).

Given these intersecting biological, cognitive, social, and structural influences, adolescence requires interventions that are responsive to the full spectrum of developmental needs. Effective SRH programmes must not only deliver accurate knowledge but also foster skills, create supportive social and physical environments, and address motivational factors that influence health-seeking behaviour (Chandra-Mouli et al., 2015). Recognising adolescence as a distinct life stage is essential for designing interventions that align with both the capabilities and vulnerabilities of young people, particularly in semi-rural contexts where environmental and social constraints are pronounced (Chandra-Mouli et al., 2015; Toska et al., 2017).

2.4 ADVERSE SRH OUTCOMES AMONG ADOLESCENTS AND YOUNG PEOPLE (AYP)

Globally, adolescents continue to bear a disproportionate burden of poor SRH outcomes. Approximately 16 million adolescent girls give birth each year, with many pregnancies occurring in unsafe or unintended circumstances (WHO, 2022). Sub-Saharan Africa (SSA) remains the epicentre of this crisis, with adolescent girls and young women (AGYW) accounting for a significant share of new HIV infections (WHO, 2022). In South Africa, particularly in KwaZulu-Natal, AGYW are up to three times more likely than their male peers to contract HIV (Kharsany & Karim, 2016). Unintended pregnancies, unsafe abortions, and sexually transmitted infections (STIs) remain prevalent despite the existence of comprehensive

SRH policies. These adverse outcomes are underpinned by structural factors including gender-based violence, socioeconomic marginalisation, and an unwelcoming health system (Melesse et al., 2020).

2.5 SRH SERVICE PROVISION FOR AYP

2.5.1 IMPROVEMENTS IN ACCESS

South Africa has implemented a range of interventions aimed at improving adolescents' access to sexual and reproductive health (SRH) services, reflecting a policy commitment to youth-friendly care. Key initiatives include the Integrated School Health Policy, which integrates health education and service delivery within the school environment, the Youth-Friendly Services (YFS) programme, which seeks to create welcoming clinic spaces and train health providers in adolescent-sensitive care, and mobile outreach clinics that bring services closer to geographically isolated communities (Department of Health, 2012; Reddy et al., 2021). These interventions aim to reduce both structural barriers, such as transportation and clinic location, and informational barriers, including limited knowledge about contraception, HIV prevention, and available SRH services (Denno et al., 2015).

Despite these efforts, utilisation of SRH services by adolescents remains uneven. Studies indicate that while many adolescents are aware of where to access services, psychological and social barriers often prevent them from acting on this knowledge (Ayalew et al., 2022; Chandra-Mouli et al., 2015). Fear of stigma, anticipated judgment by clinic staff, and concerns over confidentiality are particularly salient in smaller or semi-rural communities, where anonymity is difficult to maintain (Righi et al., 2019; Toska et al., 2017). Adolescents may avoid clinics altogether, delay care, or resort to informal and potentially unsafe sources for contraception and information, such as peers or online forums, which can perpetuate misinformation and increase risk (Usonwu et al., 2021).

Furthermore, socio-cultural norms and family attitudes towards adolescent sexuality continue to influence health-seeking behaviour. In many South African contexts, discussing sexual health is considered taboo, and adolescents, especially girls, may face censure or social repercussions for seeking SRH services (Alimoradi, 2023; Mavedzenge et al., 2011). Consequently, even well-designed programmes struggle to achieve consistent uptake, highlighting the need to complement educational and motivational interventions with structural and environmental strategies that address the broader context of service access.

2.5.2 SRH SERVICES IN SEMI-RURAL SOUTH AFRICA

Health facilities in semi-rural areas of South Africa, including KwaZulu-Natal, face persistent structural and resource constraints that limit their ability to meet adolescents' sexual and reproductive health (SRH) needs effectively (Righi et al., 2019). Clinics in these settings are often understaffed, overcrowded, and poorly equipped, resulting in prolonged waiting times and limited-service availability (Righi et al., 2019; Toska et al., 2017). The physical layout of these clinics frequently lacks private consultation rooms or dedicated adolescent spaces, forcing young people to navigate environments shared with older adults, which can provoke feelings of embarrassment, vulnerability, and exposure (Usonwu et al., 2021).

Interpersonal factors further compound these challenges. Adolescents frequently report experiences of dismissive or judgmental attitudes from healthcare providers, ranging from overt moralising to subtle discouragement (Chandra-Mouli et al., 2015; Reddy et al., 2021). Such experiences can reinforce internalised stigma around sexual activity, particularly for girls, and heighten fears about confidentiality breaches in small, close-knit communities (Usonwu et al., 2021). The combined effect of these structural and relational barriers is substantial: adolescents may delay seeking care, underutilise services, or rely on informal and potentially unsafe alternatives for contraception and sexual health information. Consequently, addressing the physical and social environment of clinics emerges as a critical intervention point for improving adolescent SRH service uptake (Chandra-Mouli et al., 2015).

2.5.3 DOMINANT MODELS OF SRH PROVISION

Current models of SRH service provision in South Africa remain largely biomedical in orientation, prioritising the availability of contraceptives, HIV testing, and clinical interventions while often neglecting the socio-behavioural and environmental contexts in which adolescents seek care (Denno et al., 2015; Chandra-Mouli et al., 2015). School-based education programmes and peer-led interventions have demonstrated potential in increasing knowledge and awareness of SRH services (Atuhaire et al., 2021; Righi et al., 2019). However, these initiatives rarely consider the clinic as an active behavioural space where physical layout, privacy, and relational dynamics interact to influence health-seeking behaviour (Atuhaire et al., 2021).

Evidence indicates that even highly informative and well-resourced programmes may fail to achieve sustained uptake if adolescents perceive the health facility as unsafe, unwelcoming, or judgmental (Chandra-Mouli et al., 2015; Reddy et al., 2021). The assumption that information alone is sufficient overlooks the critical role of opportunity and motivation, core components of the COM-B model, in driving service utilisation (Michie et al., 2011). By ignoring these dimensions, traditional SRH models may inadvertently limit adolescents' engagement, particularly in semi-rural contexts where environmental constraints and community surveillance further complicate access (Usonwu et al., 2021; Toska et al., 2017). Integrating a behavioural perspective that explicitly considers clinic design, social interactions, and adolescents' lived realities is therefore essential for improving SRH service uptake.

2.6 FACILITATORS OF SRH ACCESS AND UPTAKE

2.6.1 BEHAVIOURAL DRIVERS: A COM-B PERSPECTIVE

Facilitators of SRH service uptake among adolescents can be comprehensively understood through the lens of the COM-B model, which frames behaviour as the product of Capability, Opportunity, and Motivation (Michie et al., 2011). Each domain interacts dynamically to shape whether adolescents not only know about available SRH services but also feel able, supported, and motivated to use them.

Capability refers to both psychological and physical resources that enable adolescents to engage with SRH services. Psychological capability encompasses knowledge, awareness, and decision-making confidence, while physical capability involves skills such as communicating with health professionals or navigating clinical systems (Michie et al., 2011). School-based sexuality education programmes and peer-to-peer interventions have been shown to enhance adolescents' awareness of contraception, STI prevention, and available services (Pound et al., 2017; Napierala et al., 2018). For example, peer-led interventions in Uganda and South Africa demonstrated significant improvements in knowledge and self-reported confidence to access SRH care (Mathews et al., 2012). However, studies consistently emphasise that knowledge alone does not translate into uptake. Atuhaire et al. (2021) found that adolescents with high levels of SRH knowledge often remained hesitant to use services due to fear of stigma or lack of supportive structures. This suggests that capability must be reinforced through complementary interventions addressing environmental and emotional barriers (Michie et al., 2011).

Opportunity encompasses the external conditions that make health-seeking either possible or constrained (Michie et al., 2011). Physical opportunity is enhanced when clinics are located near schools or residential areas, offer flexible hours outside of school times, and provide adolescent-specific entry points that minimise visibility (Toska et al., 2017; Denno et al., 2015). Social opportunity is equally crucial: adolescents are more likely to access services when they feel supported by peers, family members, and community health workers. Parental approval and peer endorsement can validate adolescents' health-seeking decisions, while unsupportive social environments can reinforce stigma and fear (Mmari & Sabherwal, 2013). Righi et al. (2019) highlight that when adolescents perceive clinics as safe, confidential, and respectful spaces, their willingness to return for ongoing care increases significantly. Conversely, the absence of adolescent-friendly infrastructure and staff attitudes can nullify even well-designed educational campaigns.

Motivation refers to the internal processes that energise and direct behaviour, including reflective drivers such as goals and aspirations, as well as automatic responses such as fear or shame (Michie et al., 2011). Many adolescents are motivated by the desire to avoid unintended pregnancies, sexually transmitted infections, or the social repercussions of early childbearing (Pettifor et al., 2019). Others are guided by long-term aspirations related to continuing education and pursuing future employment opportunities (Chola et al., 2023). Positive prior experiences at health facilities can reinforce motivation by fostering trust and emotional safety, whereas experiences of judgment or confidentiality breaches can diminish motivation and discourage future engagement (Geary et al., 2014). Importantly, adolescents' motivation is not static but shaped by their interaction with opportunity and capability: for example, a motivated adolescent may still avoid clinics if privacy cannot be assured, or conversely, a less motivated adolescent may engage with services if clinics are welcoming and accessible (Chola et al., 2023).

Taken together, these three domains demonstrate that facilitators of SRH uptake extend far beyond knowledge provision. Instead, adolescents' engagement with SRH services is contingent upon the alignment of capability, opportunity, and motivation within supportive environments (Michie et al., 2011). The COM-B model thus provides a critical behavioural framework through which adolescent SRH service design can be analysed and improved in semi-rural South Africa.

2.6.2 RESEARCH GAPS

While numerous interventions have focused on enhancing adolescents' knowledge and motivation to utilize sexual and reproductive health (SRH) services, substantial evidence suggests that such improvements do not reliably translate into sustained increases in service uptake (Nyirenda et al., 2024). Interventions emphasizing education, peer-led initiatives, or incentives often fall short when the broader environment remains unaccommodating. For example, the “Yathu Yathu” community-based intervention in Zambia demonstrated that nearly two-thirds of adolescents accessed SRH services at youth hubs compared to fewer than 6% in control areas, highlighting that proximity and a youth-friendly setting, rather than awareness alone, drive utilization (Nyirenda et al., 2024).

This gap is particularly evident in South Africa, where youth-friendly infrastructure remains inconsistently implemented across semi-rural regions. Although the Youth-Friendly Services (YFS) programme was designed to standardize adolescent-responsive spaces, evaluations indicate uneven application, especially in resource-constrained rural districts (Mboweni et al., 2019). Clinics frequently lack private consultation rooms, adolescent-dedicated waiting areas, and sensitised staff, which undermines comfort and willingness to seek care (Mmari & Mmari, 2021; Mboweni et al., 2019). In smaller or close-knit communities, where anonymity is difficult to maintain, the absence of privacy further intensifies adolescents' fears of judgement or unwanted exposure, creating compounded barriers to access (Mmari & Mmari, 2021).

Addressing this gap requires moving beyond the assumption that simply providing services is sufficient (Mboweni et al., 2019). These findings underscore the need to move beyond the assumption that service provision alone is sufficient. The COM-B model illustrates that Capability and Motivation must be supported by social and physical Opportunity for behaviour to occur (Michie et al., 2011). Thus, even when adolescents possess adequate knowledge and intention, the absence of safe, private, and youth-affirming clinic environments discourages care-seeking behaviour (Mmari & Mmari, 2021; Nyirenda et al., 2024).

2.7 BARRIERS TO SRH ACCESS AND UPTAKE

2.7.1 BEHAVIOURAL BARRIERS: A COM-B PERSPECTIVE

Barriers to SRH service uptake can be effectively mapped within the COM-B framework, which recognises that behaviour results from the interplay of capability, opportunity, and motivation (Michie et al., 2011). In terms of capability, adolescents in semi-rural contexts often lack comprehensive, accurate SRH knowledge due to both structural and cultural constraints (Michie et al., 2011). School-based sexuality education is frequently inconsistent, under-resourced, or narrowly focused on abstinence, leaving many young people ill-equipped to make informed decisions (Baxen & Breidlid, 2009; MacPhail & Campbell, 2001). Cultural norms that stigmatise open conversations about sex within families and communities further restrict adolescents' psychological capability to access reliable information (Pound et al., 2017). As a result, adolescents frequently turn to peers, social media, or unverified online sources, which may perpetuate myths and misinformation about contraception, HIV prevention, or fertility (Usonwu et al., 2021). This knowledge deficit erodes adolescents' confidence, decision-making autonomy, and perceived ability to navigate SRH services.

In terms of opportunity, both physical and social constraints continue to limit service access. Many semi-rural clinics are located considerable distances from adolescents' homes, requiring significant transportation costs or time away from school or work (Toska et al., 2017). Even when accessible, clinics are often organised in ways that fail to prioritise adolescent needs. For example, a lack of private consultation rooms and waiting areas shared with older adults undermine confidentiality, while rigid clinic hours that overlap with school schedules limit physical opportunity for use (Chandra-Mouli et al., 2015; Jonas et al., 2019). Social opportunity is also constrained by prevailing community surveillance: in tightly knit rural settings, adolescents often fear being seen at a clinic and having their presence interpreted as evidence of sexual activity, leading to stigma and gossip (Mmari & Sabherwal, 2013).

Motivational barriers are equally critical. Adolescents may anticipate negative or judgmental treatment from healthcare providers, who often hold moralistic or adult-centred views that discourage open disclosure of SRH needs (Geary et al., 2014; Maseko et al., 2022). Anticipated or actual breaches of confidentiality further exacerbate mistrust, reducing adolescents' willingness to engage with services. Internalised stigma and shame surrounding sexual activity, particularly for young women, can discourage care-seeking even when adolescents recognise their risk of unintended pregnancy or HIV infection (Pettifor et al., 2019). Emotional responses such as anxiety, embarrassment, or fear of parental disapproval often override rational evaluations of the benefits of accessing SRH services. These motivational barriers are especially acute in smaller communities where anonymity is limited and the risk of social exposure is heightened (Campbell et al., 2005). Collectively, these interlinked barriers demonstrate that improving adolescent SRH uptake requires attention not only to knowledge or availability of services but also to the physical and psychosocial environments in which adolescents make health decisions.

2.7.2 RESEARCH GAPS

There is limited integration of identified barriers into a unified behavioural framework, which has led to fragmented and often ineffective interventions. While individual studies frequently highlight issues such as inadequate knowledge, stigma, or infrastructural constraints, few synthesize these elements within models such as COM-B to provide a holistic understanding of adolescent health-seeking behaviour (Michie et al., 2011). As a result, many interventions address one aspect, such as improving information dissemination, without adequately considering how opportunity and motivation interact to shape actual service use (MacPhail et al., 2020).

Another critical gap is the urban bias within existing literature. Much of the empirical research on adolescent sexual and reproductive health (SRH) originates from urban or peri-urban settings, where infrastructure, anonymity, and service delivery differ significantly from semi-rural areas (MacPhail et al., 2020). In semi-rural contexts, adolescents face a unique interplay of challenges: longer travel distances, poorly resourced clinics, and heightened visibility within tightly knit communities (Mboweni et al., 2019). These factors mean that clinic design and community surveillance intersect more sharply, amplifying fears around confidentiality and social judgment. For instance, adolescents in small communities often avoid health facilities altogether due to concerns that family or neighbours might witness their visits, a barrier less pronounced in urban settings (Geary et al., 2014).

Furthermore, despite the South African government's commitment to youth-friendly health services, implementation remains inconsistent, particularly in semi-rural districts (Maseko et al., 2022). Few studies have systematically examined how physical clinic design, such as waiting area layout, privacy in consultation rooms, or the presence of adolescent-dedicated spaces, directly influences service uptake (Mboweni et al., 2019). Instead, the focus tends to remain on service availability rather than on the behavioural environment in which adolescents navigate those services. Addressing this research gap requires integrating behavioural theory with context-specific design considerations, thereby moving toward interventions that are both holistic and adolescent-responsive (Mboweni et al., 2019).

2.8 INNOVATIONS IN YOUTH-FRIENDLY SRH SERVICE DESIGN

Several recent innovations across sub-Saharan Africa have sought to create more adolescent-responsive health systems (Toska et al., 2020). In Kenya and Uganda, for instance, facilities have piloted adolescent-only service hours, peer educator integration, and the use of mobile technology for discreet appointment bookings, with some evidence that these interventions increase adolescents' willingness to seek care (Toska et al., 2020; Nabukeera-Barungi et al., 2015). In South Africa, youth-oriented approaches have included the introduction of informal and comfortable waiting areas, adolescent-targeted educational posters, and digital feedback kiosks designed to allow young people to evaluate their experiences anonymously (Reddy et al., 2021). These initiatives aim to address both structural and psychosocial barriers by making clinics feel less intimidating and more responsive to the needs of young people.

Despite their promise, such innovations remain inconsistently applied, and their impact is often limited by a lack of institutionalisation within health systems. (Reddy et al., 2021). Too frequently, “youth-friendly” care is reduced to surface-level branding, such as colourful posters or one-off youth awareness campaigns, rather than being embedded into the physical infrastructure and the relational culture of care (Denno et al., 2015). For example, adolescents may be greeted by posters declaring “youth-friendly services,” yet still face long queues, lack of privacy, or judgmental staff attitudes once inside the clinic (Maseko et al., 2022). These inconsistencies undermine trust and perpetuate scepticism among adolescents about whether health facilities can truly meet their needs (Reddy et al., 2021).

A reimagining of clinics as behavioural spaces is therefore essential. The COM-B model underscores that adolescents’ uptake of services depends not only on their knowledge and motivation but also on the opportunities presented by their environment (Michie et al., 2011). Clinic environments, through layout, design, and staff interaction, function as behavioural cues that can either support or obstruct autonomy, trust, and engagement. Evidence suggests that when young people perceive health facilities as safe, respectful, and confidential spaces, they are more likely to seek services consistently and return for follow-up visits (Geary et al., 2014; Chandra-Mouli et al., 2019). Conversely, poorly designed clinics with minimal privacy and hostile staff interactions reinforce avoidance behaviours, regardless of the availability of services (Chandra-Mouli et al., 2019).

Therefore, innovation in adolescent SRH service delivery must move beyond aesthetic improvements to embed structural, spatial, and relational elements that actively shape behaviour (Reddy et al., 2021). By aligning clinic design with behavioural frameworks such as COM-B, health systems can create environments that do more than provide services, they can actively enable and sustain adolescents’ engagement with care.

2.G DESIGNING ADOLESCENT-FRIENDLY CLINIC SPACES

Applying the COM-B model, several design features emerge as critical for enhancing adolescents’ uptake of SRH services (Michie et al., 2011). Supporting capability requires clinic spaces that are easy to navigate, clearly defined, and explicitly welcoming to young people. Features such as well-labelled consultation rooms, youth-focused visual aids, and digital kiosks offering confidential information can enhance adolescents’ psychological capability by reducing confusion and anxiety in navigating services (Agha et al., 2019). These elements increase adolescents’ confidence in accessing services and reduce the likelihood of disengagement due to uncertainty or perceived complexity (Agha et al., 2019; Michie et al., 2011). Importantly, visual and digital support should not merely disseminate information but also reinforce adolescents’ autonomy and ability to make informed health choices (Agha et al., 2019).

Opportunity is strongly shaped by the physical and social environment within the clinic. Adolescents are more likely to use services when they feel that their privacy is protected and when service structures minimise opportunities for community surveillance (Michie et al., 2011). Design features such as separate waiting areas for youth, soundproof consultation rooms, and strategic scheduling of adolescent-only hours can create a sense of confidentiality and safety, particularly in semi-rural communities where anonymity is difficult to maintain

(Geary et al., 2014; Maseko et al., 2022). These structural interventions reduce the risk of exposure to stigma and gossip, which are often cited as key deterrents to clinic attendance among adolescents (Geary et al., 2014). By improving both physical and social opportunity, clinics can transform into spaces that adolescents perceive as safe and supportive rather than threatening.

Motivational factors are also deeply influenced by clinic design and culture. Adolescents' motivation to seek SRH services is strengthened when they feel respected, valued, and emotionally secure within the health facility (Michie et al., 2011; Maseko et al., 2022). A respectful and non-judgmental atmosphere, combined with staff trained in adolescent communication, signals to young people that their needs are taken seriously (Denno et al., 2015). Participatory mechanisms, such as anonymous feedback systems and adolescent advisory boards, further reinforce motivation by allowing adolescents to feel agency in shaping the services they receive (Toska et al., 2020). In this way, design is not only aesthetic but relational, embedding cues of trust and respect that can counteract stigma and encourage return visits.

Design must therefore be considered an active component of service delivery, not a secondary concern. A clinic that is visually appealing but fails to safeguard confidentiality or foster respectful interactions undermines its own purpose (Reddy et al., 2021). Conversely, even modest interventions, such as rearranging seating to ensure privacy, displaying youth-relevant artwork, or introducing peer navigators, can profoundly alter adolescents' behavioural responses to clinics (Reddy et al., 2021). Such adjustments exemplify how physical and relational environments interact within the COM-B framework, shaping the capability, opportunity, and motivation that underpin adolescents' health-seeking behaviours. Embedding these considerations into clinic design is crucial for creating adolescent-friendly health systems in semi-rural South Africa and beyond.

2.10 CONCEPTUAL FRAMEWORK

This study adopts the COM-B model as its central conceptual framework, situating sexual and reproductive health (SRH) service uptake among adolescents as a behaviour that is shaped by the dynamic interaction of capability, opportunity, and motivation. The model emphasises that for a behaviour to occur, all three elements must not only be present but must also interact synergistically in ways that reinforce each other (Michie, van Stralen, & West, 2011). Applied to the context of adolescent SRH service uptake in semi-rural KwaZulu-Natal, COM-B provides a structured way to identify where behavioural barriers and facilitators operate, and how clinic design may either mitigate or exacerbate these influences.

Capability refers to the knowledge, cognitive resources, and skills required to seek and effectively use SRH services. Adolescents who are well-informed about contraception, HIV prevention, and clinic procedures are better equipped to navigate health systems and make decisions about care (Agha et al., 2019). However, capability extends beyond knowledge acquisition: it includes the ability to interpret clinic signage, understand appointment processes, and communicate effectively with providers. Physical design elements such as clear wayfinding materials, youth-friendly educational tools, and confidential information kiosks can therefore directly contribute to adolescents' psychological capability by reducing uncertainty and

enhancing confidence in service use (Geary et al., 2014).

Opportunity encompasses the external factors that enable or constrain adolescents' ability to access and use services. In the COM-B model, this includes both physical opportunity (such as infrastructure, location, and clinic hours) and social opportunity (including community norms, parental attitudes, and peer influences). For adolescents in semi-rural areas, long travel distances, overcrowded clinics, and lack of private consultation spaces remain significant barriers to service uptake (Maseko et al., 2022). Social opportunity is equally critical: the fear of being recognised by community members in waiting rooms, or of being judged by healthcare workers, often discourages adolescents from accessing care (Chandra-Mouli et al., 2015). Clinic design can directly shape these opportunities by creating adolescent-only spaces, ensuring confidentiality, and aligning service delivery with young people's daily routines.

Motivation relates to the internal processes that influence adolescents' decisions to engage with SRH services. These include reflective motivation (beliefs, goals, and intentions) and automatic motivation (emotions, habits, and social cues) (Michie et al., 2011). Adolescents' motivation is strongly shaped by past experiences with the health system, including whether they felt respected, judged, or supported by clinic staff (Denno, Hoopes, & Chandra-Mouli, 2015). Clinic environments that signal respect, inclusivity, and safety, through both staff attitudes and physical design, can help build positive associations with service use, thereby reinforcing motivation. Conversely, poorly designed or emotionally unsafe environments can undermine even well-intentioned behaviour, as fear and stigma may override knowledge and intention.

Although clinic design is often conceptualised as a neutral backdrop for service delivery, this study frames it as an active behavioural determinant operating primarily through the domains of opportunity and motivation, while also reinforcing capability. The layout, signage, and atmosphere of a clinic can either facilitate adolescents' ability to act on their knowledge or discourage them from doing so (Geary et al., 2014; Maseko et al., 2022). By embedding clinic design within the COM-B model, this study offers an integrated lens through which to understand adolescent SRH service uptake in semi-rural South Africa. This approach not only highlights the behavioural mechanisms that underpin access but also provides a framework for developing interventions that align environmental design with adolescents' psychological, social, and motivational needs (Michie et al., 2011; Denno, Hoopes, & Chandra-Mouli, 2015).

2.11 RATIONALE FOR THE STUDY

Despite comprehensive policies and a growing commitment to youth health, SRH outcomes among adolescents in semi-rural South Africa remain suboptimal. Existing research has focused largely on individual or programme-level interventions, with limited attention to the clinic as an environment that shapes behaviour. By grounding the study in the COM-B framework and centring clinic design, this research addresses a critical gap. It offers actionable insights into how structural changes can support adolescent autonomy, confidentiality, and sustained engagement with SRH services.

CHAPTER 3: METHODOLOGY

3.1 RESEARCH DESIGN

This study was a non-interventional qualitative study that employed a research design informed by the COM-B model of behaviour. The COM-B model was selected because it is widely used to identify the factors that need to change for a behaviour change intervention to be effective (West & Michie, 2020). The model identifies three essential components that must be present for any behaviour to occur, namely capability, opportunity, and motivation.

Given that individuals experience health services differently, the COM-B framework assisted in understanding how adolescents experienced and perceived sexual and reproductive health (SRH) services and the process of accessing these services. The model further supported an exploration of the barriers adolescents encountered when attempting to access SRH services, as well as the factors that motivated or propelled them to seek these services. These motivating factors, referred to as drivers, were examined in relation to the intention–action gap, which reflects the disconnect between adolescents’ intentions to access SRH services and their actual service utilisation.

The COM-B model also facilitated an in-depth examination of adolescents’ experiences with the clinics they used to access SRH services, allowing for a nuanced understanding of how clinic environments, service delivery, and interpersonal interactions influenced behaviour. An interpretive qualitative approach was employed in this study. This approach involved the use of a descriptive orientation during data collection (Gentles, Charles, Ploeg, & McKibbin, 2015), with a specific focus on capturing and interpreting participants’ lived experiences and subjective meanings.

3.2 OVERVIEW OF THE PRIMARY STUDY AND SECONDARY ANALYSIS

This thesis formed part of a broader primary qualitative study conducted by the Human Sciences Research Council (HSRC) in Vulindlela, in uMgungundlovu district, KwaZulu-Natal, South Africa. The primary study explored barriers and facilitators influencing adolescents’ access to sexual and reproductive health (SRH) services, as well as adolescents’ preferences regarding adolescent-friendly clinic environments and service delivery. The primary study was conducted in two phases during 2023. Phase 1 involved in-depth interviews with adolescent women and men aged 14–25 years to explore barriers and facilitators influencing SRH service uptake. Data generated during this phase included audio-recorded interview transcripts and field notes.

Phase 2 involved individually conducted clinic design workshop activities and follow-up in-depth discussions with the same participants from Phase 1. Although referred to as clinic design workshops, these activities were conducted on a one-on-one basis rather than in group settings in order to maintain participant privacy and confidentiality. During this phase, participants engaged in participatory clinic design activities informed by a human-centred design approach. Participants discussed and illustrated their preferences for ideal adolescent-friendly SRH clinic environments using clinic floor plans, drawings, and discussions relating to service delivery models.

Across all Phase 2 activities, a total of 29 participants took part in the clinic design exercises and follow-up discussions. Data generated during this phase included audio-recorded workshop discussions, participant drawings and visual materials, observational notes, and field notes.

This thesis involved a secondary analysis of data generated during the Phase 2 clinic design activities. Specifically, the analysis focused on adolescents' preferences regarding adolescent-friendly SRH clinic environments and service delivery.

3.3 STUDY SETTING

The primary study was conducted in the Vulindlela/Edendale area, located within the uMgungundlovu District Municipality in KwaZulu-Natal (KZN), South Africa. The area comprises predominantly semi-rural and peri-urban communities with an estimated population of approximately 160,000 people, the majority of whom are isiZulu-speaking. The area is characterised by high levels of poverty, unemployment, and limited socioeconomic opportunities, particularly among adolescents and young people. Healthcare services are provided through 16 primary healthcare (PHC) clinics and three district hospitals that serve the surrounding communities. KwaZulu-Natal continues to experience a high burden of HIV infection, sexually transmitted infections (STIs), and adolescent pregnancy, particularly among adolescents and young women (Department of Health, 2017; UNAIDS, 2022). These contextual factors make the area an important setting for exploring adolescents' experiences of sexual and reproductive health (SRH) service access and clinic design preferences.

3.4 SAMPLING

Participants in the primary study constituted a community-based sample recruited from the Greater Edendale area, including Vulindlela. Community engagement was facilitated through stakeholder engagement activities conducted by the community team to promote meaningful community involvement in the design and implementation of research activities. A key component of this process involved consultation with the Community Research Support Group, which was composed of representatives from key stakeholder groups, including women, adolescents, and members of the LGBTQ+ community.

The primary study employed purposive sampling to recruit sexually active adolescent women and men aged 14–25 years, including those who had previously accessed SRH services and those who had never used these services. Purposive sampling is a non-probability sampling technique in which participants are deliberately selected based on specific characteristics that align with the study's inclusion criteria (Etikan, Musa, & Alkassim, 2015). This approach, also referred to as judgement sampling, involves the identification and selection of individuals who are knowledgeable about or experienced with the phenomenon of interest (Etikan et al., 2015). Although adolescence is commonly defined by the World Health Organization as the period between 10 and 19 years of age, this study included participants up to 25 years to capture the experiences of older adolescents and young people who continue to engage with adolescent-oriented SRH services during the transition to adulthood. Including participants across this broader age range enabled exploration of how developmental, social, and healthcare experiences may differ across younger and older youth populations within the study setting.

This sampling strategy was appropriate for the exploratory nature of the study, as it enabled the inclusion of participants with varying experiences of sexual and reproductive health (SRH) service access, including both service users and non-users. As this thesis involved a secondary analysis of Phase 2 data from the broader primary study, no additional participant recruitment was conducted.

3.4.1 SAMPLE SIZE

Participants were recruited from community venues within the Vulindlela/Greater Edendale area by the Community Programs and Stakeholder Relations Unit of the HSRC's Centre for Community-Based Research. Following recruitment, participants were stratified by sex (male and female) and age group (14 years, 15–18 years, and 19–25 years) to facilitate age- and gender-sensitive engagement during the Phase 2 clinic design activities.

Separate individually conducted clinic design workshop sessions and follow-up discussions were conducted across these strata to ensure that participants felt comfortable sharing their views and that age- and gender-specific perspectives were adequately captured. Across all Phase 2 activities, a total of 29 participants took part in the clinic design exercises and follow-up discussions (N = 29). For the purposes of this thesis, secondary analysis was conducted on data generated during these Phase 2 clinic design activities.

3.4.2 INCLUSION CRITERIA

Participants met the following inclusion criteria:

- Sexually active adolescent women and men residing in semi-rural areas who had either accessed SRH services or had never accessed SRH services
- Aged between 14 and 25 years.
- Willingness to provide written informed consent (and assent where applicable)

3.5 METHODS OF DATA COLLECTION

3.5.1 PROCEDURE

The primary study was implemented across two phases involving the same group of adolescent women and men aged 14–25 years. Phase 1 consisted of in-depth interviews exploring barriers and facilitators influencing adolescents' uptake of sexual and reproductive health (SRH) services. Phase 2 involved individually conducted clinic design workshop activities and follow-up in-depth discussions with the same participants from Phase 1, focusing on adolescents' preferences regarding adolescent-friendly SRH clinic environments and service delivery.

This thesis involved a secondary analysis of data generated during the Phase 2 clinic design activities of the broader primary study. The analysis specifically focused on adolescents' preferences regarding adolescent-friendly clinic environments and service delivery.

Phase 2 activities were conducted between November and December 2023 and involved individually conducted clinic design exercises and follow-up in-depth discussions with the same participants from Phase 1. The activities were informed by a human-centred design approach to facilitate the co-creation and exploration of ideal adolescent-friendly SRH clinic environments. During these activities, participants discussed their preferences regarding both fixed-site SRH clinics and community-based mobile service delivery models, including caravans and mobile clinics. All participants engaged in discussions and design activities relating to both service delivery models. Participants were provided with a general clinic floor plan, illustrations of mobile SRH delivery services, and a list of essential clinic components required for a clinic to operate effectively, including consultation rooms, reception areas, pharmacies, and bathrooms.

Based on these requirements, participants were asked to describe and illustrate how they would organise and design their ideal adolescent-friendly clinic environment and mobile clinic. Follow-up discussions explored participants' preferences regarding clinic characteristics, layout, privacy, confidentiality, accessibility, design preferences, and dislikes. The interviews and workshop discussions lasted between 90 and 120 minutes and were conducted in either isiZulu or English, depending on participant preference. All sessions were audio-recorded to facilitate transcription, translation, and subsequent analysis.

3.6 CRITERIA FOR REPORTING QUALITATIVE STUDIES

This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong, Sainsbury, & Craig, 2007) to enhance transparency, credibility, and methodological rigour.

3.6.1 PERSONAL CHARACTERISTICS OF THE RESEARCHER

Data collection was facilitated by members of the HSRC research team, including the Masters candidate, who holds an Honours degree in Psychology and has experience conducting qualitative research and working with adolescents. This experience was acquired through previous work as a qualitative research assistant and involved the use of qualitative data collection methods such as in-depth interviews, focus group discussions, and participatory visual methods. The Masters candidate had experience working with both adult and adolescent participants, including male and female participants.

3.6.2 RELATIONSHIP WITH PARTICIPANTS

Neither the Masters candidate nor other members of the research team had a prior personal relationship with participants before the commencement of the study. Participants were informed about the purpose of the study, as well as the potential risks and benefits associated with participation. Rapport between the research team and participants was established during the recruitment and data collection processes to facilitate open and honest engagement.

3.7 PARTICIPANT SELECTION

3.7.1 METHOD OF APPROACH

Participant recruitment in the primary study was conducted through face-to-face engagement by trained members of the HSRC research team, including the Masters candidate. Potential participants were provided with information pamphlets detailing the study. Members of the research team explained all relevant aspects of the study, including its aims, procedures, and the potential risks and benefits of participation.

Participants were informed that their involvement in the study was entirely voluntary and that they had the right to withdraw at any point without any negative consequences or repercussions. Participants were given adequate time to ask questions and to consider their participation before consenting to take part in the study. For participants under the age of 18, parents or guardians were present during the consent process, and additional assent and parental consent procedures were followed where applicable. This process ensured that all participants made informed and voluntary decisions regarding participation.

3.8 DATA COLLECTION SETTING

Data collection was carried out in locations where participants felt comfortable and safe in order to uphold privacy and confidentiality. Interviews and individually conducted clinic design activities were typically conducted in participants' homes; however, when participants indicated that there was insufficient privacy at home, data collection was conducted at the Human Sciences Research Council (HSRC) offices. These settings were selected to create an environment conducive to open discussion, particularly given the sensitive nature of sexual and reproductive health (SRH) topics. Participants who attended sessions at the HSRC offices were transported to and from the venue by the Masters candidate together with members of the broader research team. Transport arrangements were coordinated to support participant attendance and to minimise potential barriers related to travel distance and transport costs. Upon completion of the sessions, participants were transported back to their homes or agreed community collection points. Demographic and behavioural questionnaires were completed by participants during the data collection process to obtain contextual background information relating to participants' age, sex, and SRH service utilisation experiences.

3.9 INTERVIEW GUIDE

The semi-structured discussion guides and participatory materials used during the Phase 2 clinic design activities were developed collaboratively by the HSRC research team, including the Masters candidate. The guides and materials were reviewed by the broader research team to ensure clarity, cultural appropriateness, and alignment with the study objectives before being translated into isiZulu prior to data collection. The clinic design activities utilised semi-structured discussion guides to facilitate consistency across interviews and workshop discussions while also allowing flexibility for participants to elaborate on issues they considered important regarding adolescent-friendly SRH clinic environments and service delivery.

3.10 AUDIO RECORDING

All interviews and individually conducted clinic design activities were audio-recorded with participants' permission. The use of audio recording was explained to participants before data collection, and explicit consent was obtained. In addition to audio recordings, field notes and observational notes were taken during the interviews and clinic design activities to capture non-verbal cues, contextual information, and initial analytical reflections.

Participant drawings, visual clinic layouts, and completed clinic floor plans generated during the Phase 2 activities also formed part of the dataset analysed in this thesis. All audio-recorded data were transcribed verbatim and translated from isiZulu into English where necessary to facilitate analysis while preserving participants' original meanings as closely as possible.

3.11 DATA ANALYSIS

Data generated during the Phase 2 clinic design activities included interview and workshop transcripts, participant drawings and floor plans, observational notes, field notes, and demographic information. Demographic data were analysed descriptively to provide contextual background information regarding the study participants.

Qualitative data were analysed using reflexive thematic analysis as outlined by Braun and Clarke (2006, 2019, 2021). This approach was appropriate for exploring adolescents' experiences, perceptions, and preferences regarding adolescent-friendly sexual and reproductive health (SRH) clinic environments and service delivery.

Data analysis followed an inductive and iterative process involving repeated engagement with the dataset to identify recurring patterns, similarities, and differences across participants' accounts and visual materials. Participant drawings and clinic floor plans were analysed alongside participants' verbal explanations and discussions rather than as standalone visual artefacts. Visual elements such as clinic layout, privacy features, waiting areas, accessibility, and representations of safety and confidentiality were interpreted in relation to participants' narratives and descriptions during the clinic design activities.

Field notes and observational notes were used to support contextual interpretation and enhance analytic depth across the dataset. Analysis involved familiarisation with the data, inductive coding, theme development, theme refinement, and interpretation guided by the COM-B framework.

3.12 DATA CODING

Data generated during the Phase 2 clinic design activities, including workshop discussion transcripts, participant drawings and floor plans, observational notes, and field notes, were organised and managed using Atlas.ti qualitative data analysis software.

Familiarisation with the data involved repeated reading and re-reading of transcripts, field notes, and visual materials to gain an in-depth understanding of participants' narratives and clinic design preferences. Coding involved the identification of meaningful segments of data

relevant to the research questions. Participants' verbal accounts, together with their accompanying explanations of drawings and clinic layouts, were coded inductively to identify patterns, ideas, and features relating to adolescents' experiences and preferences regarding adolescent-friendly SRH clinic environments and service delivery.

Initial codes were reviewed, refined, and organised into broader themes that captured shared and divergent perspectives across the dataset. For example, participant statements relating to long waiting times, overcrowding, and transport difficulties were initially coded as "service delays," "clinic overcrowding," and "transport barriers." Through iterative review and comparison across transcripts, these codes were grouped into the broader theme of "Structural Barriers to Access." Similarly, codes relating to fear of judgement, breaches of confidentiality, and negative interactions with healthcare workers contributed to the development of themes relating to interpersonal barriers and healthcare worker attitudes. Themes were interpreted and illustrated using data extracts from workshop discussions and participants' visual materials and were situated within the COM-B framework and existing literature.

3.13 DERIVATION OF THEMES

Theme development followed the six recursive phases of reflexive thematic analysis as described by Braun and Clarke (2012). The first phase involved familiarisation with the data through immersion in the transcripts. The second phase consisted of generating initial codes across the dataset. The third phase involved constructing candidate themes by examining patterns and relationships between codes. The fourth phase focused on reviewing and refining themes to ensure coherence and distinctiveness. The fifth phase involved defining and naming themes, and the final phase involved producing the analytic narrative supported by illustrative data extracts.

Both inductive and deductive reasoning informed the analysis (Bingham, 2021). Inductive analysis allowed themes to emerge directly from participants' accounts, while deductive analysis was guided by the COM-B framework to examine how capability, opportunity, and motivation shaped adolescents' experiences and preferences. This combined approach strengthened the analytic depth while remaining consistent with the principles of reflexive thematic analysis.

Reflexive thematic analysis enabled the identification of both shared patterns and points of divergence within the data, including unexpected findings that were not anticipated at the outset of the study. Overall, this approach provided a robust and flexible analytic framework for addressing the study's research questions.

3.14 ETHICAL CONSIDERATIONS

Ethical principles guiding this study included respect for persons, autonomy, beneficence, non-maleficence, and justice. Ethical approval for the primary study was obtained from The HSRC Research Ethics Committee (HSRC REC) prior to the commencement of data collection (Ethics approval number: 9/23/11/22). All research activities were conducted in accordance with relevant ethical and regulatory guidelines.

3.14.1 INFORMED CONSENT

All aspects of the study, including its aims, purpose, procedures, and the potential risks and benefits of participation, were explained in detail to participants prior to their involvement in the study. Participation was entirely voluntary, and participants were not coerced in any way to take part. Participants were informed of their right to withdraw from the study at any point without penalty or negative consequences (Tsoka-Gwegweni & Wassenaar, 2014).

Participants aged 15 years and older provided informed consent prior to participating in any research activities. For participants aged 14 years, written parental or guardian consent was obtained in addition to participant assent. Informed consent and assent procedures were conducted by trained members of the study research staff, including the Masters candidate, and participation only commenced once the relevant consent and assent processes had been completed. The consent process was conducted in participants' preferred language, either English or isiZulu, to ensure comprehension.

Prior to obtaining consent, participants' literacy and comprehension levels were assessed. In cases where participants were not literate or experienced difficulty comprehending study information, an impartial witness was present to observe and document the consent process. Once comprehension had been established and the potential participant indicated willingness to participate, written consent was obtained. Participants were asked to sign the informed consent form by printing their initials and signature. Where an impartial witness was required, the witness also signed the consent form. Participants who were unable to write their names or sign but were able to demonstrate comprehension of the study information were given the option to consent by placing a thumbprint on the designated section of the consent form. This ensured that all participants were afforded an equitable opportunity to provide informed consent.

Participants were informed that data collected during the study could be used for future research purposes. As such, this thesis did not require the collection of new informed consent, as participants in the primary study had already consented to the future use of their data for research activities.

3.14.2 CONSENT AND ASSENT FOR MINORS

The study made provisions for the inclusion of participants under the age of 18 years. For participants under 18 years of age, additional ethical safeguards were implemented. Participants aged 12–14 years were required to obtain written parental or caregiver consent in order to participate in the study. In addition, these participants provided written assent to indicate their voluntary agreement to take part in the study (Appendix 3 and Appendix 4).

3.14.3 WAIVER OF PARENTAL CONSENT

A waiver of parental or primary caregiver consent was applied for participants aged 15–17 years. Under this waiver, adolescents in this age group were permitted to consent independently to participate in the study without requiring parental or caregiver permission. Parental or caregiver consent remained optional and was based on the preference of the adolescent participant.

The waiver of parental consent was aligned with the South African Department of Health (DoH) ethical guidelines, as outlined in Ethics in Health Research (2015). These guidelines recognise that, in certain circumstances, particularly where sensitive topics such as sexual behaviour and reproductive health are discussed, it may be ethically justifiable for older minors to decide independently whether to participate in research. Several considerations supported the application of this waiver. First, requiring parental consent may have inadvertently disclosed participants' sexual activity to parents or caregivers, potentially placing adolescents at risk of harm or distress. Second, discussions related to sex and sexuality are not always culturally acceptable within the communities from which participants were recruited, which may have acted as a barrier to participation. Third, permitting independent consent empowered adolescents aged 15–17 years to make autonomous decisions about their participation and allowed for the inclusion of valuable perspectives from this age group that may otherwise have been excluded.

It was determined that participation in the study did not expose adolescents to risks beyond those encountered in their daily lives. Although national legal and ethical frameworks generally recommend parental consent when conducting research with minors, it was concluded that the nature of this study justified the waiver of parental consent for participants aged 15–17 years.

3.14.4 CONFIDENTIALITY

Confidentiality was upheld as a fundamental ethical principle in this study and was central to demonstrating respect for participants and protecting the information they shared (Halai, 2006). All interviews and individually conducted clinic design activities were audio-recorded; therefore, identifying information such as participants' names and other personal identifiers was removed or altered during transcription and analysis to protect participants' identities. Pseudonyms were used throughout the research process and in the reporting of findings.

Participants were encouraged to speak openly and honestly during interviews and clinic design discussions, with the assurance that confidentiality would be maintained. Although Phase 2 involved clinic design workshop activities, these activities were conducted individually rather than in group settings in order to maintain participant privacy and confidentiality.

The limits of confidentiality were clearly explained to participants during the informed consent and assent processes and were outlined in the participant information and consent documents (Appendix A). Given the non-interventional nature of the study and the voluntary participation of adolescents, it was anticipated that participation would not result in harm to participants. All participants and, where applicable, their parents or guardians, were informed of their roles in the study prior to participation.

3.14.5 ONGOING RESPECT FOR PARTICIPANTS

Ongoing respect for participants was maintained throughout the research process by minimising potential risks and ensuring that all information shared by participants remained confidential within the stated ethical limits. Participants were treated with respect and sensitivity, and efforts were made to create a welcoming and non-judgmental environment during data collection. This approach allowed participants to respond freely and express their views in their own words. Participants were reminded that participation was voluntary and that

they retained the right to withdraw from the study at any time without any negative consequences (Tsoka & Wassenaar, 2014). These measures reinforced participants' autonomy and contributed to an ethically sound research process.

3.14.6 NON-MALEFICENCE AND BENEFICENCE

The principles of non-maleficence and beneficence guided the study and required that participants be protected from harm while maximising potential benefits (Halai, 2006). Participants were provided with clear information regarding any potential risks and benefits associated with participation. Given that topics such as early and unintended pregnancy and sexual and reproductive health can be sensitive, particular care was taken to ensure that participants were not harmed emotionally or psychologically during interviews. In the event that a participant experienced distress during the interview process, referral mechanisms were established in advance. These safeguards ensured that appropriate support could be accessed if needed.

3.14.7 REFERRAL PROCEDURES

All participants were offered referrals to HIV testing and counselling services should they have required such services. In addition, facilitated referrals to local primary health care clinics were arranged for participants who requested contraceptive services or other sexual and reproductive health services. Although these referral mechanisms were available throughout the study, none of the participants requested referrals during the course of data collection.

3.14.8 FAVOURABLE RISK-BENEFIT RATIO

A favourable risk–benefit ratio refers to the identification and minimisation of potential risks or harms that may arise during a study, as well as the fair distribution of risks and benefits among participants (Tsoka & Wassenaar, 2014; Wassenaar & Mamotte, 2012). Ethical consideration of the risk–benefit ratio involves assessing both the likelihood of potential risks occurring and the anticipated seriousness of any harm that may result (Wassenaar & Mamotte, 2012).

In this study, efforts were made to minimise potential risks while maximising potential benefits to participants. Given the qualitative and non-interventional nature of the study, the risks to participants were considered minimal. One potential risk involved emotional discomfort that could arise from discussing sensitive topics related to sexual and reproductive health experiences. To minimise this risk, participants were reminded that they could decline to answer any question or withdraw from the study at any point without consequence.

Another potential risk involved the inadvertent disclosure of participants' identities. This risk was mitigated through the use of pseudonyms and the removal of identifying information during transcription, analysis, and reporting of the study findings. Although Phase 2 involved clinic design workshop activities, these activities were conducted individually rather than in group settings in order to maintain participant privacy and confidentiality.

It was determined that participation in the study did not expose participants to risks beyond those encountered in their everyday lives. The knowledge generated through this study was considered to outweigh any minimal risks, thereby ensuring a favourable risk–benefit ratio.

3.14.G DATA MANAGEMENT

Robust data management procedures were implemented to ensure the security, confidentiality, and integrity of all study data. Audio recordings were transferred immediately from recording devices to password-protected computers and were subsequently deleted from the audio recorders. All hard-copy data, including transcripts and data printouts, were stored in locked and secure filing cabinets. Digital data was stored in password-protected computer databases accessible only to authorised research personnel.

All participants were assigned unique identifying codes to protect confidentiality. A separate tracking log linking participant identifiers to personal information was maintained and stored in a password-protected file separate from the main dataset. This ensured that identifying information was securely managed and accessed only when necessary. Data collection activities were conducted by staff who had received training in Good Clinical Practice (GCP), Human Subjects Protection, and study-specific procedures. Staff involved in obtaining informed consent were fully trained in consent procedures, and key study messages were reviewed to ensure that participants clearly understood the study prior to agreeing to participate. Research staff conducting data collection were experienced in qualitative research methods and received additional training to ensure the consistent and effective collection of high-quality data.

Throughout the research process, audio recordings were reviewed, and transcripts were checked to ensure accuracy and quality. This ongoing review process facilitated the identification of potential issues or areas for improvement, allowing for timely feedback and corrective action where necessary. All personal identifying data will be destroyed five years after the completion of the study in accordance with regulatory and institutional requirements. Data used in publications arising from this research will not include any participant identifiers. Participants were informed that their data might be used in future research analyses; however, all such use will remain anonymised and will not allow for individual identification.

3.15 CHAPTER SUMMARY

This chapter outlines the methodological approach employed in the study, including the research design, study setting, sampling procedures, data collection methods, analytical approach, and ethical considerations. The chapter provided a detailed account of how the study was conducted to ensure rigour, credibility, and ethical integrity. The following chapter (Chapter 4) presents the findings of the study, drawing on the qualitative analysis of the data to describe the key themes that emerged from adolescents' accounts of sexual and reproductive health service access and clinic design preferences.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

This chapter presents the findings of the study, which explored adolescents' experiences in accessing and utilizing SRH services in semi-rural areas of KwaZulu-Natal, South Africa. Drawing on qualitative interviews and participatory visual data, the chapter foregrounds the voices of adolescents as they describe the barriers and facilitators that influence their engagement with SRH care. The findings are organised thematically to illustrate the complex interplay between individual, interpersonal, and structural factors that shape young people's healthcare experiences.

The analysis is guided by the COM-B model which provides a behavioural framework for understanding the conditions that enable or constrain adolescents' ability to seek and use SRH services. In addition, the Decisions Framework (logical model), which conceptualises healthcare access as a sequence of steps from recognising a need for care to seeking, reaching, and receiving services, is applied as a cross-cutting analytical lens to trace adolescents' movement along the care pathway, from awareness and decision-making to clinic entry, service navigation, consultation, and follow-up (Levesque et al., 2013). Together, these frameworks support a holistic understanding of how access to SRH care is influenced not only by adolescents' knowledge and motivation, but also by their social environment and the organisation of healthcare systems.

In this study, both the COM-B model and the logical decision framework were used not only as interpretive tools but as analytical scaffolds that guided the process of data coding and theme development. During analysis, initial codes were generated inductively from participants' narratives and visual data; these were then organised according to the behavioural components of the COM-B model, capability, opportunity, and motivation, and mapped along the stages of the decision-making pathway, from awareness to follow-up. This dual framework enabled systematic identification of how structural, interpersonal, and psychological factors interacted to shape adolescents' SRH behaviours. Themes were therefore developed through iterative reflection between empirical data and theoretical constructs, ensuring that the final thematic structure reflected both participants' lived experiences and the behavioural logic underpinning their decisions to access or avoid care.

Findings are presented in five overarching themes that distinguish between barriers and facilitators of access. The first two themes explore structural and interpersonal barriers, focusing on issues of distance, time, stigma, privacy, and healthcare worker attitudes. The third and fourth themes examine healthcare worker characteristics and attitudes, showing how these can function either as barriers or as facilitators, depending on the nature of the interaction. The fifth theme focuses on youth-driven facilitators of access, highlighting adolescents' suggestions for improvement, including mobile clinic services and the design of youth-centred spaces.

Each theme is supported by direct quotations from participants to retain authenticity and reflect the lived experiences of adolescents. Although themes are presented separately for analytic clarity, there was overlap and interconnection between several themes, reflecting the complex and multifaceted nature of adolescents' experiences of sexual and reproductive health service environments. These overlaps were considered during interpretation of the findings.

4.2 PARTICIPANT CHARACTERISTICS

A total of 29 adolescents and young people participated in the Phase 2 clinic design activities included in this thesis. Participants ranged in age from 14 to 25 years and included both male and female participants from the Vulindlela/Edendale area in KwaZulu-Natal. Demographic information collected during the study provided contextual insight into participants' healthcare experiences and perspectives regarding adolescent sexual and reproductive health (SRH) service access. A summary of participant characteristics is presented in Table 4.2.1 below.

Table 4.2.1: Participant Demographic Characteristics

Characteristics	Description
Total Participants	29
Age range	14-25 years
Sex	Male and Female
Study setting	Vulindlela/ Edendale area, KwaZulu-Natal
Participation in phase 2	Clinic design and follow-up discussion

Participant quotations are presented using anonymised participant codes (e.g., EXP-02-022) to protect confidentiality. "EXP" refers to the study name, "02" indicates Phase 2 of the primary study, and the final set of numbers represents the participant's unique identification number. Together, these identifiers formed participants' pseudonyms and were used for data management purposes within the primary study without containing personally identifying information.

4.3 THEME1: STRUCTURAL BARRIERS TO ACCESS

Structural barriers were among the most significant challenges described by adolescents in this study. These barriers shaped the opportunity and capability components of the COM-B model by limiting adolescents' ability to initiate and sustain healthcare-seeking behaviour. Participants described several interconnected structural challenges related to distance and transport barriers, financial constraints associated with accessing services, long waiting times at clinics, and clinic environments that compromised privacy and comfort. These challenges collectively discouraged many adolescents from engaging with sexual and reproductive health (SRH) services even when the need for care was evident.

4.3.1 Distance and Transport Constraints

For many adolescents, physical distance and transport availability determined whether they could access care at all. Participants living in rural and peri-urban areas often had to take more than one taxi to reach the nearest clinic, making even routine visits costly and time-consuming. As one participant explained, "*Some of us live far; you have to take two taxis before you get to the clinic.*" (EXP-02-022). Another shared, "*If you don't have money, you just stay at home. You can't walk that far.*" (EXP-02-014).

These experiences highlight how distance and transport costs function as powerful deterrents, particularly for adolescents who are financially dependent on others. Within the Decision Framework, this challenge emerges at the earliest stage, deciding whether to initiate a visit. For many, the calculation of transport costs versus perceived benefit often ended in delayed or foregone care. Some participants also noted that travelling long distances only to find limited services available intensified frustration: *“Sometimes you go to the clinic and they say the nurse is not there. You wasted transport money.”* (EXP-02-009).

Such experiences not only reduce physical opportunity but also erode motivation to seek care in future.

4.3.2 Time Cost and Waiting Experiences

Time was another recurrent barrier that strongly influenced adolescents’ willingness to access SRH services. Many participants described spending long hours in queues, sometimes missing school or household responsibilities. These delays were not merely inconvenient; they undermined adolescents’ sense of agency and the perceived value of seeking care.

One participant explained, *“You wait from morning until afternoon, and sometimes you still don’t get helped.”* (EXP-02-025). Another added, *“Sitting in one place for hours is irritating. It would be better if you could get assisted quickly and leave, knowing that you won’t have to spend the whole day at the clinic.”* (EXP-02-018). For some, even arriving early did not guarantee faster service: *“Even if you go early, you spend three hours just waiting. You find that it’s nine and you’re still standing in one place.”* (EXP-02-029).

Long waiting times contributed not only to delays in accessing services, but also to feelings of neglect and frustration among adolescents, particularly when they perceived that their needs were prioritised less than those of older patients *“Even if you come early, they help older people first. You just sit there until they remember you”* (EXP-02-003).

The combination of uncertainty and wasted time discouraged repeat visits and, in some cases, led participants to seek alternative sources of care or rely on peers for advice. *As one adolescent explained, “Even if you come early, they help older people first. You just sit there until they remember you. Next time, I just asked my friend instead.”* (EXP-02-003). Within the Decision Framework, long waiting times disrupt the navigation and consultation stages, while in COM-B terms, they reduce both physical opportunity and reflective motivation.

4.3.3 Clinic Space, Privacy, and Infrastructure

Clinic environments themselves often reinforced feelings of discomfort and exposure. Adolescents reported that overcrowded waiting areas and thin partitions compromised confidentiality, especially when discussing sensitive sexual health issues. *“There’s no space to sit, and everyone looks at you. You can’t even talk freely.”* (EXP-02-026). Another participant observed, *“It’s not private, people can hear what you are saying to the nurse”* (EXP-02-024).

Many participants feared being recognised by neighbours or relatives during clinic visits. As one adolescent explained, *“When you go to the clinic, someone from your area might see you and tell others. It’s embarrassing.”* (EXP-02-019). These accounts illustrate how physical environments interact with social stigma to limit both capability and motivation to seek care. Some participants suggested practical changes, such as separate youth waiting areas, improved signage, and better physical screening to promote a sense of dignity and safety.

4.3.4 Organisation and Youth-Friendliness

A recurring observation was that clinics appeared organised primarily for adults, with little visible effort to accommodate young people. Adolescents described confusion about where to register, whom to approach, and how to follow clinic procedures. *“The clinic feels like it’s for older people, not for us.”* (EXP-02-022). Others mentioned that the absence of dedicated youth spaces and friendly communication discouraged them from returning. *“If they had a youth corner with friendly nurses, we would come more often.”* (EXP-02-026).

Lack of orientation and guidance within the facility reflected a gap in both structural organization and interpersonal practice. Within the Decision Framework, this confusion affects the navigation and consultation stages, as adolescents struggle to understand clinic processes. Improving youth-friendly infrastructure and communication could therefore enhance both *capability* and *motivation*, supporting smoother and more confident engagement with SRH services.

4.4 THEME 2: INTERPERSONAL BARRIERS WITHIN THE CARE ENVIRONMENT

Interpersonal barriers emerged as some of the most emotionally charged aspects of adolescents’ experiences with sexual and reproductive health (SRH) services. These barriers primarily shaped the motivation and social opportunity elements of the COM-B model, as adolescents’ interactions with healthcare workers and peers strongly influenced their willingness to seek care and disclose sensitive information. When adolescents encountered judgment, indifference, or dismissive behaviour, their motivation to engage with SRH services declined, not simply because of the unpleasant experience, but because such interactions signalled that their presence was unwelcome or inappropriate. Conversely, when they experienced respect, empathy, and clear communication, social opportunity expanded: adolescents felt recognized as legitimate clients and were more inclined to return, share positive experiences with peers, and sustain engagement over time. Across interviews, participants described experiences of being judged, scolded, or dismissed by healthcare workers, as well as fears about breaches of confidentiality and peer stigma. Such interactions created a climate of discomfort that discouraged many from returning to clinics or seeking SRH services altogether. The sub-themes presented below explore adolescents’ experiences of negative healthcare worker attitudes, concerns regarding confidentiality and privacy, communication challenges within healthcare settings, and peer-related stigma associated with accessing SRH services.

4.4.1 Judgment, Moralising, and Shame

Many adolescents described interpersonal interactions within healthcare settings as discouraging, particularly when they felt judged, dismissed, or unsupported while seeking SRH services. Participants recounted being spoken to harshly or made to feel ashamed for being sexually active. One participant stated, *“When you go there, they look at you like you’re too young to be doing these things.”* (EXP-02-015). Another added, *“Some nurses make comments that make you feel small, like you are doing something wrong.”* (EXP-02-025).

Similar sentiments were expressed in several interviews, where adolescents felt they were being “disciplined” rather than supported. *“Sometimes the nurses shout at us and say we are too young for family planning. You just keep quiet and never go back.”* (EXP-02-026). For some, the tone of the interaction itself communicated disapproval: *“You can tell from how they look at you. You feel judged even before you speak.”* (EXP-02-030).

These experiences often led adolescents to avoid clinics altogether or to rely on peers and social media for SRH information instead. Within the Decision Framework, such interactions act as a critical drop-off point at the consultation stage, when adolescents must decide whether to continue engaging or withdraw.

4.4.2 Confidentiality Anxiety and Disclosure Risks

Fear of breaches in confidentiality was another major deterrent. Adolescents worried that healthcare workers might disclose sensitive information to family members or community members. *“You don’t feel safe telling the nurse everything because she might know your aunt.”* (EXP-02-017). Another participant shared, *“Sometimes the nurses gossip, and you hear your story outside. That makes you not want to go back.”* (EXP-02-022).

This anxiety was heightened in small communities where everyone knows each other. One adolescent described, *“It’s difficult when the nurse lives in your area. You think she might tell your mother.”* (EXP-02-003). A few participants contrasted these experiences with those of more trustworthy healthcare workers: *“There’s one nurse who is kind; she keeps your information private. That’s why I always go to her.”* (EXP-02-009). The presence or absence of confidentiality directly affected motivation and the perceived safety of the clinic environment. Breaches, real or anticipated, undermined adolescents’ trust not only in individual nurses but in the healthcare system as a whole.

4.4.3 Communication Style and Explanations

Communication quality shaped adolescents’ understanding and comfort during consultations. Many participants noted that healthcare workers often gave minimal explanations or used overly technical language. *“They just give you pills without telling you what they are for.”* (EXP-02-016). In contrast, when providers took time to explain procedures or medications, adolescents felt empowered and respected. *“If they talk nicely and explain, we listen and understand better.”* (EXP-02-026).

Participants emphasised that tone and empathy mattered as much as information: *“When the nurse greets you and smiles, you feel like you can talk about anything.”* (EXP-02-024). Another adolescent reflected, *“When they shout or rush you, you forget what they said. You just want to leave.”* (EXP-02-030). Clear and respectful communication therefore enhanced both psychological capability and motivation, key components of the COM-B framework. When adolescents felt heard and supported, they were more likely to internalise information, return for follow-up visits, and recommend services to peers. In this way, effective communication acted as a behavioural catalyst, transforming confidence into sustained health-seeking action. Conversely, dismissive interactions not only discouraged engagement but also signalled that young people’s concerns were unwelcome, reinforcing avoidance patterns.

4.4.4 Peer Stigma and Social Visibility

Peer dynamics also influenced adolescents’ willingness to seek SRH care. Some participants feared being seen by friends or neighbours at the clinic, worrying that others would assume they were pregnant or ill. *“If your friends see you going to the clinic, they will say you are pregnant.”* (EXP-02-019). Another participant echoed this sentiment, *“People will start gossiping if they see you there. They think only sick people go”* (EXP-02-022). Although the participant did not explicitly specify what was meant by “sick,” the statement suggests

broader community stigma associated with attending SRH clinics, and the social meanings attached to seeking these services.

Conversely, positive peer experiences could encourage clinic attendance. *“My friend told me the nurse was nice, so I also went. Now I always go there.”* (EXP-02-025). In this way, peers acted as both barriers and facilitators within adolescents’ social environments. Under the Decision Framework, peer influence shapes both the *awareness* and *entry* stages of care-seeking, affecting how adolescents perceive the risks and rewards of accessing SRH services.

4.5 HEALTHCARE WORKER CHARACTERISTICS AND ATTITUDES – BARRIERS

Healthcare workers’ personal characteristics and attitudes were among the most frequently cited determinants of adolescents’ willingness to use sexual and reproductive health (SRH) services. Participants described how the age, gender, personality, and professional behaviour of nurses directly influenced their comfort, trust, and perceived safety during consultations. Negative encounters left lasting impressions that often discouraged re-engagement. This theme reflects the social opportunity and motivation elements of the COM-B model, as adolescents’ perceptions of healthcare workers shaped both their sense of acceptance and their confidence in the service. The sub-themes presented below explore adolescents’ experiences of rudeness, disrespect, and dismissive behaviour from healthcare workers; the lack of empathy and emotional support within healthcare interactions; and age- and gender-related disparities in provider–client interactions.

4.5.1 Rudeness, Disrespect, and Dismissiveness

Participants described healthcare worker behaviours during clinical interactions as dismissive, impatient, and at times overtly disrespectful, which negatively shaped adolescents’ experiences of SRH service provision. Participants reported instances where nurses shouted, ignored, or dismissed them, especially when asking questions about contraception or sexual activity. One adolescent expressed frustration, stating, *“There’s none, except that the nurses are rude and don’t know how to talk with people.”* (EXP-02-030). Another explained, *“It is okay... the problem is that some people are lazy to work... they just say staff shortage whereas they are just lazing around.”* (EXP-02-003).

Several adolescents perceived this behaviour as rooted in moral judgment rather than workload pressure. *“They make you feel like you did something wrong by coming there.”* (EXP-02-026). Others recalled instances of visible inattention: *“You find them on their phones or chatting while you are waiting. It’s like you don’t matter.”* (EXP-02-022). Such encounters reinforced adolescents’ feelings of exclusion and diminished their motivation to seek services again.

4.5.2 Lack of Empathy and Emotional Support

Beyond overt rudeness, participants also spoke about a general lack of empathy or emotional warmth from some nurses. Adolescents emphasised that SRH consultations require sensitivity and understanding, yet many described healthcare workers as cold or indifferent. *“Sometimes the nurse doesn’t even look at you; she just writes and says next.”* (EXP-02-019). This impersonal approach left adolescents feeling unwelcome and alienated.

In the context of the Decision Framework, these negative interactions disrupt both the consultation and follow-up stages. Adolescents who feel dismissed, judged, or embarrassed often interpret such encounters as signs that the service is not meant for them, which discourages them from returning or recommending it to peers. Rather than a single missed visit, this withdrawal represents a breakdown in the relational continuity of care, a crucial element in sustaining adolescent engagement over time. In COM-B terms, such experiences erode reflective motivation, as adolescents begin to associate care-seeking with shame or futility rather than empowerment and safety. Emotional discomfort transforms into behavioural avoidance, reinforcing a cycle where adolescents self-exclude from the very services intended for them. Over time, this pattern diminishes trust not only in individual providers but in the broader health system, undermining long-term confidence in formal SRH services.

4.5.3 Age and Gender Disparities in Provider-Client Interaction

Adolescents frequently described discomfort when healthcare workers were significantly older or of the opposite gender. For many adolescents, especially girls, discussing sexual matters with older male providers felt intimidating and inappropriate. *“It’s difficult to talk to an older man about these things. You just keep quiet.”* (EXP-02-025).

Even interactions with older female nurses could feel intimidating if the nurse adopted a parental tone. *“They talk to you like your mother, not like a nurse. You feel scolded instead of helped.”* (EXP-02-022). In contrast, participants suggested that younger nurses or those trained in youth communication were easier to approach: *“If there were young people helping in the clinic, we would feel more free to ask things. They would explain things properly, not like older nurses who rush you.”* (EXP-02-030).

These experiences reveal how age and gender disparities create relational discomfort that limits disclosure and trust during clinical encounters. The resulting communication gap contributes to emotional withdrawal and reduced confidence in navigating care environments.

4.5.4 Breaches and Inconsistency in Confidentiality

In addition to concerns regarding healthcare worker attitudes and age-related dynamics, adolescents also questioned some healthcare workers’ ability to maintain confidentiality during SRH service provision. While this sub-theme overlaps with broader interpersonal concerns relating to privacy and stigma discussed earlier, the focus here specifically relates to adolescents’ perceptions of healthcare workers’ professional conduct and inconsistencies in maintaining confidential patient information. A few participants described situations where nurses spoke loudly or left doors open during consultations. *“Sometimes they put us in the rooms with no curtains and doors. You feel nervous because people can hear.”* (EXP-02-030).

Others suspected that healthcare workers might discuss patients among themselves or with community members: *“I once heard a nurse talking about another girl’s problem in the waiting area. That made me scared to go.”* (EXP-02-017). Such breaches, or even perceptions of them, undermine the *trust* necessary for open discussion of sensitive topics like contraception or HIV testing. Within both the COM-B and Decision Frameworks, confidentiality lapses interrupt the *consultation* phase and discourage future engagement.

4.5.5 Lack of Youth-Friendly Training and Role Clarity

Several participants attributed negative interactions to inadequate training and unclear professional boundaries. They felt that some healthcare workers lacked specific skills for communicating with young people or understanding adolescent developmental needs. *“Some of them don’t know how to talk to us about these things. They just say it quickly and you leave not understanding.”* (EXP-02-009).

Adolescents called for more youth-focused training that emphasises respect, confidentiality, and approachability: *“If they were trained to deal with youth, they would not shout or judge.”* (EXP-02-022). The absence of such training not only affects interpersonal dynamics but also undermines adolescents’ *psychological capability*, their understanding of SRH processes and confidence in using them effectively.

4.6 THEME 4: HEALTHCARE WORKER CHARACTERISTICS AND ATTITUDES – FACILITATORS

Having explored how healthcare worker (HCW) attitudes and characteristics can act as barriers, this section turns to the positive dimensions of provider behaviour that encouraged adolescents to access and continue using sexual and reproductive health (SRH) services. This theme reflects the motivation and social opportunity components of the COM-B model, illustrating how empathy, respect, and professionalism enhance adolescents’ trust and confidence. The findings show that when healthcare workers demonstrate kindness, discretion, and youth-sensitive communication, adolescents perceive clinics as safer and more welcoming spaces. These positive encounters were often the reason participants re-engaged with care or recommended services to peers.

4.6.1 Respectful and Supportive Attitudes

Participants consistently highlighted the importance of respectful communication and non-judgmental treatment from healthcare workers. Many explained that being treated kindly made it easier to speak openly about sensitive issues. As one adolescent shared, *“When the nurses treat you with respect and don’t judge you, it’s easier to be open and ask for help.”* (EXP-02-007). Another noted, *“When they greet you and smile, it’s small but it helps. You feel like they care.”* (EXP-02-017).

These expressions of respect helped to rebuild trust, especially for those who had previously experienced judgmental behaviour. One participant explained, *“There’s a nurse here who is very nice; she always talks calmly and never shouts. We like her because she understands us.”* (EXP-02-026). Such experiences demonstrate how interpersonal warmth can transform adolescents’ perceptions of healthcare, fostering both immediate comfort and long-term willingness to seek care.

4.6.2 Clear Communication and Guidance

Adolescents valued healthcare workers who took time to explain procedures, medications, and SRH options in language they could understand. They appreciated when nurses provided step-by-step guidance rather than assuming prior knowledge. *“If they talk nicely and explain, we listen and understand better.”* (EXP-02-026). Another participant added, *“When they explain what the pills do and how to use them, you feel more confident and not scared.”* (EXP-02-019).

This clarity helped adolescents navigate the care process more effectively, reducing confusion and building psychological capability, one of the core dimensions of the COM-B model. For example, a participant described how helpful it was when nurses gave follow-up instructions: *“She told me when to come back and what to expect next time. That made it easy because I knew what to do.”* (EXP-02-022). Clear communication thus enhanced both comprehension and motivation, reinforcing the decision to continue care.

4.6.3 Confidentiality and Trustworthiness

Trust emerged as a foundational element in adolescents’ positive experiences. Many participants described a small number of nurses who consistently maintained confidentiality, which made them feel safe enough to return. *“There’s one nurse who is kind; she keeps your information private. That’s why I always go to her.”* (EXP-02-009). Another participant echoed this, *“When you know they won’t tell anyone, you can talk about everything freely.”* (EXP-02-017).

These trusted relationships often led to repeat visits and recommendations among peers. In some instances, adolescents even planned their clinic visits around the presence of specific healthcare workers: *“We ask each other if the nice nurse is working before we go. If she is there, then we go.”* (EXP-02-026). Confidentiality, therefore, served not only as an ethical obligation but also as a practical facilitator of adolescent engagement within the consultation and follow-up stages of the Decision Framework.

4.6.4 Approachability and Youth-Friendliness

Participants frequently contrasted unapproachable, stern nurses with those who adopted a friendly, youth-centred approach. *“Some nurses make jokes and talk to you nicely; it makes you relax.”* (EXP-02-030). Another adolescent described, *“If they talk to you like a friend and not like a parent, it’s easier to ask questions.”* (EXP-02-025). These interpersonal qualities signalled to adolescents that they were welcome and valued as clients.

Youth-friendly behaviour also extended to body language and tone of voice. One participant noted, *“When the nurse looks at you and listens properly, you can tell she cares.”* (EXP-02-003). Such simple acts of attentiveness created a sense of respect and partnership, strengthening adolescents’ confidence in navigating the health system. In behavioural terms, approachability operates as a regulating mechanism, modulating adolescents’ motivation, trust, and perceived capability. When healthcare workers demonstrate warmth, patience, and respect, they not only improve immediate comfort but also actively sustain engagement across multiple visits. Conversely, unapproachable conduct signals exclusion and breaks the behavioural chain of continued care. This positions youth-friendliness as a critical lever for intervention, one that should inform staff training, supervision, and performance frameworks within adolescent SRH services.

4.7 THEMES: YOUTH-DRIVEN FACILITATORS OF ACCESS

Having outlined the barriers adolescents encounter, this section presents the facilitators that encourage and sustain their engagement with SRH services. These findings reveal the creative and practical ways in which adolescents navigate structural and interpersonal challenges. Guided by both the COM-B model and the Decision Framework, this theme illustrates how young people exercise agency to create new pathways to care through peer education, collaboration with healthcare workers, and the promotion of youth-friendly service models such as mobile clinics. It also captures adolescents' visions of ideal clinics, spaces that feel safe, confidential, and welcoming to all youth. The sub-themes presented below explore the role of peer education and community engagement, youth involvement in service design and improvement, the perceived benefits of mobile clinics for improving accessibility, and adolescents' preferences regarding youth-centred clinic designs and safe healthcare spaces.

4.7.1 Peer Education and Community Engagement

Many adolescents viewed peer educators as essential intermediaries between young people and the healthcare system. They described peers as easier to talk to, more understanding, and better able to communicate information in relatable language. One adolescent explained, *"You can talk to your age-mate easily. They understand you better than the older people."* (EXP-02-009). Another added, *"If they teach everyone that the clinic is not only for sick people, people will stop judging."* (EXP-02-019). In this context, references to "sick people" appeared to reflect broader stigma associated with SRH clinic attendance, including possible assumptions relating to HIV infection and sexual activity. Participants therefore viewed peer education as important for challenging these perceptions and normalising adolescent use of SRH services.

Peer-led education was seen as effective in reducing stigma, increasing knowledge, and encouraging first-time clinic visits. Several participants suggested that peer educators could also accompany adolescents to clinics or help facilitate youth group discussions. *"If there were youth ambassadors who come and talk to us about health and where to go, more people would go."* (EXP-02-022).

These strategies align with the capability and social opportunity dimensions of the COM-B model by equipping adolescents with knowledge and supportive networks that normalise help-seeking behaviour.

4.7.2 Youth Involvement in Service Design and Improvement

Participants also emphasised the importance of involving adolescents directly in shaping health services. They felt that being consulted in decision-making would ensure that programmes better reflect their needs and realities. *"They should ask us what we want because we are the ones who use these services."* (EXP-02-030). Another participant suggested, *"If they include young people in planning, it will be easier for others to come."* (EXP-02-017).

Adolescents proposed feedback mechanisms such as youth forums, suggestion boxes, and school-based discussions with nurses. This active involvement would not only improve service delivery but also build trust between adolescents and healthcare providers. Within the Decision Framework, co-design enhances motivation and re-engagement, as young people feel ownership over services that are shaped by their own voices.

4.7.3 Mobile Clinics and Accessibility

Across the data, mobile clinics emerged as one of the most popular and practical solutions for improving adolescent access to SRH services. Participants viewed them as convenient, private, and youth-friendly alternatives to fixed facilities, particularly in areas where distance and transport costs were major barriers.

As one participant explained, *“If the clinic came to our area once a week, it would help. Some people can’t afford transport.”* (EXP-02-024). Another noted, *“A mobile clinic makes things easy because you don’t waste the whole day. You get there, do what you need, and go.”* (EXP-02-030). Others described the emotional relief of being able to access care discreetly: *“You don’t have to go to the main clinic where everyone sees you. You just go to the van and it’s private.”* (EXP-02-003).

Adolescents commonly described mobile clinics as creating a neutral and non-judgmental atmosphere. *“When the nurse comes with the mobile clinic, everyone goes – boys and girls. No one judges you because it’s for everyone.”* (EXP-02-026). Another added, *“When the mobile comes, you don’t feel embarrassed because people think it’s for any check-up, not only family planning.”* (EXP-02-030). Moreover, adolescents proposed that mobile services be equipped with essential SRH resources such as contraceptives, HIV testing, and counselling. *“The mobile clinic should have the same services but be youth-focused.”* (EXP-02-025). Others suggested small but meaningful improvements to enhance privacy and comfort: *“If the van had a small tent outside where we can wait, it would feel more organised.”* (EXP-02-022).

Mobile clinics, therefore, address multiple aspects of the COM-B model, expanding physical opportunity by reducing distance. *“Some of us live far; you have to take two taxis. But when the van comes close to us, it feels like they care.”* EXP-02-022 improving social opportunity by reducing stigma, *“When the mobile comes, you don’t feel embarrassed because people think it’s for any check-up, not only family planning.”* EXP-02-030 and strengthening motivation by providing safe, convenient access points. *“A mobile clinic makes things easy because you don’t waste the whole day. You get there, do what you need, and go.”* (EXP-02-026).

4.7.4 Preferred Clinic Designs and Youth-Centred Spaces

The participatory drawing exercise provided deeper insight into how adolescents imagine their ideal clinic environment. Many envisioned spaces that were bright, clean, and welcoming, with colours and designs that conveyed positivity rather than illness. *“My clinic would have music, comfortable chairs, and posters with young people smiling.”* (EXP-02-009). Another participant noted, *“There should be a youth section where we sit separately and talk freely.”* (EXP-02-022).

Privacy and comfort were recurring priorities. *“It must be colourful – not dull. Maybe light blue, white, or yellow so it feels happy.”* (EXP-02-030). *“When you walk in, you must see signs showing where to go. That helps us not to feel lost.”* (EXP-02-003). Adolescents also emphasised the importance of youth-friendly staff: *“The nurse in the youth room must be nice and greet you, not just look at you.”* (EXP-02-026).

These ideas show that adolescents conceptualise youth-friendly care not only as a matter of interpersonal interaction but also as a spatial and emotional experience. The physical environment communicates inclusion, respect, and confidentiality, all critical for encouraging adolescents to initiate and sustain engagement with SRH services.

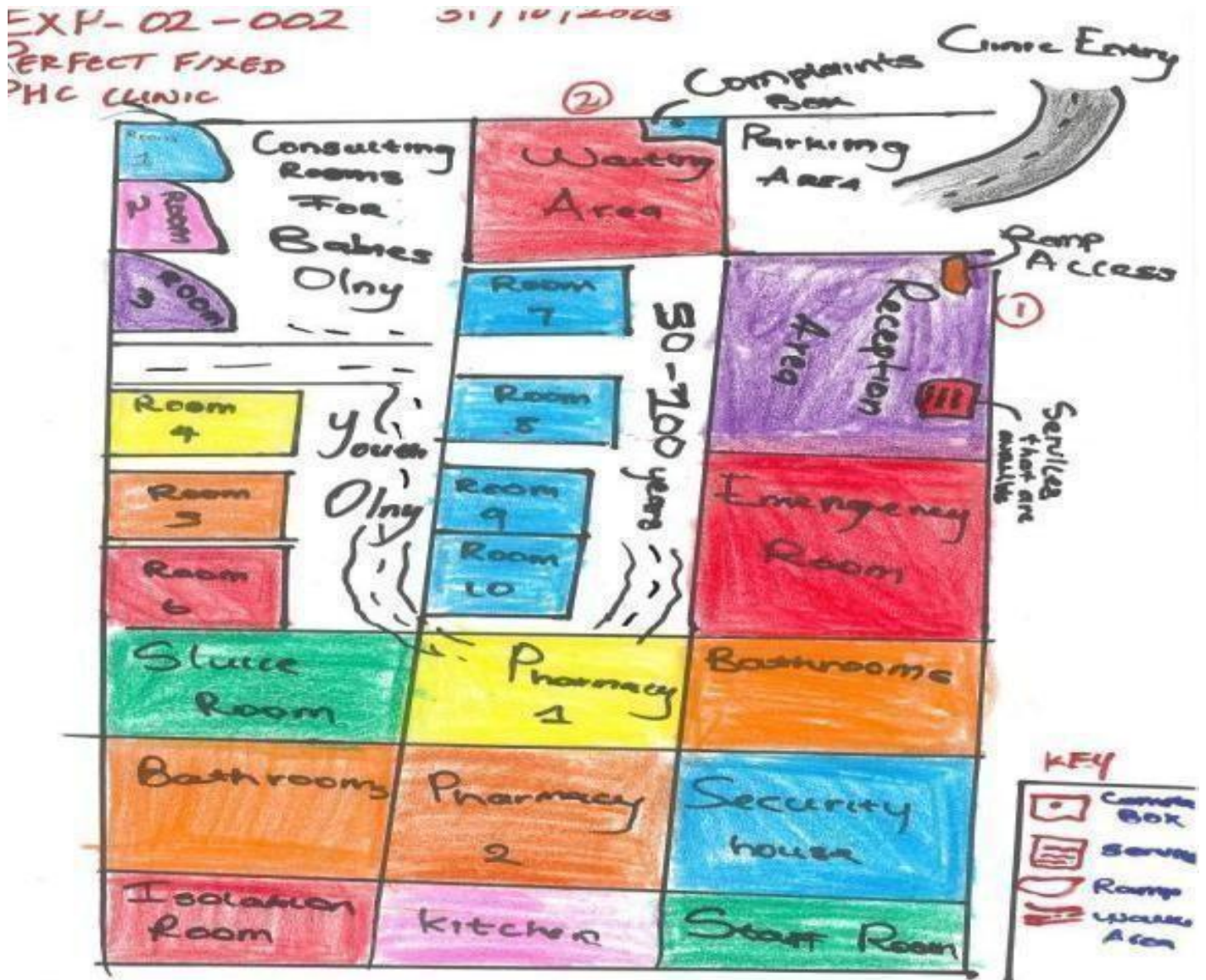
4.8 VISUALDATA: ADOLESCENT DEPICTIONS OF IDEAL CLINICS AND MOBILE CLINICS

In addition to interview and workshop discussion data, this study incorporated visual methods to capture adolescents’ perspectives on sexual and reproductive health (SRH) service environments. All participants were asked to complete drawings and design activities relating to both fixed-site clinics and mobile clinic service delivery models. These activities were used to encourage participants to express ideas and preferences that may have been difficult to articulate verbally.

The drawings provided complementary insight into adolescents’ priorities regarding privacy, accessibility, organisation, safety, and youth-friendliness, and offered visual representations of how adolescents imagined ideal SRH service environments. For analytic clarity, the visual findings are presented in two sections: fixed clinic designs and mobile clinic designs. Each section highlights the key features and characteristics adolescents identified as important within these healthcare spaces.

4.8.1 FIXED CLINIC DESIGNS

Figure 4.8.1 Preferred fixed clinic design by participant EXP-02-002 illustrates a fixed clinic layout emphasising separate waiting areas for adolescents, clear room demarcation, and organised patient flow. The inclusion of distinct youth spaces reflects a common preference among participants for privacy, reduced visibility, and emotional comfort when accessing SRH services.



KEY

- Complaints Box
- ≈ Services
- Ramp
- Waiting Area

Figure 4.8.2 Preferred fixed clinic design by participant EXP-02-026 illustrates a structured clinic environment with clearly labelled rooms and designated child-friendly areas. The emphasis on organisation and separation from adult patients reflects a shared desire among participants for predictable, respectful, and youth-oriented service spaces.



Figure 4.8.3 Preferred fixed clinic design by participant EXP-02-024 highlights the importance of an orderly clinic layout, privacy, and separation between service areas. Across multiple drawings, these features emerged as common priorities, signalling adolescents' desire for confidential, dignified, and emotionally safe clinic environments.

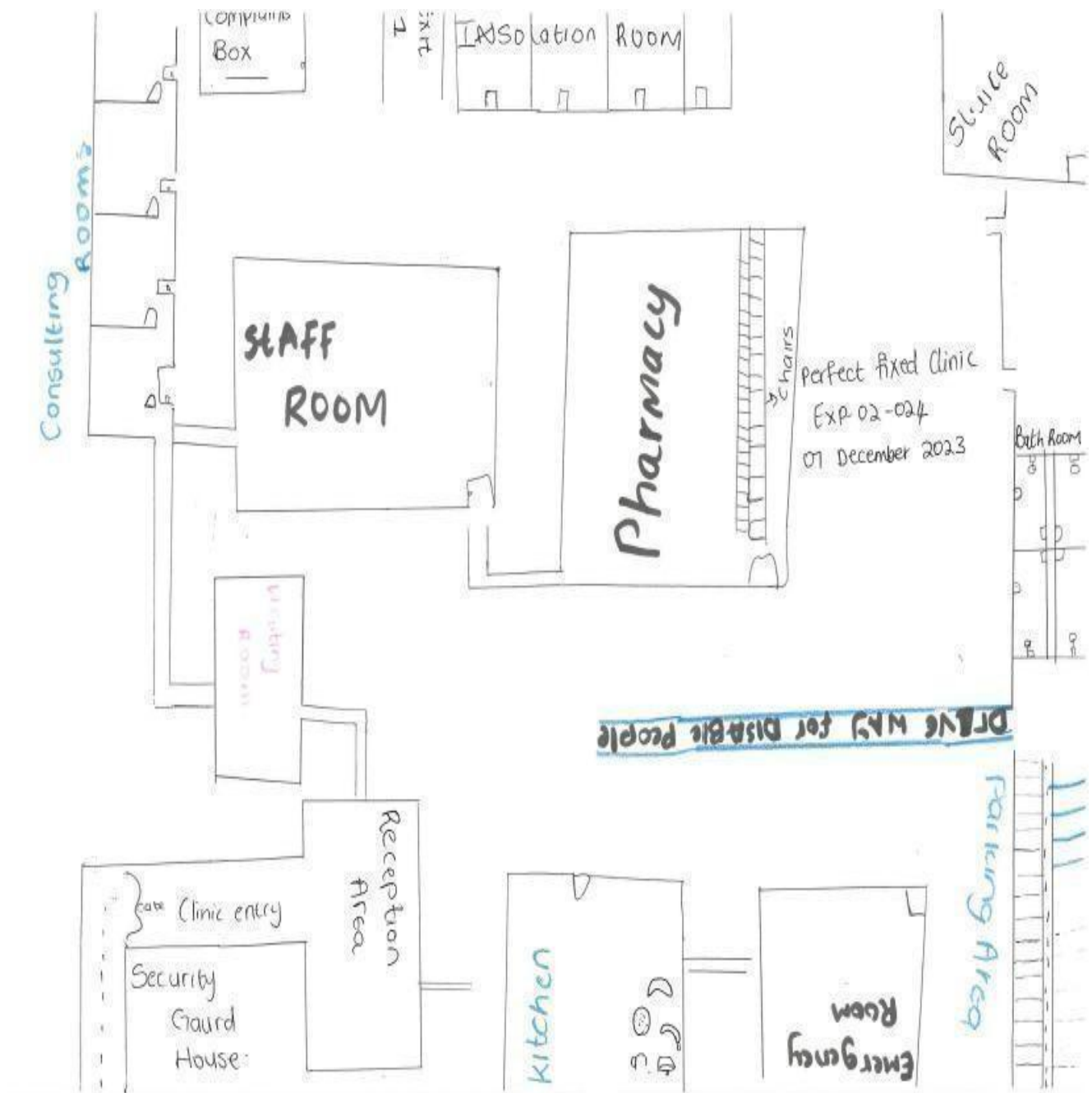


Figure 4.8.4 Preferred mobile clinic design by participant EXP-02-030. This mobile clinic drawing highlights mobility, proximity to communities, and discreet access points. Similar to other participants' depictions, the design prioritises convenience, reduced travel distance, and privacy, underscoring adolescents' preference for services that minimise time costs and social exposure.

KEY

1. Reception
2. Waiting Area
3. Consultation Room
4. Sluice Room
5. Storage Cabinet

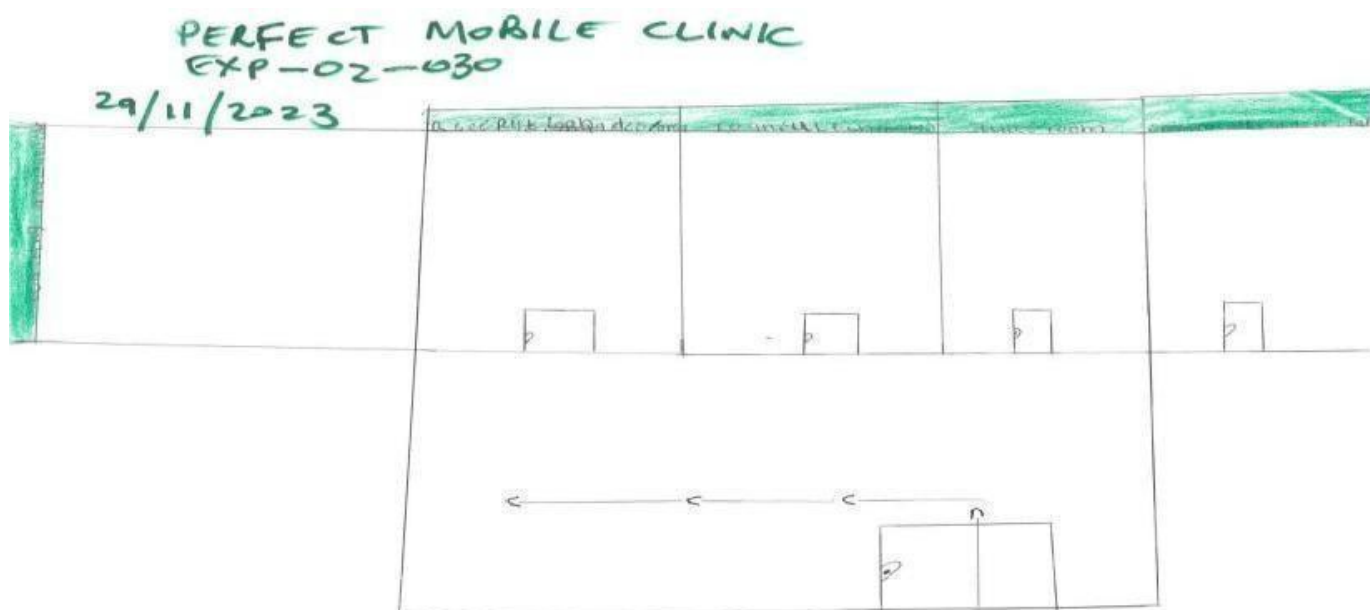
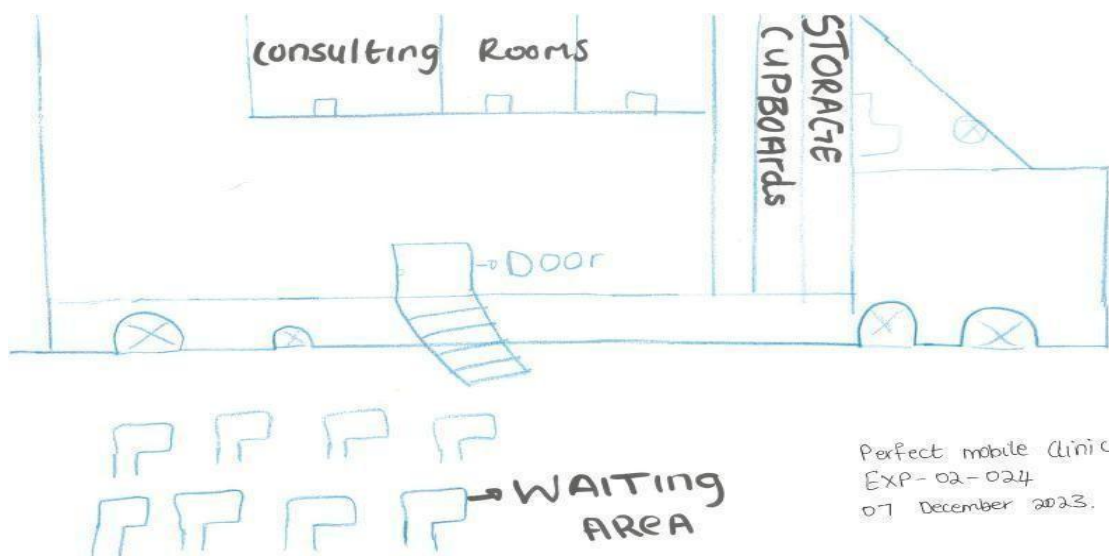


Figure 4.8.5 Preferred mobile clinic design by participant EXP-02-024. The mobile clinic drawing focuses on accessibility within the community and rapid service delivery. Consistent with other mobile clinic depictions, this design reflects adolescents' preference for services that are easy to reach, less intimidating, and associated with reduced waiting and stigma.



4.9 CHAPTER SUMMARY

In addressing the central research question, what behavioural, structural, and contextual factors influence adolescents' access to sexual and reproductive health (SRH) services? This chapter has explored how individual capability, environmental opportunity, and motivational processes interact within adolescents' lived experiences of care. Using the COM-B model and the Logical Decision Framework, the findings illustrated both the barriers that constrain service use and the facilitators that enhance engagement. The next chapter builds on these insights by discussing how these behavioural and contextual dynamics align with existing literature and theory, highlighting their implications for strengthening adolescent-responsive SRH services in South Africa.

CHAPTER5: DISCUSSION

5.1 INTRODUCTION

This chapter presents a critical discussion of the findings reported in Chapter 4, situating adolescents' experiences of accessing sexual and reproductive health (SRH) services in semi-rural KwaZulu-Natal within broader debates on healthcare access, youth wellbeing, and systems design. The discussion addresses the study's central objective: to explore the behavioural, structural, and contextual factors that influence adolescents' engagement with SRH services. Specifically, it addresses the guiding research question by examining the factors that enable or constrain adolescents' access to and utilisation of SRH services, and by exploring how these dynamics interact across individual, social, and systemic levels.

Guided by the COM-B model, which conceptualises behaviour as a function of Capability, Opportunity, and Motivation, and by the Decision Framework, which traces how adolescents move (or fail to move) from recognising a need to engaging with care, this chapter builds on the descriptive analysis of Chapter 4 by offering an interpretive synthesis. It moves beyond cataloguing barriers and facilitators to explain how and why specific service features, interpersonal interactions, and contextual conditions shape adolescents' health-seeking behaviour. In doing so, it connects the lived experiences of clinic navigation, time costs, privacy, staff attitudes, and emotional safety to the broader behavioural mechanisms that underpin adolescents' choices.

To maintain analytic clarity and narrative flow, the discussion is organized into three interlinking domains that mirror the layered nature of adolescents' encounters with SRH care. The discussion begins with Adolescent Agency, Emotional Safety, and Youth-Centred Facilitators, foregrounding how young people actively navigate health systems, articulate preferences, and propose solutions that support dignity, autonomy, and sustained engagement. It then turns to Interpersonal Dynamics and Social Norms, examining how healthcare workers' behaviours, confidentiality practices, and community expectations shape adolescents' motivation and psychological capacity to engage with care, including how anticipated judgement or breaches of trust alter decision-making pathways. The final domain, Structural and Systemic Conditions of Access, interrogates the physical, logistical, and organisational characteristics of services, such as distance, waiting times, signage, staffing, privacy, and layout, and considers how these features ultimately constrain or expand adolescents' opportunity to access care.

Across these domains, the chapter weaves together empirical themes, behavioural theory, and relevant literature to illuminate not only what adolescents experience, but what these experiences imply for service design and policy. The chapter concludes by synthesising how the findings extend or challenge existing evidence and by identifying practice and policy directions to strengthen adolescent SRH services in South Africa and comparable settings.

5.2 ADOLESCENT AGENCY AND YOUTH-CENTRED FACILITATORS

The discussion begins by foregrounding adolescents' own agency and the youth-centred facilitators that shaped their engagement with sexual and reproductive health (SRH) services. Rather than positioning adolescents as passive recipients of care, the findings reveal young people as active interpreters and navigators of health systems, capable of identifying barriers, proposing solutions, and shaping their own pathways to care. This section therefore examines how adolescents exercised agency through their preferences, strategies, and design suggestions, and how youth-friendly initiatives such as mobile clinics, dedicated service times, and emotionally safe environments functioned as facilitators of access. Interpreted through the COM-B framework, these dynamics illuminate how adolescents actively generate opportunity and sustain motivation even within constrained systems.

The findings suggest that youth-friendly service approaches may facilitate adolescents' engagement with SRH services by improving perceptions of respect, predictability, and accessibility within healthcare settings. In light of participants' concerns regarding long waiting times, negative clinic experiences, and organisational barriers, interventions such as youth-friendly service days, appointment systems, and simplified registration processes may help create more responsive and adolescent-centred healthcare environments.

Clinics that adopt such measures implicitly acknowledge adolescents as valued service users, thereby reducing the symbolic and practical barriers that often deter engagement. From a behavioural perspective, these organisational adaptations enhance physical opportunity by reducing waiting times and scheduling conflicts, while simultaneously strengthening reflective motivation by signalling that adolescents' time and needs are taken seriously. In contrast, facilities that lack youth-responsive organisational practices tend to reinforce perceptions of exclusion and marginalisation, making service use feel burdensome and unrewarding. Consistent with the COM-B framework, this contrast illustrates how seemingly modest system-level adjustments can function as powerful behavioural enablers, transforming access from a frustrating obligation into a feasible and meaningful health-seeking choice. Similar conclusions have been drawn in broader adolescent health literature, where predictable service flow and youth-dedicated provisions are associated with improved satisfaction, trust, and continuity of care (Molete et al., 2022; Mmari et al., 2023).

Within the COM-B framework, these differences illuminate how system design directly shapes adolescent behaviour. Youth-friendly clinics expanded physical opportunity by aligning service hours with school schedules, reduced logistical barriers through appointment systems, and strengthened social opportunity by fostering a sense of trust and inclusion. In contrast, poorly organised clinics constrained opportunity and eroded reflective motivation by conveying disinterest and disregard for adolescent clients. These findings align with evidence from Molete et al. (2022) and Mmari et al. (2023), which show that youth-dedicated hours and structured service flow significantly improves adolescents' satisfaction, perceived legitimacy, and continuity of care. Ultimately, this contrast demonstrates that youth-friendly service organisation functions not only as an operational improvement but as a behavioural intervention that shapes how adolescents perceive, value, and engage with SRH services. When predictability and respect are built into systems, they activate both opportunity and motivation, turning accessibility into meaningful participation.

Mobile and outreach services emerged as a critical facilitator of adolescent access to SRH care. Participants consistently described these as convenient, private, and community-centred. For many, mobile services represented the difference between unattainable and accessible care. They eliminated the need for long and costly transport, allowed adolescents to seek services discreetly within their own communities, and reduced the social scrutiny associated with attending fixed clinics. Importantly, these mobile services were interpreted not merely as logistical solutions but as symbols of care and inclusion, evidence that the health system acknowledged their needs. Such interpretations align with Smith and Chandra-Mouli (2020), who found that mobile outreach programmes improve adolescent access to contraception and HIV testing while mitigating stigma linked to facility-based services. Equally significant were the small but powerful environmental cues that communicated respect and safety. Clean waiting areas, organised queues, friendly reception staff, and clearly marked signage were repeatedly mentioned as indicators that a clinic was “professional” and “welcoming.” These environmental details, though often overlooked in policy design, carry psychological weight. Design features such as clean waiting areas, clear signage, and orderly spaces reassure adolescents that their well-being is valued and signal that confidentiality and order are priorities. In behavioural terms, these features enhance reflective motivation by making adolescents feel worthy of care, a finding consistent with the WHO (2018) quality standards for adolescent-friendly health services.

Beyond system-level facilitators, adolescents also described the ways in which they exercised agency to overcome structural constraints. They shared information with peers about service options, accompanied one another to clinics to reduce fear, and used online platforms to learn about contraception and sexual health when formal education was inadequate. These self-directed strategies demonstrate that adolescents are not passive beneficiaries but active problem-solvers. They create opportunity where systems fall short and expand capability through peer learning. Similar patterns of peer-driven support have been documented in other contexts, where young people’s social networks play a crucial role in sustaining engagement with SRH care (Mbadu et al., 2022). Emotional and psychological safety also emerged as an essential enabler of access. Adolescents frequently noted that their decisions to return to a clinic depended as much on how they were treated as on what services were available. Positive encounters, such as being greeted politely, spoken to confidentially, or simply being acknowledged as responsible decision-makers, were described as deeply motivating. Conversely, negative experiences such as scolding or being dismissed in front of others often resulted in complete disengagement. This finding supports earlier research showing that even seemingly routine clinical interactions can have lasting emotional effects on adolescents’ trust in health institutions (Holt et al., 2012; James et al., 2022).

For many participants, the clinic experience was not purely transactional but deeply symbolic. Seeking care involved issues of identity, self-esteem, and autonomy. The emotional tone of interactions, whether reassuring or judgmental, communicated broader messages about belonging and respect. Adolescents who felt listened to and included were more likely to perceive themselves as capable health actors. In contrast, those who felt shamed or silenced internalised stigma, often withdrawing from services altogether. This dynamic illustrates the interplay between automatic motivation (the emotional, instinctive response to environmental cues) and reflective motivation (the conscious evaluation of value and trust), both central to the COM-B framework. Furthermore, the developmental phase of adolescence amplifies the

significance of these experiences. As individuals negotiate autonomy and self-identity, they are especially sensitive to interactions that affirm or undermine their sense of control. Research from similar contexts suggests that adolescents' engagement with SRH care depends on whether they are treated as capable decision-makers rather than as children to be corrected (Atuhaire et al., 2021; Isaacs et al., 2024). Such encounters satisfy the developmental need for autonomy while reinforcing motivation to engage in healthy behaviour.

Overall, the findings demonstrate that when services become responsive to adolescents' needs, through efficient organisation, youth-dedicated hours, mobile outreach, and emotionally safe interactions, they activate the behavioural mechanisms of capability, opportunity, and motivation simultaneously. The result is not only improved access but also a stronger sense of partnership between adolescents and the health system. Importantly, this study confirms that adolescents are not simply end-users of care but key stakeholders in shaping its delivery. Their proposals, drawings, and reflections highlight a practical and conceptual shift: youth-centred services are not built for adolescents but with them. This ethos aligns with global frameworks on participatory health governance (UNFPA, 2014; WHO, 2015) and supports Chandra-Mouli et al. (2015)'s call for young people to be recognised as co-designers of SRH systems.

Ultimately, the intersection between adolescent agency and youth-centred facilitators represents a point of transformation. When adolescents encounter systems that treat them with dignity, predictability, and respect, they respond with engagement, responsibility, and trust. The transformation, therefore, is mutual: institutions become more responsive, and adolescents more empowered. It is at this intersection, between structural reform and individual agency, that sustainable, equitable SRH access for young people can be realised. While adolescent agency and youth-centred facilitators play a critical role in enabling access, these efforts are profoundly shaped by the interpersonal environments adolescents encounter within clinics and communities.

5.3 INTERPERSONAL DYNAMICS AND SOCIAL NORMS

Building on adolescents' own agency, this section turns to the interpersonal dynamics and social norms that mediate young people's engagement with SRH services. While youth-centred initiatives may create enabling conditions, the quality of interactions with healthcare workers, the credibility of confidentiality, and the influence of peer and community expectations determine whether adolescents feel emotionally safe, respected, and willing to disclose sensitive concerns. Through the lens of the COM-B model, these interpersonal factors primarily shape motivation and psychological capability, while the Decision Framework highlights their role as critical decision points that can either facilitate continuation or trigger disengagement.

A consistent finding from Chapter 4 was the decisive role of healthcare-worker attitudes and communication. Adolescents interpreted abrupt, moralising, or dismissive interactions as implicit messages that they did not belong in the clinic space. The literature is unequivocal that judgmental communication and moralising tones deter adolescents from disclosing sensitive concerns, undermine the quality of counselling, and depress return rates (Beksinska et al., 2020; Molete, Gilbert, & Hira, 2022). Conversely, empathetic, non-judgemental communication

enhances adolescents' reflective motivation, enabling them to seek clarification about contraceptive methods, side effects, and follow-up. In COM-B terms, supportive communication simultaneously strengthens motivation (by building trust) and capability (by translating information into usable understanding). This dual effect explains why adolescents in this study were more likely to re-engage when they encountered staff who listened, explained, and treated them as partners in care, a pattern widely documented in youth-friendly services research (Chandra-Mouli, Lane, & Wong, 2015).

Closely linked to communication is the question of confidentiality and trust, both of which emerged as decisive factors shaping adolescents' engagement with SRH services. Adolescents' willingness to discuss sexuality, contraception, or HIV testing depended heavily on credible assurances of privacy. When adolescents felt uncertain about confidentiality, for example, when consultation doors were left open, conversations could be overheard between rooms because the walls between rooms are thin, or staff appeared to know their family members, they described withholding information or avoiding services altogether. These breaches, whether real or perceived, generated a deep sense of vulnerability and fear of exposure.

This study's findings are consistent with evidence from South Africa and across sub-Saharan Africa, where perceived or actual confidentiality breaches have been identified as a major deterrent to adolescent SRH service utilisation (Geary et al., 2019; Beksinska et al., 2020; Mmari et al., 2023). In such contexts, the clinic environment itself becomes a symbolic test of trust: when privacy is compromised, adolescents interpret it as a signal that the system is unsafe or untrustworthy. Within the COM-B framework, these dynamics primarily erode psychological capability by undermining adolescents' confidence to disclose sensitive information, and reflective motivation by reducing their belief that accessing care will lead to positive, respectful outcomes.

Within the Decision Framework, confidentiality functions as a "gate" variable: when trust is credible, adolescents proceed from consultation to treatment and follow-up; when it is not, they disengage before the clinical encounter achieves its purpose. Practically, this suggests that privacy assurances must be performed (e.g., closing doors, lowering voices, signalling confidentiality policies) as well as promised.

Interpersonal comfort is also mediated by provider–client harmony in age and gender. Many adolescents prefer younger, or same-gender, providers for intimate topics, reporting that these pairings feel less hierarchical and more relatable. Evidence from sub-Saharan Africa supports the value of perceived similarity and reduced social distance in improving disclosure and satisfaction (Mmari, Leddy, & Kennedy, 2023; Ninsiima, Leye, & Michielsen, 2021). Although staffing realities may limit perfect matching, a behaviourally informed approach recognises that simple adjustments, such as offering adolescents a choice where possible or ensuring that the most youth-experienced nurses handle adolescent queues, can meaningfully affect comfort and disclosure. In COM-B terms, these adjustments increase social opportunity, making the clinic a context in which open conversation is normatively and practically supported.

While the clinic encounter is pivotal, peer norms and social visibility also interact with interpersonal dynamics inside facilities. Fear of being seen by acquaintances in mixed-age waiting areas, or of reputational harm among peers, can suppress care-seeking even before any provider contact occurs. The literature has repeatedly shown that adolescent concerns about labelling (e.g., being seen as sexually active, pregnant, or “sick”) reduce attendance and timely help-seeking, particularly for girls (Jonas, Crutzen, & van den Borne, 2018; Chandra-Mouli et al., 2015). In our analysis, these social forces amplify interpersonal risks: when adolescents anticipate judgement both outside (peers, neighbours) and inside (staff), they rationally avoid disclosure. Interventions that reduce visibility (e.g., youth-specific times) or normalise adolescent presence (e.g., youth corners with visible information) thus mitigate peer-stigma effects and lower the interpersonal threshold for open dialogue.

Taken together, these dynamics show that interpersonal quality is not a “soft” add-on but a core determinant of adolescent engagement. Respectful communication, privacy of consultations, and thoughtful attention to comfort and choice operate as behaviour-change mechanisms that convert intention into action. Within COM-B, they work by raising motivation and capability; within the Decision Framework, they stabilise progress through consultation and into follow-up. In summary, the interpersonal environment can either neutralise structural barriers by making every minute in the clinic feel safe and worthwhile or compound them when adolescents feel judged or exposed. The next section turns to adolescent agency and youth-centred facilitators, examining how young people’s own strategies and design preferences (including mobile clinics and youth-friendly spatial features) can be leveraged to build relationally and structurally enabling systems. These interpersonal experiences, however, do not occur in isolation; they are embedded within broader structural and systemic conditions that ultimately shape the accessibility, predictability, and sustainability of SRH services for adolescents.

5.4 STRUCTURAL AND SYSTEMIC CONDITIONS OF ACCESS

The final layer of the discussion examines the structural and systemic conditions within which adolescent SRH access occurs. These include the physical organisation of clinics, distance and transport costs, waiting times, staffing patterns, and the availability of resources. While adolescents may demonstrate agency and navigate interpersonal challenges, these structural factors define the boundaries of what is practically possible. Interpreted through the COM-B framework, such conditions primarily shape physical opportunity and, over time, influence reflective motivation by signalling whether accessing care is feasible, worthwhile, and respectful.

The first layer of adolescents’ engagement with SRH services relates to the structural and systemic conditions within which access occurs. These include the organisation of health facilities, clinic layout, waiting times, resource availability, and the physical distance between services and users. Each of these factors affects what the COM-B model identifies as opportunity, the external context that enables or hinders behaviour (Michie, van Stralen, & West, 2011).

Participants in this study repeatedly emphasised how distance and transportation costs constrained their ability to visit clinics. For many adolescents in semi-rural areas, travelling to a facility required multiple taxis or long walks, turning even routine SRH visits into time-consuming and expensive undertakings. Such findings echo those of Jonas et al. (2018) and Sidamo et al. (2024), who observed that distance remains a persistent structural barrier for adolescents in low-resource contexts. The challenge is compounded by opportunity costs; attending the clinic often means missing school or work, which discourages repeat visits. Beyond geography, time cost emerged as a major deterrent. Long queues, limited staff, and unpredictable service hours meant adolescents could spend an entire day waiting for care. Several participants described arriving early in the morning only to be seen late in the afternoon or turned away when services closed. These experiences created frustration and resentment, undermining their motivation to return. Similar evidence from South African public-sector clinics confirms that prolonged waiting and inefficient triage reduce service utilisation among young people (Beksinska et al., 2020).

Collectively, these structural barriers primarily restrict physical opportunity within the COM-B framework by limiting access through distance and time and diminishing reflective motivation, as repeated logistical frustrations erode adolescents' belief that seeking care is worthwhile or achievable. The internal organisation of space within clinics intensified these frustrations. Shared waiting areas with adults created embarrassment and reinforced fears of gossip, especially among girls seeking contraception or STI testing. Many adolescents felt "watched" or "judged" when waiting in mixed-age lines. Poor signage and a lack of privacy at reception exacerbated confusion and anxiety. As one participant explained in Chapter 4, the absence of separate youth areas made it hard to be comfortable. This aligns with WHO (2018) guidance that physical layout and signage are crucial to establishing confidential, welcoming environments for adolescents.

Although the COM-B model provided a useful framework for understanding behavioural influences on adolescent SRH service utilisation, the model may not fully capture broader structural inequalities, historical contexts, and power dynamics that shape healthcare access within resource-constrained settings. Factors such as poverty, gender inequality, and community-level social norms interact with behavioural determinants in complex ways that extend beyond individual motivation, capability, and opportunity. The findings also suggest that adolescents' healthcare experiences are influenced not only by behavioural and environmental factors, but also by wider socio-economic and cultural conditions. Community stigma, gender expectations, family dynamics, and economic constraints may further shape adolescents' willingness and ability to access SRH services.

Beyond the physical inconvenience, however, these experiences reveal an important emotional dimension to structural barriers. Feelings of exposure, confusion, and anxiety generated psychological fatigue and avoidance; adolescents were not only delayed by the clinic's organisation but also emotionally distanced from care. This finding extends existing studies that have largely framed access barriers in logistical terms (Jonas et al., 2018; Sidamo et al., 2024), by showing that disorganised or non-youth-sensitive clinic environments communicate symbolic messages about belonging and exclusion. When young clients perceive a space as unsafe or judgmental, the barrier becomes not merely physical but affective, leading to self-

ensorship and reduced motivation to return. In COM-B terms, these emotional responses undermine psychological capability by reducing confidence to ask for help, and reflective motivation by weakening belief in the safety and value of the service.

Furthermore, resource shortages, such as inconsistent availability of contraceptive supplies, lack of educational materials, and staff absenteeism, added to systemic frustration. Participants noted instances where they were asked to “come back next week” because stock had run out, or where nurses rotated frequently, preventing continuity of care. These gaps illustrate how systemic inefficiencies undermine both physical and psychological opportunity, eroding adolescents’ trust in the health system.

Taken together, these findings underscore that service design is not merely logistical but fundamentally behavioural. Each aspect of the health system, including distance, time, spatial layout, resource reliability, and staff conduct, communicates implicit expectations and values to adolescent users. When services are experienced as unpredictable, overcrowded, or alienating, they signal exclusion and diminish adolescents’ sense of legitimacy as clients, a pattern well documented in studies of youth engagement with public-sector health services (Jonas et al., 2018; Beksinska et al., 2020). Such environments undermine trust and weaken motivation by framing care as burdensome or emotionally unsafe. Conversely, when systems are orderly, responsive, and considerate, they foster a sense of belonging and affirm adolescents’ right to care, thereby strengthening motivation and sustained engagement (WHO, 2018; Sidamo et al., 2024). From a COM-B perspective, effective structural and systemic design expands physical opportunity while reinforcing reflective motivation and psychological capability, enabling adolescents to seek SRH care with dignity and confidence.

5.5 IMPLICATIONS FOR POLICY AND PRACTICE

The findings of this study underscore a multidimensional set of implications for the design, delivery, and governance of adolescent sexual and reproductive health (SRH) services in semi-rural South African contexts. While structural limitations and social stigma in healthcare provision have been widely reported in existing literature, this research contributes uniquely by prioritising the lived experiences, perceptions, and strategies of adolescents themselves as they engage with health services. In doing so, it affirms the importance of centering youth voices in both diagnostic and solution-oriented policy frameworks. By drawing on the COM-B model of behaviour change, which frames human action as the product of capability, opportunity, and motivation, this section outlines implications that can be leveraged to improve SRH service access and experience for adolescents. These implications span across infrastructural, social, informational, and institutional domains and emphasise the importance of contextualised, youth-informed, and equity-driven interventions.

5.5.1 STRUCTURAL REFORM: SERVICE DESIGN, FLOW, AND PHYSICAL OPPORTUNITY

A recurring theme in this study is the persistent inadequacy of physical and organisational infrastructure in clinics servicing semi-rural youth populations. Despite national policies that affirm adolescent access to SRH care, the practical ability to exercise this right is routinely undermined by systemic inefficiencies. Adolescents described facilities as overcrowded, confusing, and at times emotionally uncomfortable, with long waiting times, unclear navigation routes, and a lack of privacy within clinic layouts. These challenges are more than operational inconveniences; they constitute structural barriers that directly limit adolescents' physical opportunity to access care.

Policy responses, such as dedicated adolescent service hours or days, directly respond to these critiques and align with WHO (2012) recommendations for youth-specific scheduling. Visual tools like signage and maps, along with clearer zoning within clinics, also respond to Govathson et al.'s (2023) call for spatial reorganisation and improved wayfinding as critical components of youth-friendly care. The emphasis on increased staffing and youth-trained providers aligns with the broader critique in Chapter 2 that provider availability and training remain inconsistent in rural settings (Atuhaire et al., 2021; Holt et al., 2012). Similarly, the reconfiguration of spatial layouts to preserve privacy responds directly to findings in Chapter 2 that adolescent clients feel exposed and vulnerable when physical environments do not safeguard discretion (James et al., 2022).

In addition, spatial layouts must be revised to prioritise privacy and reduce the potential for exposure or embarrassment, particularly in areas related to consultations, sample submissions, and pharmacy queues. Adolescents in this study repeatedly voiced discomfort with the proximity of consultation rooms to public waiting areas, the audible discussions of sensitive health issues, and the public handling of diagnostic specimens. Additionally, adolescents' concern with exposure and visibility within public clinic spaces echoes findings from Usonwu et al. (2021) and Ninsiima et al. (2021), who noted that many young people avoid clinics due to fears of being seen and associated shame. These physical and procedural elements compromise confidentiality and, more broadly, erode the sense of dignity and safety that is essential for sustained engagement. Importantly, these recommendations should not be viewed as technical upgrades alone, but as necessary structural conditions for a service delivery model that is genuinely youth-accessible and developmentally appropriate.

5.5.2 WORKFORCE DEVELOPMENT: TRUST, CONFIDENTIALITY, AND SOCIAL OPPORTUNITY

While physical access to clinics is essential, the study demonstrates that adolescents' experiences with healthcare workers are equally, if not more, influential in shaping their willingness to seek and continue care. Participants conveyed a nuanced understanding of clinical interactions, often recalling specific moments where they felt respected, judged, ignored, or supported. These interpersonal dynamics directly influenced adolescents' decisions to return or disengage. Thus, social opportunity, the relational and cultural environment within which adolescents interact with services, emerged as a crucial dimension of service accessibility.

This aligns with substantial literature reviewed in Chapter 2, where provider attitudes and community norms were repeatedly cited as central deterrents to adolescent service use (Issacs et al., 2024; Ninsiima et al., 2021; Usonwu et al., 2021). Adolescents' accounts of feeling judged or morally policed when seeking SRH care echo what James et al. (2022) and Atuhaire et al. (2021) found: that healthcare workers often impose adult moral frameworks onto adolescent behaviour, discouraging open dialogue and trust. Therefore, policy and practice must focus on building an adolescent-responsive workforce that is skilled not only in clinical delivery but also in youth-centred communication and ethical engagement. Mandatory training programmes in adolescent-responsive care should be implemented and continuously reinforced across all levels of health personnel. These should encompass non-judgmental communication techniques, active listening skills, and strict adherence to confidentiality protocols. Emphasis must be placed on understanding adolescents' diverse socio-cultural realities, as well as the power asymmetries that shape clinical encounters. Furthermore, the strategic recruitment, deployment, and retention of youth-dedicated nurses, peer navigators, and youth liaison officers within high-volume clinics can offer consistent relational anchors for adolescents and help build trust in the health system. These individuals can serve not only as service providers but also as role models and informal counsellors who can mediate between adolescents and institutional systems.

To ensure accountability and foster trust, clinics should also integrate anonymous reporting and feedback mechanisms. This may include suggestion boxes, digital surveys, or SMS-based platforms that allow adolescents to report instances of mistreatment or breaches of confidentiality without fear of reprisal. Additionally, community-level education campaigns should be expanded to sensitise adults, including healthcare providers, parents, and traditional leaders, to adolescents' SRH rights, particularly for adolescents under the age of 18. Previous studies have also highlighted the importance of values clarification and attitude transformation training for healthcare providers in improving adolescent-friendly service delivery and reducing judgmental attitudes towards young people seeking SRH services (Geary et al., 2014; Chandra-Mouli et al., 2015). Although the effectiveness of these interventions has varied across settings, evidence suggests that training initiatives are more effective when combined with broader institutional support, ongoing mentorship, and structural improvements within healthcare environments (Denno, Hoopes, & Chandra-Mouli, 2015). These interventions are therefore critical in transforming clinics into socially enabling environments where adolescents feel affirmed rather than alienated.

5.5.3 EMPOWERMENT THROUGH INFORMATION: ENHANCING PSYCHOLOGICAL CAPABILITY

Despite relatively high levels of general SRH awareness, this study revealed notable gaps in health literacy, particularly regarding service options, procedural expectations, and medical terminology. Adolescents frequently expressed confusion, mistrust, or inadequacy when information was delivered in overly technical or dismissive ways. These cognitive and emotional barriers inhibit psychological capability, that is, the knowledge, confidence, and communication skills needed to meaningfully engage with SRH services (Michie et al., 2011). Similar findings have been documented in adolescent SRH research across sub-Saharan Africa, where limited clarity and poor communication deter engagement even when services are available (Denno, Hoopes, & Chandra-Mouli, 2015; Geary et al., 2019).

Strengthening youth-adapted health communication is therefore essential. The World Health Organization (2018) recommends that adolescent-friendly services use clear, developmentally appropriate information, maintain confidentiality, and ensure providers adopt supportive communication styles. Evidence from several low- and middle-income countries shows that youth-friendly interventions combining staff training with tailored educational materials improve adolescents' knowledge, satisfaction, and service utilisation (Chandra-Mouli et al., 2015; Mmari et al., 2023). These findings align with the COM-B framework: when adolescents understand procedures and expectations, their capability and reflective motivation increase, fostering trust and consistent help-seeking.

A comparative look within this study underscores these mechanisms. In clinics that had implemented youth-friendly initiatives, such as clear signage, simplified registration, and predictable appointment systems, adolescents described smoother navigation and greater confidence. By contrast, facilities lacking such adaptations were described as confusing, intimidating, and disorganised. This local divergence mirrors international evidence that adolescent-specific adaptations improve engagement compared to standard adult-oriented models (Molete, Gilbert, & Hira, 2022; Mmari et al., 2023). Behaviourally, youth-centered communication enhances adolescents' capability (they know what to expect and what to ask) and motivation (they feel respected and valued).

Peer education further reinforces these behavioural enablers. Studies across the region have shown that trained peer educators improve SRH literacy and confidence while reducing stigma through relatable, youth-to-youth dialogue (Mbadu et al., 2022; Sidamo et al., 2024). In COM-B terms, peer-based learning bolsters social opportunity by providing trusted, non-judgmental spaces and capability, through shared understanding and language. However, the sustainability of these interventions depends on adequate support, integration with clinical services, and provider buy-in (Denno et al., 2015).

Digital interventions also show promise. Mobile health applications, SMS reminders, and anonymous chat platforms have improved SRH knowledge and access among adolescents who value privacy and discretion (Smith & Chandra-Mouli, 2020; Govathson et al., 2023). South African examples, such as the Wits RHI "Sister Unathi" chatbot as well as "MomConnect", demonstrate how digital design can provide real-time guidance, clarify procedures, and link users to local clinics, directly strengthening psychological capability and reducing the anxiety of first visits (Sewpaul et al., 2023).

Finally, first-time user orientation, whether brief induction sessions, informational posters, or guided tours, addresses the uncertainty many adolescents reported in this study. Orientation practices are consistent with WHO (2018) quality standards on information and continuity, converting procedural ambiguity into predictable, manageable steps. Behaviourally, these measures enhance psychological capability while easing automatic motivation by reducing anxiety and building confidence.

In summary, developing adolescents' psychological capability requires more than distributing pamphlets; it involves designing information that is clear, youth-centred, emotionally safe, and consistently delivered. When healthcare providers communicate with empathy and are supported through values clarification and adolescent-friendly service training, adolescents may feel more respected and comfortable engaging with SRH services. Peer support and predictable healthcare processes further strengthen adolescents' confidence and understanding of how to navigate services. Where these elements are absent, confusion, mistrust, and doubt may persist, limiting both capability and motivation despite apparent awareness.

5.5.4 EMOTIONAL SAFETY AND DIGNITY AS CLINICAL PRIORITIES

One of the most striking insights from this study is the centrality of emotional safety in shaping adolescent health behaviours. Participants repeatedly recounted experiences of shame, fear, and distress associated with clinic visits, whether from being publicly questioned, having their privacy breached, or navigating unwelcoming spaces. These emotional responses, while often dismissed as peripheral to clinical care, are in fact integral to adolescents' automatic motivation, the unconscious affective processes that drive health-seeking behaviour.

To address this, a paradigm shift is needed in how healthcare quality is defined and measured. Emotional and psychological safety must be recognized as legitimate, non-negotiable dimensions of quality care. Clinics should actively engage adolescents in co-designing service environments, including the placement of consultation rooms, waiting areas, and sample collection points. Incorporating youth feedback into layout changes can help ensure that spatial arrangements support, rather than undermine, their sense of dignity. Moreover, aesthetic improvements, such as the use of calming colours, youth-friendly artwork, and comfortable seating, can significantly transform the emotional tone of healthcare spaces. These are not merely cosmetic changes, but tangible indicators that clinics value and respect adolescent clients. Practical innovations, such as the use of opaque specimen containers and discreet submission windows, can also help mitigate embarrassment during diagnostic procedures.

While some environmental and structural modifications may require additional financial and infrastructural investment, several youth-friendly improvements may be implemented at relatively low cost through organisational and operational changes. Simple interventions relating to privacy, staff communication, signage, clinic flow, and the creation of respectful adolescent-centred spaces may substantially improve adolescents' experiences even within resource-constrained settings. Furthermore, the recommendation to involve youth in co-design reflects a broader push for youth participation highlighted in Chapter 2 (Govathson et al., 2023), as well as by international frameworks such as UNFPA (2014). Aesthetic improvements and dignified sample handling, while seemingly minor, have a profound impact on motivation, an insight supported by Holt et al. (2012), who noted that small environmental changes often produce disproportionately large gains in adolescent comfort and trust.

These changes signal a deeper institutional commitment to adolescent well-being, acknowledging that the clinical encounter begins long before a consultation and extends far beyond the delivery of medication. In doing so, they foster motivation not only for initial service uptake but for long-term, repeated engagement.

5.5.5 ELEVATING ADOLESCENT VOICE IN POLICY AND PLANNING

A final and critical implication of this study concerns the role of adolescents in shaping the very systems intended to serve them. Across the findings, participants consistently demonstrated analytical insight and practical imagination, identifying service gaps, proposing design improvements, and articulating the moral and emotional qualities of respectful care. This highlights that adolescents are not passive consumers of health services but active agents capable of shaping, monitoring, and sustaining change. Their capacity to critique and reimagine health systems aligns with the “reflective motivation” component of the COM-B model (Michie et al., 2011), which emphasizes intentionality and goal-oriented reasoning as core behavioural drivers. When adolescents are engaged in decision-making processes, they experience autonomy and competence, motivational states that, in turn, enhance sustained engagement with services.

From a Decision Framework perspective, youth participation also strengthens the navigation and evaluation stages of the health-seeking process. When young people are involved in service planning, they help to clarify pathways, simplify procedures, and identify barriers that adults may overlook (WHO, 2018). This participatory insight enables system designers to anticipate real-world bottlenecks in clinic flow, privacy, and communication, ultimately increasing the capability and opportunity dimensions of access at a population level. Empirically, the inclusion of adolescent voices in policy processes is associated with more responsive and effective service delivery. Research in South Africa and East Africa has shown that adolescent advisory panels, youth-friendly health committees, and participatory design workshops improve service relevance, uptake, and satisfaction (Denno et al., 2015; Mathews et al., 2022; Mbadu et al., 2022). These mechanisms move beyond symbolic consultation to embed youth perspectives into governance, planning, and monitoring. However, as Chandra-Mouli et al. (2018) caution, genuine participation requires institutional support, including capacity building for both youth and health staff, and must be integrated into standard operating procedures rather than treated as ad hoc outreach.

To operationalize this, policy frameworks should institutionalize structured youth participation at multiple levels. At the clinic level, youth advisory boards can provide feedback on facility layout, staff conduct, and communication strategies. At district and provincial levels, adolescents can contribute to SRH policy evaluation and service audits, ensuring that implementation metrics reflect lived experience. Evidence from participatory governance initiatives shows that such youth involvement improves accountability and enhances trust between young people and service providers (Patton et al., 2016; United Nations Population Fund [UNFPA], 2014).

Incorporating adolescent perspectives into health information systems can also strengthen learning loops. Routine quantitative data, such as service utilization rates, often obscure the emotional and experiential dimensions of access. By integrating qualitative indicators, such as measures of satisfaction, perceived safety, and relational quality of care, policymakers can capture more holistic insights into adolescent experience (World Health Organization, 2020). This approach reflects a shift from measuring attendance to evaluating empowerment, a distinction critical to adolescent-centred care.

Finally, the communication of SRH policy itself should model inclusivity. Integrating youth narratives into public messaging, through storytelling, digital platforms, or peer-led advocacy can humanise health policy and reinforce collective motivation for system change (Mmari et al., 2023). In behavioural terms, such visibility normalises adolescent engagement and expands social opportunity by redefining participation as legitimate and valued civic behaviour.

In sum, embedding adolescents not merely as beneficiaries but as partners in SRH policy and planning transforms participation from a procedural ideal into a behavioural enabler. Theoretically, this approach activates all three domains of the COM-B model, enhancing capability through knowledge-sharing, opportunity through structured inclusion, and motivation through ownership and recognition. Practically, it aligns with global youth participation frameworks (UNFPA, 2014; WHO, 2018) and national health transformation agendas that call for co-production of policy with end-users. Future research should therefore examine how participatory governance can be institutionalised sustainably in South African SRH programmes, evaluating not only its process outcomes but its behavioural and equity impacts.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This final chapter presents a critical synthesis of the study's findings, offering overarching conclusions and outlining recommendations for strengthening adolescent sexual and reproductive health (SRH) service uptake in South Africa, with particular emphasis on semi-rural contexts such as KwaZulu-Natal. Drawing from the lived experiences of adolescents and analysed through the combined lenses of the COM-B behaviour change model (Michie et al., 2011) and the Decision Framework for healthcare navigation, this chapter examines how capability, opportunity, and motivation intersect to shape patterns of SRH service utilisation, avoidance, and innovation among young people.

The primary aim of this study was to explore how adolescents in semi-rural KwaZulu-Natal experience and navigate SRH services, and how individual, interpersonal, and structural factors influence their health-seeking behaviour. In pursuit of this aim, the research sought to identify the key barriers and facilitators that shape adolescents' access to and use of SRH services; to examine how perceptions of healthcare workers, clinic environments, and organisational practices affect adolescents' willingness to engage with care; and to interpret these findings through the COM-B model to understand how capability, opportunity, and motivation interact to influence behaviour. The study also aimed to generate evidence-based recommendations for enhancing the accessibility, acceptability, and responsiveness of SRH services for adolescents. These objectives were guided by the central research question: How do adolescents in semi-rural KwaZulu-Natal experience and negotiate access to sexual and reproductive health services, and what factors shape their motivation and opportunity to seek care? Subsidiary questions further explored how clinic structures, staff attitudes, and community norms influence adolescents' willingness to engage with SRH care, as well as the forms of support or reform that could enhance youth-centred service delivery.

Each of these research objectives was addressed through a qualitative research design that integrated semi-structured interviews, visual elicitation exercises, and thematic analysis. The findings presented in Chapter 4 directly responded to these questions by identifying a range of structural, social, and interpersonal barriers, such as distance, waiting times, staff attitudes, and confidentiality concerns, alongside important facilitators, including mobile clinics, peer support networks, and youth-friendly organisational reforms. The subsequent discussion in Chapter 5 built upon these findings, employing the COM-B and Decision Frameworks to explain how these barriers and facilitators interact dynamically to influence adolescents' decision-making processes and patterns of engagement with SRH services.

This concluding chapter, therefore, synthesises the study's key insights, situating them within broader theoretical, policy, and practical debates on adolescent health. It begins by summarising the main conclusions in relation to the study's objectives and research questions, before exploring the implications of these findings for theory development, health policy, and clinical practice. The chapter then presents specific, evidence-based recommendations for improving the accessibility and responsiveness of SRH services for adolescents and identifies areas requiring further research. It concludes with a reflection on the broader significance of

adolescent SRH in advancing health equity, empowerment, and participatory governance in South Africa. Collectively, the findings underscore the urgent need for youth-centred, emotionally safe, and structurally responsive SRH systems that recognise adolescents not only as service users but as co-architects of a more inclusive and equitable health system.

6.2 KEY CONCLUSIONS

This study concludes that adolescent access to sexual and reproductive health (SRH) services in semi-rural KwaZulu-Natal is shaped by a complex interaction of psychosocial, environmental, and systemic forces that extend beyond individual awareness or intention. Service utilisation emerges from the alignment of capability, opportunity, and motivation, as conceptualised in the COM-B model (Michie et al., 2011). The framework highlights that adolescent health behaviour is not simply a matter of personal responsibility but is produced within institutional and social environments that can either enable or constrain agency. Access, therefore, must be understood as relational and structural, not merely behavioural.

In terms of capability, the central conclusion is that adolescents require more than factual SRH knowledge; they need practical and emotional competence to navigate healthcare systems confidently. Procedural uncertainty, inconsistent communication, and fear of negative judgement undermine adolescents' ability to act on existing knowledge. Capability is thus inseparable from the quality of interpersonal engagement within clinics. When healthcare interactions are respectful and affirming, adolescents experience increased confidence and willingness to participate in care. When interactions are dismissive or moralising, psychological capability is weakened, even when information is available. This finding underscores that health literacy must include institutional literacy and emotional safety, not only biomedical understanding.

Opportunity emerged as a decisive structural determinant of access. Physical barriers such as distance, transport costs, inefficiencies, and long waiting times impose disproportionate burdens on adolescents whose mobility and time are already constrained by schooling and economic limitations. Equally significant are the social dimensions of opportunity. Stigma surrounding adolescent sexuality, fear of community surveillance, and inadequate privacy within clinic spaces transform routine healthcare encounters into experiences of vulnerability. Opportunity, therefore, operates simultaneously through infrastructure, organisational design, and social norms. Without addressing these layers, improvements in knowledge or service availability alone are unlikely to translate into sustained utilisation.

Motivation is shaped less by abstract health intentions than by lived emotional experience. Adolescents continuously weigh the benefits of seeking care against the risk of embarrassment, judgement, or humiliation. Positive relational encounters reinforce trust and normalise help-seeking, whereas negative experiences can produce long-lasting disengagement. Emotional safety functions as a behavioural driver, demonstrating that service quality cannot be reduced to clinical competence alone. Respect, dignity, and relational equality are not peripheral aspects of care; they are central mechanisms through which motivation is either strengthened or eroded.

A further key conclusion is that adolescents are not passive recipients of healthcare systems but active interpreters and critics of them. Participants demonstrated a high degree of reflexivity and proposed concrete, contextually grounded solutions to improve access, including spatial redesign, youth-dedicated services, and decentralized outreach models. Their recommendations reflect a sophisticated understanding of confidentiality, dignity, and structural constraint. This finding reinforces the principle that youth participation is not symbolic but instrumental: adolescents possess experiential knowledge that is essential for designing responsive SRH services. Excluding their voices risks reproducing systems that fail to align with lived realities.

Overall, adolescent SRH service utilisation in semi-rural KwaZulu-Natal is best understood as the outcome of interdependent behavioural, relational, and structural conditions. Deficits in procedural capability, constraints in opportunity, and emotionally mediated motivation converge to shape patterns of engagement with care. Yet within these constraints, adolescents exhibit agency, adaptability, and critical insight. Sustainable improvements in SRH access will therefore require integrated interventions that transform not only information delivery but also clinic environments, institutional cultures, and participatory governance. Services must be designed to be structurally accessible, socially legitimate, and emotionally safe if they are to support long-term adolescent health outcomes.

6.3 THEORETICAL AND POLICY IMPLICATIONS

Theoretically, this study contributes to the growing body of research that applies behavioural frameworks, such as COM-B, to adolescent health. While the COM-B model has been used extensively in adult health contexts, its application to adolescent SRH in low- and middle-income countries remains limited. This study demonstrates the model's utility in capturing the multi-layered realities of youth health-seeking behaviour and calls for its wider use in adolescent-focused health system research and intervention design.

In terms of policy, the findings resonate with and extend existing national strategies, such as South Africa's National Adolescent and Youth Health Policy (2017–2022), which emphasises integrated, youth-friendly, and rights-based approaches to health services (Department of Health, 2017). However, the study also highlights the gap between policy and implementation. While adolescent-friendly care is a stated goal in national and global health policies (World Health Organization [WHO], 2012), many adolescents in this study experienced services that were unfriendly, inflexible, or emotionally unsafe. This disconnect underscores the need for not only policy reform but accountability mechanisms that ensure policy commitments translate into service-level realities.

Moreover, the study adds weight to global calls from organizations such as UNFPA and WHO for meaningful adolescent participation in health system planning and evaluation (UNFPA, 2014; WHO, 2012). Adolescents in this study demonstrated both the willingness and the capability to contribute to service improvement through thoughtful suggestions, such as youth-dedicated clinic hours, mobile outreach, and redesigning waiting areas to ensure privacy. Yet, despite this demonstrated potential, few formal pathways currently exist for them to engage in health system governance. Institutionalizing their involvement requires moving beyond ad hoc

consultation toward structured, ongoing participation. This could be operationalized through mechanisms such as adolescent advisory boards at clinic and district levels that provide routine feedback on service delivery, inclusion of youth representatives in primary healthcare management committees, and the creation of co-design workshops or participatory audits where adolescents collaborate with healthcare workers to evaluate service accessibility and responsiveness. Embedding these participatory structures within existing governance frameworks would not only ensure continuity but also create feedback loops that inform policy and training. In this way, adolescent involvement becomes not merely an ethical obligation but a practical and evidence-based strategy for improving service relevance, sustainability, and behavioural alignment with adolescent needs.

6.4 PRACTICAL RECOMMENDATIONS

Based on the study's findings, several practical recommendations can be made for improving adolescent SRH services in South Africa and similar contexts. First, it is essential to invest in youth-centered service design. This includes creating physically separate service points for adolescents, improving signage and navigation within clinics, and ensuring that waiting areas and consultation rooms are designed to protect confidentiality and reduce exposure. Clinics should be places where adolescents feel emotionally and socially safe, not only medically served.

Second, training and sensitisation of healthcare staff must be prioritised. Staff should be equipped with the skills to engage with adolescents in ways that are respectful, non-judgmental, and developmentally appropriate. This training should not be delivered as a one-time workshop but as part of continuous professional development, with mechanisms for feedback and evaluation based on adolescent experiences. Third, peer education and youth leadership should be expanded. Peer navigators can play an instrumental role in demystifying services, supporting first-time users, and providing psychosocial support. Their presence within clinics can create a more approachable and relatable service environment, while also building youth leadership and employment opportunities.

Fourth, community-level interventions are essential to dismantle the stigma and moralisation that continue to surround adolescent SRH. Educational campaigns, intergenerational dialogues between parents and adolescents, and the engagement of traditional and religious leaders can help shift prevailing social norms, fostering a more supportive environment where young people can access care without shame or fear. Equally important is the institutionalisation of adolescent participation in health system governance. This should extend beyond consultation to include formal accountability mechanisms that ensure adolescents' perspectives are systematically integrated into decision-making and evaluation. For example, clinics could establish youth advisory boards at both clinic and district levels, including adolescent representatives in primary healthcare committees, and conduct routine satisfaction audits or participatory service evaluations where young people assess the accessibility, privacy, and responsiveness of services. These feedback loops would not only enhance transparency but also generate actionable data for quality improvement. Embedding such participatory and accountability structures within existing health governance systems ensures that adolescents

Involvement is sustained, measurable, and directly linked to improvements in service quality and trust.

6.5 DIRECTIONS FOR FUTURE RESEARCH

While this study has contributed important insights into adolescent SRH service experiences in semi-rural South Africa, it also raises questions that merit further exploration. One notable limitation is the geographic focus. Future research could benefit from comparative studies that examine SRH access across rural, peri-urban, and urban contexts, allowing for a richer understanding of how spatial inequality and health infrastructure interact to shape adolescent health behaviours.

Additionally, while this study prioritised adolescent voices, future work should incorporate multi-perspective approaches that include the views of healthcare providers, clinic managers, and caregivers. Such triangulation would help to uncover systemic tensions, including those related to staff shortages, resource constraints, and provider perspectives on adolescent care, thereby providing a more holistic picture of the health system ecosystem. Moreover, there is also a need for longitudinal research that explores how adolescents' early interactions with the SRH system influence their future health-seeking behaviour and reproductive outcomes. Tracking patterns of trust, disengagement, and re-engagement over time would be particularly valuable in evaluating the long-term effectiveness of youth-focused interventions.

Methodologically, this study has shown the value of participatory and visual research tools, such as clinic layout drawings and scenario-based interviews. Future studies could expand these approaches through design thinking, photovoice, or digital storytelling, which may be particularly effective in eliciting the emotional and symbolic meanings adolescents attach to health services.

Lastly, more work is needed to evaluate the cost-effectiveness and scalability of adolescent-responsive models. Pilot projects that demonstrate impact on SRH outcomes should be rigorously evaluated and supported by economic modelling to inform health financing and budget allocation decisions.

6.6 FINAL REFLECTIONS

This study affirms what adolescent health advocates have long known: that youth are not only stakeholders in the SRH system, but also critically aware, emotionally attuned, and imaginatively engaged actors in their own health journeys. The findings show that when adolescents encounter services that are emotionally safe, structurally accessible, and socially affirming, they engage with those services, not just for themselves, but often in ways that uplift their peers and communities. Conversely, when they encounter judgment, disorganisation, or emotional harm, they withdraw, sometimes permanently, from care that could protect or even save their lives.

What emerges, therefore, is a clear imperative: to design adolescent SRH systems not simply for efficiency, but for equity, dignity, and co-ownership. Adolescents in this study articulated not only what is wrong with current systems, but what is possible, what care could look like if young people were respected, trusted, and invited to help shape their own services. Their visions were not utopian; they were practical, specific, and grounded in lived experience.

Transforming adolescent SRH care requires more than policy commitments or increased funding. It requires a culture shift, in which emotional intelligence, youth participation, and power-sharing become standard practices within public health systems. This study adds its voice to a growing global movement that recognises that real health equity begins when we listen, not only to what young people need, but to what they already know.

6.7 CONTRIBUTIONS TO KNOWLEDGE

This study contributes to both academic understanding and practical implementation of adolescent sexual and reproductive health (SRH) services in several important ways. Conceptually, it advances the use of the COM-B model as a behavioural framework for understanding adolescent engagement in SRH care within a South African context. By integrating COM-B with a decision-making framework, the study moves beyond identifying barriers and facilitators to explain the dynamic processes through which adolescents weigh opportunity, capability, and motivation in their health-seeking behaviour. This integrated approach offers a more nuanced explanation of adolescent decision pathways and provides a theoretical lens that future studies can adapt when examining other youth health behaviours.

Empirically, the research generates context-specific insights into adolescents' lived experiences of SRH access in semi-rural KwaZulu-Natal, a region often underrepresented in existing literature. Through workshop discussions and visual methods, the study documents how adolescents interpret healthcare environments, navigate stigma, and exercise agency in designing youth-friendly services. These findings extend current knowledge by demonstrating that young people possess sophisticated awareness of how spatial design, staff attitudes, and emotional cues influence their engagement, insights that have often been overlooked in policy discourse.

Methodologically, the inclusion of participatory visual techniques, such as clinic drawings and conceptual mapping, illustrates the value of creative qualitative tools for eliciting adolescent perspectives on health system design. This participatory method not only enriched the dataset but also modelled a youth-inclusive research approach that aligns with global principles of co-production and rights-based health research. The success of this approach suggests a promising direction for future inquiry and practice-based innovation.

Practically, the study contributes to the improvement of youth-responsive health systems by identifying design and organisational interventions that can enhance accessibility, confidentiality, and emotional safety. Recommendations emerging from the research, such as implementing youth-dedicated hours, expanding mobile outreach, and embedding adolescent participation in service design, provide actionable guidance for health managers, policymakers, and practitioners. These insights can inform the operationalisation of South Africa's Adolescent and Youth Health Policy (2017–2022) and support ongoing efforts to realise the goals of

universal, equitable SRH access under the National Strategic Plan for HIV, TB, and STIs (2023–2028).

In sum, this study bridges theory and practice by showing how behavioural frameworks, participatory methods, and youth-centered service design can converge to create more effective, dignified, and sustainable models of adolescent healthcare. It underscores that improving SRH access for young people requires not only structural investment but also emotional intelligence, respect, and partnership. Through this contribution, the study positions adolescents not merely as beneficiaries of care but as co-creators of health systems capable of responding to their evolving needs and aspirations.

6.8 STRENGTHS AND LIMITATIONS

6.8.1 STRENGTHS OF THE STUDY

This study possesses several methodological and conceptual strengths that contribute to the rigour, originality, and relevance of its findings within the broader discourse on adolescent sexual and reproductive health (SRH) in South Africa. One of the foremost strengths lies in the diversity and richness of the qualitative dataset. By conducting in-depth interviews with adolescents from the semi-rural Vulindlela/Edendale area in KwaZulu-Natal, the study captures a broad range of lived experiences across different ages, genders, and service-use histories. This heterogeneity enhances the credibility and transferability of the findings, as the analysis does not rest on isolated or atypical accounts but rather reflects the variability of adolescent interactions with SRH systems in under-resourced settings. Notably, the deliberate inclusion of both male and female perspectives strengthens the gender sensitivity and inclusivity of the analysis, offering insights into how gendered dynamics shape health-seeking behaviours and service perceptions.

A second key strength is the participatory and youth-centred approach that underpinned the study's data collection and interpretive processes. Adolescents were not treated solely as research subjects but were engaged as active co-constructors of knowledge. Through creative methods such as clinic mapping and spatial redesign exercises, participants were encouraged to articulate both their critiques and their aspirations for SRH service environments. This methodological innovation allowed for the elicitation of deeply contextualised, emotionally nuanced insights that are often overlooked in more conventional data collection formats such as structured surveys or focus group discussions. The incorporation of visual data enabled a more holistic understanding of the effective and environmental dimensions of care, such as how noise, layout, or aesthetics influence emotional safety and service engagement.

Third, the application of the COM-B behaviour change framework provided a robust analytical lens that elevated the study's theoretical coherence. Rather than presenting adolescent experiences as a disconnected list of service barriers and facilitators, the COM-B model facilitated a structured examination of how adolescents' behaviours are influenced by interlinked domains of capability, opportunity, and motivation. This enabled the identification of behavioural drivers at both individual and systemic levels, contributing to a more comprehensive and actionable understanding of health-seeking dynamics. The integration of COM-B not only supported internal analytical consistency but also increased the relevance of the findings to policy and practice, where behaviour-change models are frequently employed

in intervention design.

Finally, a notable strength of this study lies in its practical utility and policy relevance. The findings do not merely extend academic knowledge but offer concrete, context-specific recommendations that are directly applicable to programme designers, service providers, and health system planners. The emphasis on adolescents' own interpretations and proposals ensures that the recommendations are grounded in lived realities, rather than imposed assumptions. Furthermore, the study's emphasis on adolescent agency, including their ability to critique existing services and imagine alternatives, affirms young people as legitimate stakeholders in health system reform. This participatory orientation enhances the trustworthiness of the conclusions and aligns with global calls for youth-inclusive health governance.

6.8.2 LIMITATIONS OF THE STUDY

Despite its strengths, the study is subject to several limitations that must be acknowledged in interpreting the findings and assessing their broader applicability. The first limitation concerns the scope and generalisability of the research. As a qualitative study focused on semi-rural communities within a single province, the findings are deeply contextual and cannot be presumed to represent the experiences of adolescents in markedly different settings, such as urban centres, informal settlements, or other provinces with differing healthcare infrastructures. While the goal of the study was not statistical generalisation, the specificity of the setting may limit the transferability of certain insights to areas with different social, economic, or institutional conditions.

A second limitation relates to the linguistic and interpretive challenges inherent in multilingual qualitative research. Interviews were conducted in isiZulu and later translated and transcribed into English for analysis. Although care was taken to preserve the integrity of participants' original expressions, including attention to tone and cultural reference, some degree of semantic loss or distortion is inevitable in translation. Subtle meanings, affective inflections, and culturally embedded nuances may not have been fully conveyed in the translated transcripts, potentially affecting the depth and accuracy of interpretation. This limitation is particularly salient given the study's focus on emotional safety, where tone and context carry significant analytic weight.

Third, the age range of study participants, spanning from 14-25 years, introduces some interpretive complexity. While the primary focus was on adolescents, the inclusion of older youth and young adults may have introduced perspectives shaped by different developmental stages, social responsibilities, and health system expectations. Although this broader age range allowed for intergenerational insights and retrospective reflection, it may also have diluted the specificity of adolescent-focused findings. A more granular, stratified analysis by developmental stage, distinguishing, for example, between early adolescents (12–14), middle adolescents (15–18), and late adolescents/young adults (19–25), might have yielded further nuance in understanding age-specific needs and behaviours. Another limitation is the absence of triangulation through other stakeholder perspectives. While the study provides an in-depth account of adolescents' views, it does not incorporate the voices of key system actors such as healthcare workers, caregivers, or community leaders.

Their perspectives on service delivery constraints, adolescent readiness, and institutional norms could have enriched the findings and offered a more multidimensional view of the challenges and opportunities in SRH provision. Including these perspectives in future research could provide critical insight into system-level barriers that are not always visible from the user's standpoint alone.

Lastly, the timing of the research within the broader context of systemic strain, including the lingering effects of the COVID-19 pandemic, as the study was conducted in 2023 post COVID-19, and ongoing socio-economic hardship, may have amplified certain themes. Participants frequently cited issues such as prolonged waiting times, staff shortages, and emotional fatigue, which, while long-standing in many respects, may have been exacerbated by post-pandemic service backlogs and economic distress. These contextual pressures should be considered when interpreting the intensity and frequency of participant concerns, as they may reflect not only structural inadequacies but also temporary system disruptions.

In sum, while the study provides valuable and actionable insights into adolescent SRH service access in semi-rural South Africa, its conclusions should be understood within the methodological, contextual, and demographic boundaries described above. These limitations do not diminish the importance of the findings but instead offer direction for future research and cross-sectoral dialogue.

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02 April 2025

Miss Nomagugu Vera Mabaso (215063474)
School Of Applied Human Sc
Pietermaritzburg

Dear Miss Nomagugu Vera Mabaso,

Original application number: 00027322

Project title: Understanding Barriers and Facilitators of Sexual and Reproductive Health services uptake among adolescent women and men in semi-rural areas in KwaZulu-Natal, South Africa: A Secondary Analysis.

Exemption from Ethics Review

In response to your application received on 5 August 2024, your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW**.

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

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.

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

Yours sincerely,



Prof Nirmala Devi Gopal
Academic Leader Research
School Of Applied Human Sc

UKZN Research Ethics Office
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Website: <http://research.ukzn.ac.za/Research-Ethics/>

Appendix A

INFORMATION SHEET AND CONSENT FORM (In-depth Interviews)

EXPLORES Study

Exploring the factors that influence Sexual and Reproductive Health (SRH) Service uptake amongst young women and men in KwaZulu-Natal, South Africa.

Singobani

Sawubona, ngingu (*igama lomsebenzi*). Ngisebenzela i-Centre for Community Based Research (CCBR) ye-Human Sciences Research Council.

Esikwenzayo

Senza ucwaningo oluhlola izici ezinomthelela ekuthathweni kwezinsiza zezempilo yezocansi kanye nokuzala (SRH) kwabesifazane abasebasha nabesilisa KwaZulu-Natal, eNingizimu Afrika. Senza ucwaningo ukuze sithole mayelana nezici ezithinta ukuthi abantu abasha bayazisebenzisa yini izinsiza ze-SRH nokuthi yiziphi izici zabasebenzi bezempilo nemitholampilo ezithinta isinqumo somuntu osamusha ukuthi asebenzise izinsizakalo ze-SRH.

Ukubamba kwakho iqhaza Sikucela ukuthi usivumele senze izingxoxo ezimbili nawe mayelana nezici ezithinta ukusebenzisa kwakho izinsiza ze-SRH, izici zabasebenzi bezempilo ezinomthelela ekusebenziseni kwakho izinsiza ze-SRH nokuthi ungawakha kanjani umtholampilo wakho ophelile we-SRH. Ngaphambi kokuba kuqale ingxoxo 1, uzocelwa ukuthi ugcwalise uhlu lwemibuzo olufushane olumayelana nolwazi lwezenhlalo nezomnotho oluqondene nawe. Uma uvuma, sizokucela ukuthi ubambe iqhaza ezingxoxweni ezimbili:

1. Ingxoxo 1 izophenya bese ibheke ukuthi yiziphi izici ezikwenza ukuthi unqume ukusebenzisa noma ukungazisebenzisi izinsiza ezibalulekile ze-SRH njengokuhlola i-HIV, i-PrEP eyiphilisi eliphuzwayo, nezinsiza zokuvimbela inzalo. Sizophinde sihlale izimfanelo kanye nezici zabahlinzeki bezempilo (HCP) ozincamelayo. Sizokhuluma nawe ngohlobo lohlinzeki ongathanda ukuthi akusize emtholampilo. Ngemva kwalokhu sizosebenzisa izincazelo zakho ukuze senze izithombe ezimele umhlinzeki wakho ofanelekile. Sizosebenzisa uhlelo lwe-computer olukhethekile oluzothatha incazelo yomhlinzeki wakho ofanelekile bese lwakhe ngazo izithombe. Sizokwenza futhi lokhu ukuze sakhe isithombe somhlinzeki ongamuncamela kakhulu. Sizophinde sikubonise izithombe zezinhlobo ezahlukeneyo zabahlinzeki bese sikubuza ukuthi kungani ubathanda, ungabathandi, nokuthi kungani.
2. Ingxoxo yesi-2 izodingida uhlobo kanye nesakhiwo sezinsiza ze-SRH abazincamelayo (izinhlobo zokulethwa ezingaguquki kanye nezisekelwe emphakathini). Sizohlola okuncamelayo okuhambisana nezici kanye nokwakheka kwemitholampilo futhi sikucele ukuthi wenze uhlobo lwakho lomtholampilo olufanelekile. Sizokubuza futhi ukuthi ungayiklama kanjani kabusha imitholampilo yamanje. Lezi zakhiwo zosetshenziselwa i-Design Workshop yesikhathi esizayo ozocelwa ukuthi ubambe iqhaza kuyo ngokuhamba kwesikhathi.

Silindele ukuthi ingxoxo ngayinye izoqhubeka cishe ihora nohalf.

Sicela uqonde ukuthi **ukuhlanganyela kwakho kungokuzithandela** futhi awuphoqwa ukuba ubambe iqhaza kulolu cwaningo. Ukukhetha ukuthi ubambe iqhaza noma ungalibambi, kungokwakho wedwa. Uma ukhetha ukungabambi iqhaza, angeke uthinteke nganoma iyiphi indlela. Uma uvuma ukubamba iqhaza, ungayeka ukubamba iqhaza ocwaningweni nganoma yisiphi isikhathi futhi ungitshele ukuthi awusathandi ukuqhubeka.

Uma wenza lokhu, ngeke kube khona izinhlawulo futhi ngeke ubandlululwe nganoma iyiphi indlela.

Ukugcinwa kuyimfihlo

Lonke ulwazi oluveza ubuwena luzogcinwa ekhabetheni lamafayela akhiyiwe, egumbini elingangeni noma ubani futhi ngeke litholakale kwabanye lizogcinwa luyimfihlo ngendlela okungenzeka ngayo ngokomthetho. Amarekhodi aphuma ekubambeni kwakho iqhaza angabuyekwezwa abantu abaqinisekisa ukuthi ucwaningo lwenziwa ngendlela efanele, okuhlanganisa namalungu ekomiti lezimiso zokuziphatha eliyinxenye ye-HSRC. (Bonke laba bantu kudingeka ukuthi bagcine ubuwena buyimfihlo.) Kungenjalo, amarekhodi akhomba ubuwena azotholakala kuphela kubantu abasebenza ocwaningweni, ngaphandle uma unikeza imvume abanye abantu ukuthi babone amarekhodi.

Sicela ukuthi usinike imvume yokuqopha ingxoxo ukuze sikwazi ukuqopha kahle okushiwoyo.

Your answers will be stored electronically in a secure environment and used for research or academic purposes now or at a later date in ways that will not reveal who you are. All future use of the stored data will be subject to further Research Ethics Committee review and approval. Izimpendulo zakho zizogcinwa kwi-computer endaweni evikelekile futhi zisetshenziselwe injongo zocwaningo noma zezemfundo manje noma ngokuhamba kwesikhathi ngezindlela ezingeke zidalule ukuthi ungubani. Yonke i-data egciniwe engase isetshenziswe ngokuzayo ingase ibuyekwezwe okanye igunyazwe yikomidi lokuziphatha locwaningo.

Ngeke sirekhode igama lakho noma kuphi futhi akekho ozokwazi ukukuxhumanisa nezimpendulo ozinikezayo. Izimpendulo zakho zizoxhunywana nenombolo yekhodi engelona iqiniso, noma igama-mbumbulu (elinye igama) futhi sizobhekisela kuwe ngale ndlela kudatha, noma yikuphi ukushicilelwa, umbiko noma okunye okukhipha ucwaningo.

Izingozi/ukungaphatheki kahle

Okwamanje, asiyiboni ingozi yokulimala ngokubamba kwakho iqhaza. Izingozi ezihlobene nokubamba iqhaza kulolu cwaningo azinkulu kunalezo okuhlangatshezwana nazo ekuphileni kwansuku zonke. Nokho, ungase uzizwe unamahloni, uphatheke kabi noma udangele lapho uxoxa ngezindaba ezithinta ucansi nokuzala futhi kufanele usazise uma ufuna ukuyeka nganoma yisiphi isikhathi phakathi nocwaningo.

Izinzuzo

Azikhona izinzuzo ezisheshayo kuwe ngokubamba iqhaza kulolu cwaningo. Nokho, lolu cwaningo luzoba usizo kithi ngoba sethemba ukuthi luzothuthukisa ukuqonda ukuthi singathuthukisa kanjani izinsiza ze-SRH entsheni.

Uma ungathanda ukuthola impendulo ngocwaningo lwethu, sizorekhoda inombolo yakho yocingo ephepheni elihlukile futhi singakuthumelela imiphumela yocwaningo uma seluqedliwe esikhathini esithile ngemva kukaDisemba 2023.

Imbuyiselo

Sizokunika u-R160 ingxoxo ngayinye ngokubamba kwakho iqhaza.

Ongathintana naye uma ulinyaziwe noma kukhona okukukhathazayo Lolu cwaningo lugunyazwe yi-HSRC Research Ethics Committee (REC). Uma unezikhalazo mayelana nezimiso zokuziphatha zocwaningo noma unomuzwa wokuthi ulinyazwe nganoma iyiphi indlela ngokubamba iqhaza kulolu cwaningo, sicela ushayele inombolo yamahhala ye-HSRC ethi 0800 212 123 (uma ushayelwa ucingo lwasendlini eNingizimu Afrika) noma uthinte iHuman Sciences Research Council REC Administrator, kule nombolo yocingo 012 302 2012 noma nge-email research.ethics@hsrc.ac.za.

Uma unokukhathazeka noma imibuzo mayelana nocwaningo ungashayela umphenyi omkhulu, uDkt Hilton Humphries ku- [REDACTED].

IMVUME

Ngalokhu ngiyavuma ukubamba iqhaza ocwaningweni lokuhlola izici ezinomthelela ekuthathweni kwezinsiza zempilo yocansi nezokuzala (SRH) kwabesifazane abasebasha nabesilisa KwaZulu-Natal, eNingizimu Afrika. Nginyaqonda ukuthi ngibamba iqhaza ngokukhululeka futhi ngaphandle kokuphoqwa nganoma iyiphi indlela ukwenza kanjalo. Nginyaqonda futhi ukuthi ngingayeka ukubamba iqhaza nganoma isiphi isikhathi uma ngingafuni ukuqhubeka nokuthi lesi sinqumo ngeke nganoma iyiphi indlela singithinte kabi. Nginyaqonda ukuthi lena i-project yocwaningo, injongo yayo ayikho ekungizuziseni maduzane noma isikhathini esifushane. Nginyaqonda ukuthi ukubamba kwami iqhaza kuzohlala kuyimfihlo.

.....
Isgnesha yombambiqhaza

Usuku:.....

IMVUME YOKUREKHODA/YOKUQOPHA

Ngiyavumelana nokuqoshwa kwekhasethi yokubamba kwami iqhaza ocwaningweni.

.....
Isgnesha yombambiqhaza

Usuku:.....

Nginyaqonda ukuthi ulwazi engilunikezayo luzogcinwa ngekhompuyutha futhi luzosetshenziselwa izinjongo zocwaningo manje noma esikhathini esizayo.

.....
Isgnesha yombambiqhaza

Usuku:.....

.....
Isgnesha yomsebenzi wocwaningo

Usuku:.....

.....
Isgnesha kafakazi

Usuku:.....

Appendix B

INFORMATION SHEET AND CONSENT FORM (In-depth Interviews)

EXPLORES Study

Exploring the factors that influence Sexual and Reproductive Health (SRH) Service uptake amongst young women and men in KwaZulu-Natal, South Africa.

Who we are

Hello, I am (*fieldworker's name*). I am working for the Centre for Community Based Research (CCBR) of the Human Sciences Research Council.

What we are doing

We are conducting research exploring the factors that influence Sexual and Reproductive Health (SRH) Service uptake amongst young women and men in KwaZulu-Natal, South Africa. We are conducting a study to find out about the factors that affect whether or not young people use SRH services and what characteristics of healthcare workers and clinics affect a young person's decision to use SRH services.

Your participation

We are asking you whether you will allow us to conduct two interviews with you about the factors that affect your use of SRH services, the characteristics of the healthcare workers that influence your use of SRH services and how you would design your perfect SRH clinic. You will also be asked to complete a short demographic and behavioural questionnaire before interview one. If you agree, we will ask you to participate in two interviews:

1. Interview 1 will investigate and map what factors affect whether or not you decide to use key SRH services like HIV testing, oral PrEP use, and contraception services. We will also explore your preferred attributes and characteristics of healthcare providers (HCP). We will talk to you about the type of service provider you would like to help you at a clinic. After this we will use your descriptions to create pictures that represent your ideal service provider. To create the images, we will use a special computer programme that will take the description of your ideal service provider and use this to create an image. We will also do this to create an image of your least preferred service provider. We will also show you images of different types of service providers, and ask you tell us about why you like them, do not like them, and why.
2. Interview 2 will discuss the type and design of your preferred SRH services (both fixed and community-based models of delivery). We will explore your preferences surrounding the characteristics and design of clinics and ask you to create your ideal type of clinic. We will also ask you how you would re-design current clinics. These designs will be used for future Design Workshops that you will be asked to participate in at a later stage.

We anticipate that each interview will continue for approximately one and a half hour.

Please understand that **your participation is voluntary** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to continue. If you do this, there will be no penalties and you will not be prejudiced in any way.

Confidentiality

All identifying information will be kept in a locked file cabinet in a locked, access-controlled room and will not be available to others and will be kept confidential to the extent possible by

law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the ethics committee at the Human Sciences Research Council. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

We are asking you to give us permission to tape-record the interview so that we can accurately record what is said.

Your answers will be stored electronically in a secure environment and used for research or academic purposes now or at a later date in ways that will not reveal who you are. All future use of the stored data will be subject to further Research Ethics Committee review and approval.

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number, or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output.

Risks/discomforts

At the present time, we do not see any risk of harm from your participation. The risks associated with participation in this study are no greater than those encountered in daily life. However, you may feel embarrassed, upset or sad when discussing issues around sexual and reproductive health and you should let us know if you want to stop at any time during the research.

Benefits

There are no immediate benefits to you from participating in this study. However, this study will be helpful to us in that we hope will promote understanding of how we could improve SRH services for adolescents.

If you would like to receive feedback on our study, we will record your phone number on a separate sheet of paper and can send you the results of the study when it is completed sometime after December 2023.

Reimbursement

You will be reimbursed R160 per interview for your participation.

Who to contact if you have been harmed or have any concerns

This research has been approved by the HSRC Research Ethics Committee (REC). If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the HSRC's toll-free ethics hotline 0800 212 123 (when phoned from a landline from within South Africa) or contact the Human Sciences Research Council REC Administrator, on Tel 012 302 2012 or e-mail research.ethics@hsrc.ac.za.

If you have concerns or questions about the research you may call the Principal Investigator, Dr Hilton Humphries at [REDACTED].

CONSENT

I hereby agree to participate in research on exploring the factors that influence Sexual and Reproductive Health (SRH) Service uptake amongst young women and men in KwaZulu-Natal, South Africa. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term. I understand that my participation will remain confidential.

.....
Signature of participant

Date:.....

CONSENT FOR TAPE RECORDING

I hereby agree to the tape-recording of my participation in the study.

.....
Signature of participant

Date:.....

I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage.

.....
Signature of participant

Date:.....

.....
Signature of study staff

Date:.....

.....
Signature of witness

Date:.....

Appendix C

Questionnaire Guides (Adolescent and young person Interviews/Focus Group Discussions and Experiments)

Demographic and Behavioural Questionnaire

1) What is your date of birth? dd/mm/yy

D	D	M	M	M	Y	Y

2) What is the highest level of education you have completed?

Response	X
No education	
Primary school (grade)	
High school (grade)	
Tertiary / vocational	

3) What race do you identify do you identify as?

Response	X
Black	
Coloured	
White	
Indian	
Other: specify:	

4) What gender do you identify as?

Response	X
Man	
Transgender man	
Transgender women	
Intersex	
Other: specify	

5) What is your sexual orientation?

Response	X
Heterosexual (straight) / attracted to people of the other sex	
Homosexual (Gay / lesbian) / attracted to people of one's own sex	
Bisexual person / attracted to people of either sex	
Pansexual: Attracted to people of any gender identity	
Asexual: Not sexually attracted to other people	
Other: specify	

6) What is your main activity?

Response	X
Student / learner	
Informally employed	
Formally employed	
Unemployed	
Choose not to work	
Other: Specify	

7) What is your source of income? (Mark all that apply)

Response	X
Salary	
Social Grant	
Family Support	
Partner Support	
Married, living separately	
Not in a relationship	
Other: specify	

8) What is your Relationship Status?

Response	X
Living with your partner	
Have a partner but living separately.	
Married, living together	
Married, living separately	
Not in a relationship	
Once of sex partners	
Other: specify	

9) If in a relationship (a-d or other response marked), how long have you been in this relationship?

Response	X
Short term (≤ 3 months)	
Medium term (3-6 months)	
Long term (> 6 months)	

10) Who is the head of your household? (Mark all that apply)

Response	X
Birth father	
Grandparent	
Me	
Partner	
Sibling over 18	
Sibling under 18	
Aunt or uncle	
Birth mother	

Friend	
Other: specify	

11) Who is part of your household? (Mark all that apply)

Response	X
Birth father	
Grandparent	
Me	
Partner	
Sibling over 18	
Sibling under 18	
Aunt or uncle	
Birth mother	
Friend	
Other: specify	

12) Are you religious?

Response	X
Yes	
No	
If yes, specify religion:	

Key Behaviours

13) How old were you when you first had vaginal sex?

Specify Age in Years			X
Age		I have not had sex	

14) How old were you when you had:

Specify Age in Years			X
Oral Sex		I have not had oral sex	
Anal Sex		I have not had anal sex	

15) How many sexual partners have you ever had?

Specify Number			X
Number		I have had no sexual partners	

16) How many sexual partners do you currently have?

Specify Number			X
Number		I have no sexual partners	

17) How old is your current partner?

Specify Age in Years			X
Age		I have no partner currently	

18) Do you have other sexual partners?

Response	X
Yes	
No	

19) Does your partner have other sex with other people?

Response	X
Yes	
No	
Do not know	

20) How old were your last three sexual partners (prior to current partner)

Specify Age in Years		Specify Age in Years	
Partner 1 Age		Your age at time of relationship	
Partner 2 Age		Your age at time of relationship	
Partner 3 Age		Your age at time of relationship	

21) Did you use condoms the last time you had sex?

Response	X
Yes	
No	

22) Have you ever used oral PrEP?

Response	X
Yes	
No	

23) Are you currently using oral PrEP to prevent HIV infection?

Response	X
Yes	
No	

24) Do you use anything to protect you against HIV infection?

Response	X
Yes	
No	
If yes, what do you use?	

25) How many children do you have?

Specify Number		X
Number		I have had no children

26) Do you currently use any contraception?

Response	X
Yes	
No	
If yes, what are you using?	

27) What Sexual and Reproductive Health (SRH) services have you used? (mark all that apply)

Response	X
Contraceptive services	
HIV Testing	
STI screening/testing	
Pregnancy Testing	
Antenatal services	
HIV treatment services	
Termination of pregnancy services	
Other: Specify:	

28) Which SRH issue are you most worried about experiencing yourself? (Rate the one you are most worried about as one, second most worried as two and least worried about as three).

Response	Rating
Getting a Sexually Transmitted Infection (STI)	
Becoming HIV positive	
Being Pregnant/Making someone pregnant	

29) Who influences your choice to use SRH Services? (Mark all that apply)

Response	X
Mother	
Father	
Grandmother	
Grandfather	
Sister	
Brother	
Aunt	
Uncle	
Friends	
Partner	
Teachers	
No one, I make the decision myself	
Other: specify	

30) Where do you think you get the truest information about SRH issues from? (List the three sources you believe are the truest)

1.
2.
3.

In-depth Interview Guide 1

Hello, we are so happy that you agreed to speak with us today, we hope that you will feel free to talk with us. Please remember to tell me if you would like to take a break during the interview.

We are conducting a study to find out about the factors that affect whether or not young people use SRH services and what characteristics of healthcare workers and clinics affect a young person's decision to use SRH services. We would like to ask you a few questions to learn from your experiences of using SRH services.

	Question	Thematic Area
1	Activity: Show the 112 AI generated image combinations. For each combination, allow the participant 5 seconds to choose the preferred picture of the provider they would want to receive SRH services from, and capture the choice on the picture selection form. <u>After the activity is completed</u> briefly ask which providers they preferred the most and the least, and ask why?	Activity
2	I am going to say a few words now, and I want you to quickly tell me the first three things/words you think about when you hear these words. There are no right or wrong answers, so just say whatever comes to mind as quickly as possible: • Supermarket • School • Healthcare clinic • Sexual Health • HIV • Nurse • Contraception • Doctor • Pregnancy • STI • HIV infected person • Oral PrEP • HIV test	Recency Bias/Anchoring
3	Let us talk about using SRH services: • When do you think it is important to use these services? (<i>Probe: Each type of service [HIV testing/Pregnancy testing/contraception/STI screening]. For all probe on why they think this</i>) ○ How do you decide if it's important to use the services – what do you use to make this decision? ○ For each service probe for the motivation to use, and where this motivation comes from? ○ The things in their context that makes it easy or difficult to do use each of these services. ○ How they decide if it is important to try use each of the services or not? • Often people think it is important to use SRH services, but they still struggle to <u>actually</u> go and use them? Why do you think this happens? ○ Probe for what social and environmental obstacles makes it difficult even if you want to use the services. ○ Can they explain how you feel when you think you need an SRH service but cannot use it because of barriers? • What has stopped you from using SRH services when you have wanted to in the past? (<i>Probe for: beliefs about risk, concerns about what partners/families/peers would think, social influences i.e., family, partner,</i>	Intent/Importance

	<i>friends, clinic, community, environmental factors, lack of motivation, the costs of using services may not be worth the benefits)</i>	
4	- How do you think your community feels about adolescents using SRH services? - Probe: Parents/older people/younger people - Probe: Do you think they feel young people can be sexually responsible? When do you think people become sexually responsible and why? - Is this different for boys and girls? Why?	Community and Gender Norms
5	- How do you make the decision to use SRH services? - How do you think you are different from other people who use SRH services? - How do you decide that you need to use them? (Probe for each service/risk) - Explain what information you use to make this decision? (probe: How do you find information/how do you assess if it is correct) - Who do you think about when you make the decision? (Probe: your partners thoughts/family/friends) - How much effort does it take to use SRH services? Tell me about what makes it effortful/not effortful/how do you decide when it is too much trouble to use the services and just give up?	Decision-making/social influences/plausible pathways/effort
6	There are things that you may be good or bad about using SRH services, this could lead to you gaining things or losing things. These things could be real, material things or other things like feelings or how others think about you? - What do you think you risk losing by using SRH services? (Probe: time/status/social standing/partner) - What do you think you potentially gain by using these services? - How do you decide if the gains are worth the potential losses?	Cost/benefit analysis
7	Now, we are going to talk about the staff at the clinics where you can access SRH services. Tell me about what it is like at the clinics? Especially what it is like to use SRH services	SRH Service Experiences
8	Tell me about the things that make a good healthcare worker?	
9	- Describe your preferred attributes in a health care worker (for each probe about why this is the case): - Personality (e.g., friendly, serious, calm) - Characteristics (young, well-dressed, female) - Appearance	Attributes
10	*** Use the generated pictures*** AI generation of potential health care worker activity. For each picture generation activity probe about why they like this HCW, and how it makes them feel to see this HCW and why.	Activity
11	- Describe your least preferred attributes in a health care worker (for each probe about why this is the case): - Personality (e.g., friendly, serious, calm) - Characteristics (young, well-dressed, female) - Appearance	Attributes
12	*** Use the generated pictures*** AI generation of potential health care worker activity. For each picture generation activity probe about why they dislike this HCW, and how it makes them feel to see this HCW and why.	Activity
13	Thank you so much for your participation in today's interview. Do you have any questions you would like to ask us? We will now book your next interview at a time convenient to you. Thank you for such a wonderful session today.	Closing

**** for all questions use the “why” approach, by continuously asking why until a full explanation is achieved.**

In-depth Interview Guide 2

Hello, we are so happy that you agreed to speak with us today, we hope that you will feel free to talk with us. Please remember to tell me if you would like to take a break during the interview.

We are conducting a study to find out about the factors that affect whether or not young people use SRH services and what characteristics of healthcare workers and clinics affect a young person's decision to use SRH services. We would like to ask you a few questions to learn from your experiences of using SRH services.

	Question	Thematic Area
1	Let us talk about the clinic where you can access SRH services. What do you think about the design of these clinics? (Probe: the space, their experience of attending the clinic, does it look inviting for young people)	Experience
2	How do you think the design of the clinic (the way it looks) impacts your experience of going to the clinic? (Probe: is it private, probe about feelings towards the waiting room, the outside, its location, bathrooms, nurses' rooms, colour, etc)	Preferred Attributes
3	Today we are going to ask you about how you would design the perfect clinic for young people to use, and access SRH services. Now, there are some things you have to have when you think about designing a clinic, these are clinic rooms, reception, pharmacy, emergency room, bathrooms etc. You will need to make sure these things are included in the clinic design. We will provide you with a floorplan of a basic clinic so you can see how it is laid out and what things a clinic needs to have.	Instruction and activity set-up
4	Activity 1: Design their perfect fixed and mobile clinic (Probe about decisions, why the choices have been made and how this would improve the experience of using the clinic)	Activity
5	Activity 2: Re-design and existing model of a fixed and mobile clinic (Probe about decisions, why the choices have been made and how this would improve the experience of using the clinic)	Activity
6	Are there any changes you would want to make to your design of the perfect clinic? (Probe for why any changes are made).	Accommodation of any changes
7	Thank you so much for your participation in today's interview. Do you have any questions you would like to ask us? Thank you for such a wonderful session today.	Closing

- **Focus Groups Basic Guide (The FGD guides will be finalised after Interviews 1 and 2 are complete)**

Appendix D

Questionnaire Guides (Adolescent and young person Interviews/Focus Group Discussions and Experiments)

Demographic and Behavioural Questionnaire

- 1) Luthini usuku lakho lokuzalwa? dd/mm/yy _____
- 2) Iliphi izinga lemfundo lokugcina oliqedile?
 - a) Ayikho imfundo
 - b) Isikole samabanga aphansi (Ibanga)
 - c) Isikole samabanga aphakeme (Ibanga)
 - d) Iteshiyari / Isikoleni semi sebenzi yezandla
- 3) Yiluphi uhlanga oyilo?
 - a) Omnyama
 - b) Ikhaladi
 - c) Omhlophe
 - d) Umndiya
 - e) Okunye: chaza _____
- 4) Uzichaza njengabuphi ubulili??
 - a) Owesilisa
 - b) Owesilisa onobulili obuguqukile
 - c) Owesifazi
 - d) Owesifazane onobulili Okuguqukile
 - e) Onobulili Obuxubile
 - f) Okunye: chaza _____
- 5) Imuphi umumo wakho wocansi omayelane nobudlelwano?
 - a) Oba nobudlelwane nobulili obuhlukile (Oqondile) /
 - b) Oba nodlelwane nobulili obufanayo (O-geyi / O-lesbhiyeni) /
 - c) Umuntu onobudlelwane onobulili obufana kanye nobungafani nobakhe /
 - d) I-Pansexual: Obanobudlelwane nabantu banoma yiluphi uhlobo lobulili
 - e) I A-sexual: Ongakhangeki ngokocansi kwabanye abantu
 - f) Okunye: chaza _____
- 6) Yikuphi okwenzayo?
 - a) Umfundi
 - b) Ongaqashiwe ngokusemthethweni
 - c) Oqashwe ngokusemthethweni
 - d) Ongasebenzi
 - e) Okhetha ukungasebenzi
 - f) Okunye: chaza _____
- 7)) Iziphi izindlela othola ngazo imali? (Khetha konke okuqondene nawe)
 - a) Umholo wokusebenza
 - b) Isibonelelo sezenhlalakahle
 - c) Ukusekwa umundeni

- d) Ukusekwa umlingani
 - e) Oshadile, ohlala ngokuhlukile
 - f) Ongekho ebudlelwaneni bothando
 - g) Okunye : chaza _____
- 8) Sithini isimo sakho sobudlelwano?
- a) Uhlala nomlingani wakho
 - b) Nginomlingani kodwa angihlali naye
 - c) Ngishadile, sihlala ndawonye
 - d) Ngishadile, sihlala ngokuhlukene
 - e) Angikho ebudlelwaneni
 - f) Umlingani wezocansi wesikhathi esisodwa
 - g) Okunye : chaza _____
- 9) Uma usebudlelwaneni (a-d noma enye impendulo ephawuliwe), usunesikhathi esingakanani ukulobudlelwane?
- a) Isikhathi esifushane ($\leq$ Izinyanga ezi-3)
 - b) Isikhathi esiphakathi (Izinyanga ezi 3-6)
 - c) Isikhathi eside ($>$ Izinyanga ezi-6)
- 10) Ubani oyinhloko yekhaya lakho? (Khetha konke okuqondene nawe)
- a) Ubaba okuzalayo
 - b) Umama okuzalayo
 - c) Ugogo noma umkhulu
 - d) Yimi
 - e) Umlingani wami
 - f) Ingane yakini engaphezu kweminyaka eyi-18
 - g) Ingane yakini engaphansi kweminyaka eyi-18
 - h) U-anti noma umalume
 - i) Umngani
 - j) Omunye: chaza _____
- 11) Ubani oyingxenywe yekhaya lakho? (Khetha konke oku okuqondene nawe)
- a) Ubaba okuzalayo
 - b) Umama okuzalayo
 - c) Ugogo noma umkhulu
 - d) Yimi
 - e) Umlingani
 - f) Ingane yakini engaphezu kweminyaka eyi-18
 - g) Ingane yakini engaphansi kweminyaka 1 eyi-8
 - h) U-anti noma umalume
 - i) Umngani
 - j) Omunye: chaza _____
- 12) Engabe uwumuntu wezenkolo ?
- a) Yebo
 - b) Cha
 - c) Uma kuwu yebo, chaza inkolo: _____

Ukuziphatha Okubalulekile

- 13) How old were you when you first had vaginal sex? Wawuneminyaka emingaki ngenkathi uqala ukwenza ucansi lwesitho sangasese sangaphambili?
- a) Iminyaka: _____
 - b) Angikaze ngibe socansini
- 14) Wawuneminyaka emingaki ngenkathi uba:
- a) Socansini olubandakanya umlomo: _____ noma angikaze ngibe socansini olubandakanya umlomo _____
 - b) Socansini ngesitho sangasese esingemumva: _____ noma angikaze ngibe socansini ngesitho sangasese esingemumva _____
- 15) Bangaki abantu onobudlelwano bocansi nabo njengamanje?
- a) Inani: _____
 - b) Anginaye umlingani wezocansi
- 16) Mudala kangakanani umlingani wakho onaye njenga manje?
- a) Iminyaka yobudala: _____
 - b) Anginaye umlingani njengamanje
- 17) Engabe unabo abanye abalingani onobudlelwano bocansi nabo?
- a) Yebo
 - b) Cha
- 18) Engabe umlingani wakho uyaba socansini nabanye abantu?
- a) Yebo
 - b) Cha
 - c) Angazi
- 19) Babebadala kangakanani abalingani bakho bocansi abathathu bokugcina (ngaphambi komlingani wakho wamanje)
- a) Iminyaka yobudala yomlingani wo-1 _____ Iminyaka yakho ngenkathi yobudlelwano: _____
 - b) Iminyaka yobudala yomlingani we-2 _____ Iminyaka yakho ngenkathi yobudlelwano
 - c) : _____
 - d) Iminyaka yobudala yomlingani we-3 _____ Iminyaka yakho ngenkathi yobudlelwano: _____
- 20) Ingabe walisebenzisa ijazi lokuzivikela ngenkathi ugcina ukwenza ucansi?
- a) Yebo
 - b) Cha
- 21) Uke wawusenbenzisa u-PrEP oyiphilisi?
- a) Yebo
 - b) Cha
- 22) Ingabe njengamanje uyawusebenzisa u-PrEP oyiphilisi ukuvikela ukutheleleka nge-HIV?
- a) Yebo
 - b) Cha
- 23) Ngabe kukhona okusebenzisayo ukuzivikela ukuthi ungatheleleki ngesandulela ngculaziNgabe uyakusebenzisa okuthile ukuzivikela ukukwasuleleka ngegcikwane lesandulela ngculaza

- a) Yebo
 - b) Cha
 - c) Uma kungu yebo, yini oyisebenzisayo? _____
- 24) Unabantwana abangaki?
- a) _____ Umntwana/Abantwana
- 25) Ingabe uyakusebenzisa okokuvimbela inzalo njenga manje?
- a) Yebo
 - b) Cha
 - c) Uma kungu yebo, usebenzisana: _____
- 26) Yiziphi izinsizakalo zezempilo zocansi nezokuzala (ama-SRH) okewazisebenzisa? (Khetha konke okewakusebenzisa)
- a) Izinsiza zokuvimbela inzalo
 - b) Ukuhlolwa i-HIV
 - c) Ukuhlolwa/ Ukuhlolwa i-STI
 - d) Ukuhlolwa ukukhulelwa
 - e) Izinsiza zokubeletha
 - f) Izinsiza zokwelashwa kwe-HIV
 - g) Izinsiza zokunqanyulwa kokukhulelwa
 - h) Okunye: _____
- 27) Iyiphi inkinga ye-SRH okhathazeke kakhulu ngokubhekana nayo? (Linganisa lokho okhathazeke kakhulu ngakho kube okokuqala, okulandelayo okhathazeke kakhulu ngakho kube okwesibili, bese lokhu okhathazeke kancane ngakho kube okwesithathu).
- a) Ukuthola isifo esithathelana ngokocansi (STI)
 - b) Ukuba ne-HIV
 - c) Ukukhulelwa/Ukukhulelisa umuntu
- 28) Ubani onomthelela ekukhetheni kwakho ukusebenzisa izinsiza ze-SRH? (Khetha konke okungenayo)
- a) Umama
 - b) Ubaba
 - c) Ugogo
 - d) Umkhulu
 - e) Udadewethu
 - f) Umfowethu
 - g) U-anti
 - h) Umalume
 - i) Umngani
 - j) Umlingani
 - k) Uthisha
 - l) Akekho omunye, izinqumo ngizithathela ngokwami
 - m) Omunye: _____

Ingxoxo Egxilile Umhlahlandlela 1

Sawubona, siyajabuae kakhulu ngokuthi uvume ukukhuluma nathi namuhla, Siyethemba ukuthi uzoziya ukhululekile ngokukhuluma nathi. Ngicela ukhumbule ukungitshela uma ungathanda ukuthatha ikhefu phakathi nengxoxo.

Senza ucwaningo ukuze sithole izinto eziyimbangela yokuthi abantu abasebasha/intsha isebenzise noma ingazisebenzisi izinsiza ze-SRH siphinde sibheke ukuthi yiziphi izici zabasebenze bezempilo kanye nezomtholampilo eziba nomthelela kubantu abasha/intsha ekuthatheni izinqumo zokusebenzisa izinsiza ze-SRH. Singathanda ukukubiza imibuzo emibalwa ukuze sifunde kohlangene nakho ngenkathi usebenzisa izinsiza ze-SRH

	Imibuzo	Isihloko Sendima
1	Ngizosho amagama ambalwa manje. Ngicela ungitshele ngokushesha izinto ezintathu zokuqala/ amagama owacabangayo uma uzwa lamagama. Azikho ezimpendulo ezilungile nezingalungile, sicela usho noma yini efika engqondweni ngokushesha: • Umtholampilo wokunakekelwa kwezempilo • Ezempilo zocansi • I-HIV • Umhlengikazi • Izindlela zokuvimbela inzalo • Udokotela • Ukukhulelwa • I-STI • Umuntu one-HIV • u-PrEP oyiphilisi • Ukuhlolwa kwe-HIV	Ukuchema/Ukugxila kokusha
2	Ake sikhulume ngokusebenzisa izinsiza ze-SRH: • Ucabanga ukuthi kubaluleke nini ukusebenzisa lezi zinsiza? (Hlolisisa: Uhlobo ngalunye hwezinsiza [Ukuhlolwa i-HIV /ukuvimbela inzalo/ ukuhlolwa i-STI]. Kukho konke hlola ukuthi kungani becabanga lokhu) • Ngokuvamile abantu bacabanga ukuthi kubalulekile ukusebenzisa izinsiza ze-SRH, kodwa basakuthola kunzima ukuya bayozisebenzisa? Ucabanga ukuthi kungani lokhu kwenzeka? ? • ○ Yini eyakuyekisa ukusebenzisa izinsiza ze-SRH ngenkathi ubufuna ukuzisebenzisa esikhathini esidlule ? (hlolisisa umthelela wokuhlalisana kwabantu i.e., womndeni, wabalingani, wabangani,womtholampilo,womphakathi)	Inhloso/Nokubalukela
3	• Ucabanga ukuthi umphakathi wakho uzizwa kanjani ngentsha esebenzisa izinsiza ze-SRH? ○ Hlolisisa: Abazali/abantu abadala/abantu abancane ○ Hlolisisa:Ingabe ucabanga ukuthi banomuzwa wokuthi abantu abasha bangakwazi ukuzilawula mayelana nocansi? Engabe ucabanga ukuthi abantu bakwazi nini ukuzilawula ngokocansi futhi kungani? ○ Engabe lokhu kuhlukile kumantombazane nabafana? Kungani?	umphakathi kanye nezimiso zobulili
4	• Usenza kanjani isinqumo sokusebenzisa izinsiza ze-SRH? ○ Ucabanga ukuthi wehluke kanjani kwabanye abantu abasebenzisa izinsiza ze-SRH? ▪ Usenza kanjani isinqumo ngokuthi udinga ukuzisebenzisa (Hlolisisa izinsiza ngazinye/ ubungozi) ○ Chaza iluphi ulwazi olusebenzisayo ukwenza lesisinqumo? (Hlolisisa: Uluthola kanjani ulwazi/futhi uhlola kanjani ukuthi luhungile) ○ Ubani ocabanga ngaye uma wenza isinqumo? (Hlolisisa: imicabango yomlingani/yomndeni /yabangani bakho)	Uthatha isinqumo/Imthelela wokuhlalisana kwabantu /izindlela eziywayelekile /Imizamo

	Kudingeka umzamo ongakanani ukusebenzisa izinsiza ze-SRH? Ngisthele ngokuthi yini eyenza kubenzima/ kungabinzima/ usenza kanjani isiqumo uma kuyinkinga kakhulu ukusebenzisa izinsiza bese uvele uyeke?	
5	- Yini ocabanga ukuthi usengozini yokulahlekelwa yiyo ngokusebenzisa izinsiza ze-SRH? (Hlolisisa isikhathi/isimo/ umumo wezenhlalo) - Ucabanga ukuthi yini ongase uyizuze ngokusebenzisa lezi zinsiza? - Usithatha kanjani isiqumo sokuthi izinzuzo zakho zingaba ngaphezulu kwezindleko?	Izindleko/ ukuhlaziya Inzuzo
6	Manje, sesizokhuluma ngabasebenzi basemtholampilo lapho uthola izinsiza ze-SRH. Ngitshele ukuthi kunjani emtholampilo? Ikakhulukazi ukuthi kunjani ukusebenzisa izinsiza ze-SRH	Ohlangene nakho ngezinsiza ze-SRH
7	Ngitshele ngezinto ezenza umsebenzi wezempilo omuhle?	
8	- Cacisele izici ozincamelayo kumsebenzi wezempilo (hlolisisa ngakunye ukuthi kungani kunjalo): - Ubuntu (e.g., onobungani, olukhuluni, othobekile) - Izimpawu (omncane, ogqoka kahle, owesifazane) Ukubukeka	Izici
9	Umsebenzi wokwenziwa kwabasebenzi bezempilo abangancamelwa,. Hlolisisa umsebenzi wokwenziwa kwesithombe ngasinye ukuthi kungani bethanda le HCW, nokuthi kubenza bazizwe kanjani ukubona le HCW futhi kungani.	Umsebenzi
10	- Cacisa izici ongeke uzincamele kumsebenzi wezempilo (hlolisisa ngakunye ukuthi kungani kunjalo): - Ubuntu(e.g., onobugani, olukhuni, othobekile) - Izimpawu(omncane, ogqoka kahle, owesifazane) Ukubukeka	Izici
11	Umsebenzi wokwenziwa kwabasebenzi bezempilo abangancamelwa,. Hlolisisa umsebenzi wokwenziwa kwesithombe ngasinye ukuthi kungani bengayincameli le HCW, nokuthi kubenza bazizwe kanjani ukubona le HCW futhi kungani.	Umsebenzi
12	Umsebenzi wokugcina ukuhlolisisa imizwa yababambiqhaza kwizithombe eziyi-16 ezenziwe zahlanganiswa.. Kwinhlanguanisela ngayinye hlolisisa isithombe esincameliwe nokuthi kungani bekhethe leso sinqumo	Umsebenzi
13	Ngiyabonga kakhulu ngokubama iqhaza kwakho kulengxoxa namhlanje. Ngabe unayo imbuzo ofisa ukuyibuza kithina? Sizohlela manje ingxoxo yakho elandelayo ngesikhathi esilungele wena. Siyabonga ngesikhathi esihle namuhla.	Ukuvala

Ingxoxo ejulile Umhlahlandlela 2

Sawubona, siyababula ngokuthi uvumile ukuxoxa nathi namhlanje, sithemba ukuthi uzokhululeka ukuxoxa kanye nathi. Ngicela ukhumbule ukungitshela uma ufuna ukuthatha ikhefu ngesikhathi sisaxoxa. Senza ucwaningo ukuze sithole izinto eziyimbangela yokuthi abantu abasebasha/intsha isebenzise noma ingazisebenzisi izinsiza ze-SRH siphinde sibheke ukuthi yiziphi izici zabasebenze bezempilo kanye nezomtholampilo eziba nomthelela kubantu abasha/intsha ekuthatheni izinqumo zokusebenzisa izinsiza ze-SRH. Singathanda ukukubuza imibuzo emibalwa ukuze sifunde kohlangene nakho ngenkathi usebenzisa izinsiza ze-SRH

	Ubuzo	Isihloko sendima
1	Ake sixoxe ngomtholampilo lapho uthola khona izinsiza ze SRH. Ucabangani mayelana nendlela lemitholampilo eyakhiwe ngayo Hlolisisa: indawo, abahlangabezane nakho ngenkathi bevakashele emtholampilo, , engabe ubukeka ubalungele abantu abasebasha)	Okuhlangenwe nakho
2	Ucabanga ukuthi isakhiwo somtholampilo (ukubukeka kwawo) sinomthelela kwindlela oyangayo emtholampilo? (Hlolisisa: ngabe inemfihlo, hlolisisa indlela azizwa ngayo wayelana nokuhlala egumbini lokulinda, ingaphandle, indawo ekuyo, izindlu zangasese, amagombi abahlengikazi etc)	Izici ezithandwayo
3	Namuhla sizokubuza ngokuthi ungawakha kanjani umtholampilo olungele abantu abasha ukuthi bawusebenzise nokuthi bathole izinsiza ze-SRH kuwo. Kunezinto okumele ubenazo uma ucabanga ngokwenza umtholampilo, kulokho kubalwa amagombi asemtholampilo, igumbi lokwamukelwa (i-reception), ikhemisi, izindlu zangasese etc. Kuzodingeka uqinisekise ukuthi lezi zinto zifakiwe ekwakhiweni komtholampilo.. Sizokunikeza i-plan yomtholampilo ojwayelekile ukuze ubone ukuthi wenziwa kanjani nokuthi yiziphi izinto okufanele umtholampilo ube nazo.	Ukwakheka kokufundisa nokusebenza
4	Umsebenzi 1: Ukwakha umtholampilo ongaguquki Kanye nomtholampilo ongumahamba nendlwana Hlolisisa mayelana nezinqumo, kungani izinqumo zenziwe nokuthi lokhu kungakwenza kubengcono kanjani ukuzizwa kwakhe ngokusebenzisa umtholampilo)	Umsebenzi
5	Umsebenzi 2: Ukwakhiwa kabusha kanye nemodeli ekhona yomtholampilo oqinile nohambayo (Ukuhlola izinqumo, ukuthi kungani izinqumo zenziwe nokuthi lokhu kungathuthukisa kanjani ulwazi lokusebenzisa umtholampilo)	Umsebenzi
6	Ngabe zikhona izinguquko othanda ukuzenza kwisakhiwo sakho somtholampilo (hlolisisa ukuthi kungani enza izinguquko).	Ukuhambisana nanoma yiziphi izinguquko
7	Ngyabonga kakhulu ngokubamba kwakho iqhaza kwingxoxo yanamhlanje. Ngabe unayo imibuzo ongathanda ukuyibuza thina? Ngyabonga ngesikhathi esihle namhlanje..	Ukuvala

- **Umhlahlandlela Ovisisekelo Wamaqembu Agxilile (Imihlahlandlela ve-FGD izophothulwa ngemva kokuthi Izingxoxo 1 no-2 seziqediwe)**