BARRIERS IN ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG WOMEN IN A RURAL CLINIC IN ALFRED NZO DISTRICT, EASTERN CAPE, SOUTH AFRICA

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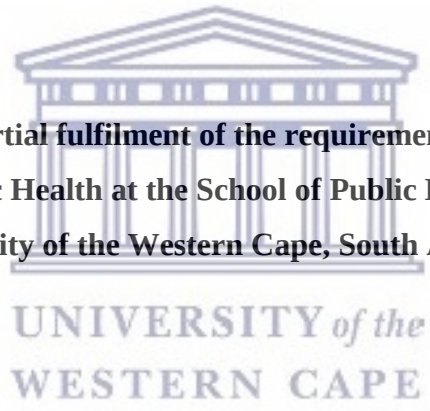

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KEY WORDS

Sexual and reproductive health (SRH)

Adolescents

Youth

Alfred Nzo health district

Primary healthcare (PHC)

District Health Information Systems (DHIS)

Integrated School Health Programme (ISHP)

Ward Based Primary Health Care Outreach Teams (WBPHCOTs)

Contraceptives

HIV/Aids

ACRONYMS

AYFS	Adolescent and Youth Friendly Services
DHIS	District Health Information Systems
GIS	Geographic Information Systems
ISHP	Integrated Schools Health Programme
NGO	Non-government organisation
PHC	Primary healthcare
PPTICRM	Perfect Permanent Team for Ideal Clinic Realisation and Maintenance
SANAC	South African National Aids Council
SRH	Sexual and reproductive health
SRHR	Sexual reproductive health and rights
STI	Sexually transmitted infections
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WBPHCOT	Ward-based primary health care outreach teams
WHO	World Health Organisation

DEFINITION OF KEY TERMS

Youth

Youth are those between the ages of 14 and 35, according to the National Adolescent and Youth Policy of 2017.

Sexual Health

The World Health Organisation (WHO) defines sexual well-being as a state of sexuality that is analogous to physical, profound, mental, and social wellness; it isn't just the absence of illness or sickness. A positive and respectful approach to sexuality and sexual relationships is necessary for sexual well-being, as is the opportunity to enjoy joyful, safe sexual encounters free from pressure, segregation, and brutality. Sexual freedoms should be taken into consideration, secured, and gratified in order to develop and maintain sexual well-being (WHO, 2006).

Reproductive health

The United Nations (UN) characterises reproductive health (RH) as physical, mental and social prosperity in all matters connecting with the regenerative framework and capabilities, at all phases of life (UN, 1995).

Reproductive health services

As per the UN, reproductive health services incorporate prevention, diagnosis and treatment of sexually transmitted infections, contraceptive administrations, counselling, pre-and post-natal care, delivery care, safe early termination and post-abortion care, and access to information and education on the above issues (UN, 1995).

Adolescent sexual and reproductive health

Adolescent sexual and reproductive health alludes to the physical and emotional prosperity of young people, and incorporates their capacity to be healthy, avoid unintended pregnancy, unsafe abortions, maternal disability and demise, all types of sexual viciousness and coercion, and sexually transmitted sicknesses, including HIV/AIDS (Senderowitz, 1995; WHO, 1998).

ABSTRACT

Access to sexual and reproductive health (SRH) services for young women is a global challenge, and South Africa is no exception (WHO, 2016). Less than 1% of adolescent girls and young women aged 15 – 24 years visit health facilities in Alfred Nzo district (DHIS, 2019/2020). This raises a public health concern, as sexual activity amongst young women is high, with the sexual debut for many girls in the district being as early as 14 years (UNFPA, 2016). Given the poor SRH outcomes for young women, exploring barriers to accessing these services by young women is critical.

Methodology

In-depth interviews were conducted with sixteen purposively selected young women from the catchment communities of one primary healthcare (PHC) facility. In addition, four key informants were included: one programme coordinator from the district, and one SRH nurse, clinic committee member and peer educator from the same facility. Interviews were transcribed and analysed thematically.

Findings

The findings confirmed that access to SRH services by young women was low in Alfred Nzo district. A combination of health system, family structure and parenting context, individual and geographical barriers influenced access to SRH services by young women. Health system barriers included long waiting times, facility operating times, infrastructural challenges, resource shortages and minimal programme support for the total SRH services package. Poor parent-child communication and gender socialisation were identified sub-themes of family structure and context of parenting. Individual barriers were knowledge about SRH services, personal SRH service provider preferences and feelings of shame and guilt. Geographical barriers were also found to hinder young women's access to SRH services.

Conclusion

Barriers to accessing SRH services by young women are complex and multifaceted, within the young women themselves and those beyond their control. Addressing one aspect would not make the necessary impact to improve access to SRH services. The study therefore recommends collaboration of different government departments and other sectors, a will to implement what is already policy and law and financial support.

Declaration

I declare that Barriers in accessing sexual and reproductive health services by young women in a rural clinic in Alfred Nzo health district, Eastern Cape, South Africa is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Patricia Noluthando Gwiji

Signed 

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CHAPTER 1

INTRODUCTION

1.1 Background of the study

Youth sexual and reproductive health remains a global public health concern. Sexual and reproductive health problems are one of the main causes of morbidity and mortality amongst youth globally (WHO, 2016). According to Pringle (2017), sexual activity amongst youth has been on the increase in many countries around the world. The South African Adolescent and Youth Policy (2017) defines youth as persons between the ages of 14 and 35 years. According to the National Integrated Sexual and Reproductive Health and Rights Policy (2019), the sexual and reproductive health (SRH) service package offered to youth in South Africa includes sexuality education, contraceptive dissemination and counselling, HIV prevention and management, sexually transmitted infection (STI) prevention and management, screening and management of sexual and gender-based violence and assault, and antenatal, intra-partum and post-partum care. Worldwide, the highest rates of STIs occur among 20 to 24 year-olds, followed by 15 to 19 year-olds (Center for Disease Control and Prevention, 2014). Out of 22 million unsafe early terminations of pregnancy that happen every year, 15% happen among young women between 15 to 19 years (WHO, 2020). The global AIDS Roadmap also show that new HIV incidents are significantly high among youngsters between 15 to 24 years in non-industrial nations (WHO, 2022). STI rates are the most elevated in Africa, with sub-Saharan Africa (SSA) having 110 million new cases each year (WHO, 2021).

The unmet need for SRH services in South Africa has been estimated to vary between 11% and 24% across provinces, as indicated by the low utilisation rate of primary healthcare (PHC) by 15 to 24-year-olds, low couple-year protection rates and high rates of delivery among 10 to 19 year-olds (District Health Barometer, 2018/2019). These health indicators need attention, as they demonstrate that there has not been much improvement in the uptake of sexual and reproductive health services over the years. The Eastern Cape Province has shown a significant increase in deliveries in the 10 to19-year-old age group (DHIS, 2021). In Alfred Nzo district, despite repeated commitments and the many well-intentioned plans of the Department of Health, SRH

services are not readily accessible to young women (United Nations Population Fund (UNFPA), 2016). In the Adolescent and Youth Friendly Services (AYFS) assessment that was done in Alfred Nzo in 2016, none of the 74 primary healthcare facilities achieved all ten adolescent and youth friendly services standards (Health Focus, 2017).

The South African National Integrated Sexual and Reproductive Health and Rights Policy (2019) advocates for the prioritisation of adolescents, especially girls, as a key population for nearly all SRH services, including prevention, detection and treatment of HIV and other STIs. Other South African health systems like Reengineering of Primary Health care (2012) feature the requirement for teenagers and youngsters to approach youth-accommodating administrations and school-based services, including thorough sexuality instruction, the anticipation of undesirable pregnancies and dangers related with adolescent pregnancy, the avoidance of HIV and other STIs, and access to safe choice termination of pregnancy. The South African National Department of Health further showed its commitment to improving access to SRH services by developing the Integrated Sexual Reproductive Health and Rights Policy in 2019. The policy dictates that all health facilities should remove barriers to accessing SRHR services by:

- refraining from moral judgement and discrimination by health workers;
- encouraging adolescents to access sexual and reproductive health and rights (SRHR) services and information;
- promoting personal choice and decision-making guided by friendly, non-judgmental and empathetic health workers, social workers and community workers, and the support of family;
- challenging taboos, myths, misperceptions, stereotypes and discrimination on sexuality, culture and traditional practices, along with prejudices against certain groupings, with positivity, facts and openness; and
- informing adolescents of risky sexual behaviors, such as early sexual debut, intergenerational sex and multiple concurrent partners, often driven by patriarchal gender norms and poverty.

In South Africa, SRH services are provided mainly by PHC facilities and through the Integrated School Health Programme. Clearly, access to these services by young women is vital in

preventing adverse sexual and reproductive health outcomes. Achieving optimal sexual and reproductive health among young women is also necessary to protect future generations from negative health consequences.

1.2 Problem statement

In South Africa, youth constitutes 17, 2% of the total population (Stats SA, 2021). However, only 1, 2% of young people visit health facilities for any reason (DHIS, 2020). According to the District Health Information System (2021), in the Eastern Cape Province only 0, 86% of young people aged 10 to 19 access health services. The median age of sexual debut in South Africa is 16 years for females (Richter, 2015). The Alfred Nzo Integrated Development Plan (2019/2020) reported that youth between the ages of 18 and 24 years account for 12% of the total district population, with a total of 310 753 people in this group. A survey conducted by the United Nations Population Fund (UNFPA) (2016) in a senior secondary school in Alfred Nzo found that 68% of the female participants first engaged in sexual intercourse at 14 years, on average. Despite this reported early sexual debut, the PHC utilisation rate by young people remains low in Alfred Nzo (Alfred Nzo Performance Reviews, 2020). In 2016-2017, the district had the highest rate of deliveries among 10 to 19-year-olds in South Africa, at a rate of 24, 7% of females in this age group (District Health Barometer, 2017/2018). In more recent years, the picture has not changed; in the first quarter of the 2020/2021 financial year, 23% of female 10 to 19-year-olds in the district gave birth (DHIS, 2020/2021). The district continues to have the lowest couple-year protection rate in the country (District Health Barometer, 2018/2019: 69). In the first quarter of 2020/2021, no female condoms were distributed and only 25, 3% of male condoms were distributed (DHIS, 2020/2021). The HIV transmission rate in young women is significantly high in the district, at 2, 1%. The reports sent by Alfred Nzo district STI sentinel sites indicate that 58% of treated STIs were young women between the ages of 20 and 24 years. Evidence of poor access to SRH services by young women is reflected in research and statistical data from international organisations, national and District Health Information Systems (DHIS).

The study therefore examines the perceived and experienced barriers to accessing SRH services by young women in a rural high-volume PHC facility in Alfred Nzo, in an attempt to provide evidence-based recommendations to improve access to these services.

1.3 The purpose of the study

According to research, offering SRH services to young people can improve their reproductive health (Hock Long, Herceg-Baron, Cassidy & Whitaker, 2003; Stone & Ingham, 2003). An in-depth understanding of these barriers can therefore be gained by looking at the actual and perceived obstacles adolescent girls and young women face when trying to obtain SRH services. The data gathered can be utilised to increase adolescent girls and young women's access to SRH services and, as a result, improve their reproductive health outcomes in South African regions that are similar. WHO (2023) supports evidence based interventions that will ensure that SRH services are designed for young people considering their health needs and challenges in their own context.

1.4 Aim

The proposed study aims to examine perceived and experienced barriers to accessing SRH services by young women at a high-volume PHC facility in Alfred Nzo district, Eastern Cape, South Africa.

1.5 Objectives

The objectives of this study are

a) to explore and describe the knowledge and attitudes of young women towards using SRH services;

b) to explore the perceived and experienced individual, social, cultural and health-system barriers in accessing SRH services by young women; and

c) to identify and describe the factors that key informants perceive as barriers to accessing SRH services by young women.

CHAPTER 2

LITERATURE REVIEW

2. 1 Introduction

The literature reviewed describes the concept of adolescent and young person's sexual reproductive health services, explores barriers to accessing SRH services by young women globally, and considers initiatives that aim to improve access and utilisation of SRH services by young women in South Africa.

2.2 Global adolescents' and young persons' sexual reproductive health and rights services

As adolescents and young people transition to adulthood, they have varying health needs and face peculiar reproductive wellbeing weaknesses (UNFPA, 2007). To effectively address their SRH requirements, teenagers need programs that are particular, appropriate, accessible, and simple to use (WHO, 2012). According to the South African National Integrated Sexual and Reproductive Health and Rights Policy (2019), SRH services offered to teenagers and young adults must be private, confidential, specifically designed for them, and given with their informed consent. Their cultural and religious values must be respected, and services must adhere to any applicable existing international accords (UN, 1994). SRH services in South Africa comprise the following, in accordance with the Adolescent and Youth Health Minimum Services Package (2020)

- the provision of information, education and counselling on sexuality, reproductive health, safe sex, the reduction of risky behaviours and the promotion of healthy lifestyles;
- the provision of information, education, counselling and services on pregnancy prevention, and the prevention and treatment of sexually transmitted infection (STIs) to reduce the harmful effects of risky sexual behaviours;
- the provision of HIV/Aids prevention and management services that include HIV counselling and testing services, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), anti-retroviral treatment (ART) and treatment adherence support;

- the provision of contraceptives, along with demonstrations on their correct use;
- the provision of pregnancy support, antenatal care and PMTCT;
- psycho-social support and management of sexual and gender-based violence (GBV); and
- assistance with problem screening, management and referrals for substance abuse, violence and sexual assault, mental health problems, malnutrition, juvenile diabetes and hypertension.

Young people need reproductive healthcare now more than ever, in light of the high numbers of STIs and pregnancies among youth. Addressing these needs is crucial to preventing poor reproductive outcomes (UNFPA, 2017). The Ideal Clinic Realisation Programme in South Africa seeks to facilitate implementation of the minimum youth SRH service package through Perfect Permanent Teams for Ideal Clinic Realisation and Maintenance (PPTICRM) reviews conducted in all the public health facilities (Ideal Clinic Components and Definitions, 2019).

2.3 Individual barriers to accessing SRH services

A qualitative study carried out in Nigeria by Nmadu, Mohamed and Usman (2020) cited limited knowledge about SRH services and poor attitudes of young women towards SRH services as individual barriers to accessing SRH services. The study revealed that adolescents and young women have limited knowledge about SRH services and the various types of contraceptives available. The South African National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) identified women's education levels as having a strong influence on women's abilities to access SRH services. According to a survey conducted by Restless Development and UNFPA (2016) in Alfred Nzo health district, contraceptive utilisation among sexually active women with a post-high school qualification is twice as high (75%) than among women with primary school education (38%). Higher levels of education and the retention of girls in school are also linked to lower rates of teenage pregnancy, STIs and HIV among adolescent and young women (Department of Health, 2016).

2.4 Socio-cultural barriers

Factors operating at the socio-cultural level that deter young women from accessing SRH services include parenting styles, community and cultural factors. Gender inequalities, frequently

arising differences in the upbringings of girls and boys at home, in the community and in society, also play a role in causing women to suffer disproportionately from reproductive ill health (UNFPA, 2007). When young women are compliant, they lack autonomy and ability to make decisions on SRH issues, which increases their vulnerability; this has been found to restrict their access to reproductive health information, services and contraceptives (Mbeba et al, 2012; Morris & Rushwan, 2015).

2.4.1 Parenting styles

The type and quality of a young woman's relationship with her parents can have a significant impact on the choices she makes regarding her sexual orientation. Teenagers are more likely to use SRH services if their parents create a warm, loving, and nurturing atmosphere (Cox, 2007). A meta-analysis of more than twenty research studies revealed that parental warmth, support, and proximity reduce the incidence of adolescent pregnancy by encouraging young people to engage in healthy sexual and contraceptive practices (Miller et al., 2001). However, an excessively harsh and authoritarian parenting approach is linked to unhealthy behaviour and a higher likelihood of teen pregnancy (Miller, 1998).

2.4.2 Community and cultural barriers

Most studies identify religious and cultural factors as the most significant barriers to accessing SRH services by young women (Godia, 2013; Mbeba, 2012; Upadhyay, 2016). Misconceptions that exist in many communities about contraceptives – such as that they cause infertility later in life, especially after the use of injectable contraceptives – serve as a hindrance to accessing SRH services (Mbeba, 2017). The study by Nmadu, Mohamed and Usman (2020) referred to under point 2.3 revealed that cultural taboos surrounding sexuality in many communities prevent young women from openly discussing sex and reproductive health issues, making them unlikely to access SRH services. The study also established that many young women in these communities feel guilty, not only about having sex but also about accessing SRH services. Girls and women often suffer disproportionately from reproductive ill health which affects their wellbeing in a negative manner, as a result of gendered barriers to accessing healthcare (WHO, 2015).

2.5 Economic factors

High unemployment and poverty rates were cited as a barrier to SRH services in South Africa in the 2012 South African National Contraception and Fertility Planning Policy and Service Delivery Guidelines. Dinkelman, Lam, and Leibbrandt (2008) demonstrated that community-level poverty significantly predicts early sexual debut for both boys and girls as well as higher rates of unprotected sex using the Cape Area Panel Study data for the years 2002 and 2005.

'When young people can't complete school, struggle to find work and see few opportunities, they are likely to discount the costs of pregnancy and HIV, and display a willingness to take greater risks' (Kaufman, 2004; 52). Gender inequality plays a significant role in preventing access to SRH services; in many countries around the world, women and girls still have lower status, fewer opportunities, lower income, less control over resources and less power than men and boys (UNFPA, 2016). Even though SRH services are offered free at PHC facilities, the cost of transport is often too high for young women from poor and rural communities.

2.6 Health system barriers

Universal access to SRH services forms one of the Sustainable Development Goals (SDGs) (Lince-Deroche et al., 2020). As in other developing countries, South Africa delivers SRH services through the public health system. Providing universal access to SRH services is usually beyond the public health system's capacity. This is because of challenges that include scarce resources, poor provider skills, inconvenient health facility operational times and the overburdened state of the system, caused by other health programmes such as HIV/Aids and, in recent years, the Covid-19 pandemic.

2.6.1 Scarce resources and poor provider skills

Scarce SRH resources include human, material, transport and infrastructural resources. Despite the inclusion of SRH services in the UN's Sustainable Development Goals, financial support for SRH programmes depends on departmental budgets. The Health Systems Trust (2020) states that, unlike programmes such as HIV/Aids that are supported by conditional grants and international organisations, the recruitment and procurement of SRH commodities, transport and

infrastructural development depends solely on the equitable share of domestic health department budgets. A survey conducted by UNFPA (2016) identified that very little had been done to develop and capacitate SRH providers. Few SRH providers were trained in SRH services, and even fewer were sufficiently skilled to provide all service in the minimum SRH package. Most health providers did not have the skills to provide long-acting contraceptives. As a result, the survey further reported that women are mostly provided with injectable contraceptives as the provider's method of choice, rather than the client's method of choice. Infrastructural challenges clearly compromise the quality of SRH services provided. UNICEF (2017) reported that inadequate and poorly maintained health infrastructure is a major barrier to access of SRH services for women living in the rural areas. WHO (2018) concurs, stating that poor infrastructure will be a major obstacle in achieving millennium developmental goals and addressing gender inequalities in developing countries.

2.6.2 Negative attitudes of SRH providers

In a study by Souksamone et al. (2019), negative provider attitudes were found to compromise the quality of services offered. The study also revealed that not enough effort was made by healthcare providers to inform adolescent and young women about SRH services. Most young women still held misconceptions and myths about SRH, even after visiting health facilities. The study by Nmadu, Mohamed and Usman (2020) revealed that negative attitudes and behaviours by health service providers made it difficult for young women, in particular, to access SRH services. The negative attitudes reported were unfriendly and hostile behaviour, and being inconsiderate to young people's needs. Tsebe (2012) concluded that the consequences of provider's negative attitudes are far reaching; these attitudes make the healthcare system unfriendly to young women, who prefer, as a result, to seek information from their peers and social media, which may sometimes provide incorrect information.

2.6.3 Health facility operational times

A survey conducted by UNFPA (2016) in Alfred Nzo identified that facility operating hours were not convenient for the majority of school-going adolescents and young people as they were at school when clinics were open, and clinics were closed in the afternoons and during weekends. This is consistent with the findings of youth focus group discussions (2020) held in

Alfred Nzo, where young people cited facility operating times as one of their major challenges in accessing SRH services. They further advised that SRH services should be tailor made to suit them, in light of their school schedules and timetables.

2.6.4 Impact of other diseases on the provision of SRH services

Previous public health emergencies have shown that the impact of an epidemic on SRH services often goes unrecognised, because the effects are often not the direct result of the epidemic, but the indirect consequence of a strained health care system, disruptions in care and the redirection of resources (WHO, 2016). According to Sully (2020), evidence from the Ebola virus outbreak in 2013-2016 in Western Africa showed the negative, indirect effects that such health crises can have on SRH service delivery. According to an analysis of data from Sierra Leone's Health Management Information System, the utilisation of maternal, new-born and women's health services decreased owing to disruptions in services and the fear of seeking treatment during the Ebola outbreak. This led to an estimated 3,600 maternal deaths, neonatal deaths and stillbirths, a number that was close to the number of deaths directly caused by the Ebola virus in the country (Sully, 2020). Different studies found that Ebola out-break brought about sharp decrease in the uptake of preventative use of contraceptives in Guinea, Liberia and Sierra Leone.

The Coronavirus pandemic has raised worries that it might compromise women's access to SRH services worldwide. In spite of the fact that data is still emerging, few reports show decreased access to SRH services to a great extent attributable to disturbances in demand and supply of contraceptive commodities (UNFPA, 2020). With major pharmaceutical companies that produce contraceptive commodities currently focusing on Covid-19 vaccine production, there have been reported contraceptive stock shortages. One such pharmaceutical company is Pfizer, which reported capacity challenges to produce medroxyprogesterone acetate contraceptive injectables, as they are now focusing on producing the Pfizer Covid-19 vaccine (NDoH, 2021). The diversion of staff and resources to Covid-19 response and vaccination has left a big gap in SRH delivery (Babatunde, et al., 2021). The Eastern Cape Department of Health also identified travel restrictions and lockdowns as one of the causes of low contraceptive uptake in the 2020/2021 fiscal year (ECDoH Annual Performance Reviews, 2021). The closure of health facilities and fear of getting infected owing to increased Covid-19 infections amongst healthcare providers and

communities was also cited as a major cause of poor performance across maternal, child and women's health services.

2.7 Initiatives and programmes to improve access to SRH services by young people

South African initiatives and programmes geared towards ensuring that SRH services and health services are accessible to adolescent and young people include, amongst others, comprehensive sexuality education as part of the Life Orientation programme in schools, the annual funding and roll-out of AYFS in government clinics, and programmes such as loveLife, which combines highly visible sustained national multi-media sex education and HIV/Aids awareness campaigns (UNFPA, 2016).

The provision of a comprehensive contraceptive package in all clinics would ensure that young people have a varied, individualised choice in their contraceptive options. The current South African public health contraceptive package comprises long-term contraceptives, injectables, oral pills, barrier methods and referral, should the need arise. Several policies were launched by the National Department of Health in 2012 that are related to increasing access to SRH services and prevention of teenage pregnancy. These policies include: the National Youth Policy (2015), the Integrated School Health Policy (ISHP) (jointly launched by two government departments, Health and Basic Education), the updated National Contraceptives Guideline Policy, the National Adolescent Youth Health Policy in 2017 (Department of Health), and the Integrated National SRH&R guidelines, in 2019. The National Department of Health also launched the 'She Conquers' campaign in 2016 with the aim of safeguarding the rights and wellbeing of adolescent girls and young women in South Africa.

Despite all these interventions, reproductive health outcomes are still poor among adolescent girls and young women across South Africa. Teenage pregnancies are still increasing, STI and HIV infections among adolescent girls and young women are still increasing.

2.8 Gaps in the literature reviewed

A great deal of research has been conducted on barriers to accessing SRH services, but there are still gaps in the understanding of complex interrelated factors that inhibit access and utilisation of

SRH services, the socio-cultural barriers and the impact of shifts in the family structure, individual barriers, standards of SRH services rendered in the health facilities, emerging health emergencies and their impact on access to such services by adolescent and young women. The study therefore seeks to address these gaps.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The research study's methodology is described in this chapter. It provides context for the study's design, setting, population, and sample methods. Additionally, it outlines the methods for collecting data, data collection tools, and how data was analysed. The chapter concludes by discussing the study's rigour, limitations, and ethical considerations.

3.2 Research design

For this study, an exploratory qualitative design was employed. This study's exploratory design made it possible to comprehend young women's views, emotions, and experiences with regard to barriers to obtaining SRH services in some detail. Exploratory qualitative studies seek to fully grasp a phenomenon in a novel setting in order to gain a thorough understanding of the individuals' actual experiences (Polit & Hungler, 1999). A qualitative method is unconstrained by the fixed constraints that define the quantitative approach and allows for unfettered, unstructured expression (Pope & Mays, 1995). In a qualitative study, the researcher attempts to comprehend the underlying structures of the phenomenon being examined in addition to describing the complexity of what is being studied in order to make sense of the complexity (Green & Thorogood, 2005; Neuman, 2010).

3.3 Study setting

The study was conducted in a high volume rural PHC facility in Alfred Nzo district, Eastern Cape, South Africa. The facility was serving a population of 26 466 people, including 1 792 young women aged 18 to 24 years (Stats SA Mid-year Population Estimates, 2020). Statistics South Africa (2020) listed Alfred Nzo as the poorest district in South Africa with more that 90 percent of its population earning less than R 1 600 per month. The study facility had the lowest uptake of SRH services with Couple Year Protection rate at 10 percent, none of the area health facilities offered choice termination of pregnancy and the delivery of 10 – 19 years was at 25,2

percent, the second highest in the district (DHIS, 2020/2021) . SRH services offered in the facility included sexuality education, the contraceptive package, HIV prevention, HIV management, STI prevention, STI management, antenatal care services and referrals for SRH management. The contraceptive package offered to women included long-acting contraceptives, injectable contraceptives, oral pills, female and male condoms (Department of Health Ideal Clinic Peer Reviews, 2019).

3.4 Study population

The study population comprised young women aged 18 to 24 years residing in the catchment area of the study PHC facility. Key informants included a programme coordinator, facility nurse, clinic committee member and a peer educator working in the facility catchment area.

3.5 Sample and sampling process

Purposive sampling (Robson, 2011) was used to select sixteen young women for the study. Young women from 18 to 24 years who came for any service in the facility were approached to participate in the study. Young women in the community were also approached to participate in the study. The inclusion criteria of the study were young women between 18 and 24 years, residing in the study facility catchment area, attending school in junior secondary schools and tertiary institutions, those out of school and those staying at home or working. The exclusion criteria of the study were young women below 18 years, above 24 years, not residing in the facility catchment area, young women with mental disorders and those not willing to participate in the study. Key informants were recruited to give their expertise and unique perspective on the barriers to accessing SRH services for young women. These individuals were selected because of their experience or position and their ability to provide supplementary information and deeper insight into the issue at hand (Marshall, 1996). They included one programme coordinator, one professional nurse working in the PHC facility and providing SRH services in the facility, one clinic committee member, and one peer educator working in the PHC facility catchment area. Recruitment took place over five weeks, after permission was granted to conduct the study. Young women who visited the health facility for any service and met the inclusion criteria were identified by the professional nurses in each consulting room. Those who agreed to participate in the study were then introduced to the researcher who was given a private room in the facility.

The researcher would then introduce herself and inform them about the study. The researcher also joined the scheduled community youth dialogues as advised by the area peer educators, and recruited some of them to the study. All key informants were individually recruited by the researcher and were all willing to participate in the study.

3.6 Data collection methods and tools

Data was collected through in-depth interviews in the study participants' preferred language (isiXhosa and/or English). In-depth interviews were useful for exploring individual perspectives and for prompting participants to share their personal experiences regarding barriers to accessing SRH services (Mack, 2005). The in-depth interview is a qualitative data collection method appropriate for exploring sensitive topics, where participants may not want to discuss issues in a group environment (Gill, Steward, Treasure & Chadwick, 2008). This data collection method was used to collect data from both the young women and the key informants. The participants were asked to choose a suitable time for the interviews. All young women were interviewed in the study health facility. All the key informants were interviewed in their workplaces, i.e., the district office and health facility.

Covid-19 safety protocols were adhered to by both the researcher and the participants during the interview. Masks were worn, and the researcher and interviewees sat two metres apart, kept windows open and sanitised hands before and after each interview. Chairs and tables were decontaminated before and after each interview. Interviews lasted 45 to 60 minutes each. The interview guide for all participants consisted of open-ended questions focusing broadly on their experiences and perceptions of the barriers preventing access to SRH services, and their recommendations for removing these barriers. Interviews were audio recorded with the consent of each participant. The researcher wrote brief notes and also observed the participants' non-verbal cues during interviews. At the end of each day of data collection, the researcher made comprehensive notes using the audio tapes, reflected on the interview(s), and identified emerging issues for follow-up (Pope et al. 2000).

3.7 Data analysis

The transcribed data was translated and analysed using thematic analysis (Robson, 2011). As proposed by Braun and Clarke (2006), data analysis was inductive, meaning that the themes emerged from the data. The researcher read the transcripts and interview notes repeatedly and listened to the recordings several times so as to become familiar with the data. Codes were then generated by identifying words and phrases with similar meanings. Identified codes were defined so that they did not lose meaning during the analysis process (Robson, 2011). Similar codes were grouped together to create categories that could later be collapsed to form themes (Barbour, 2001). Themes were then defined and described to highlight the key issues in each theme. The process of analysing the data unveiled perceptions and experiences of young women regarding barriers in accessing SRH services.

3.8 Rigour

Rigour was ensured through the use of reflexivity, triangulation, testing of the data collection tools, member checking and measures to ensure transferability of the study.
Reflexivity in the study was ensured by keeping a reflective diary to record the researcher's own perspectives and feelings regarding sexual reproductive health. Keeping a reflective journal raised the researcher's awareness of how her own attitudes and thoughts might influence every step in the research process (Creswell & Miller, 2000), and helped guard against such an influence. Thoughts and ideas jotted down by the researcher were used during data analysis to help identify and deal with potential bias. Triangulation, was achieved through the use of different data sources; the young women, the key informants and the literature review, which added necessary context to the findings. The data collection tools were also tested before the study started in order to improve clarity and avoid ambiguity of questions (Malterud, 2001).

Member checking is a method for ensuring credibility and dependability in qualitative investigations, according to Creswell & Miller (2000). This was accomplished by the researcher summarising important topics at the conclusion of each in-depth interview to allow participants to confirm the accuracy of the researcher's comprehension and interpretation of their experiences, views, and opinions. To ensure that the data was not manipulated in any manner, the researcher would revisit areas of this study where the data lacked consistency and analyse the

themes and significance of the data collected with specific study subjects. To ensure transferability, the researcher provided description of the study setting and participants to give the context of the study (Creswell & Miller, 2000). The study thus provides insights into other similar settings and contexts.

3.9 Ethical considerations

The Eastern Cape Department of Health, Alfred Nzo district, and the study PHC facility all gave their support for the project after receiving ethical clearance from the University of Western Cape's Biomedical Research Ethics Committee. All young women and key informants participated voluntarily in the study, and they had the option to stop at any point. A letter outlining the research study, asking for their participation, and guaranteeing their confidentiality throughout the study was given to each participant (see Participant Information Sheet, Appendix 3 – 6). To participate in the research project, their consent was requested, and a consent form was made available for them to sign (see Participant Consent Form, Appendix 1 – 2).

Participants were informed that even though the study carried minimal risks, the sexual and reproductive health topic was a sensitive one and participants might feel emotional or depressed; for such an eventuality, the researcher had arranged with the social worker for psycho-social support to be available for counselling during and after data collection. Participants were assured of the confidentiality of all information shared and that when the research outcomes were written up, neither their identities nor any identifiable places would be revealed. Participants could choose on the form whether or not they wanted their audio recordings to be made. Participants were also told that their names would be changed to research identification codes in order to preserve their privacy.

A "do not disturb" sign was posted on the door to discourage anyone from entering or leaving the area while data collection was being done. Data was stored on the researcher's personal computer in password-protected, coded files. The raw data was maintained on the researcher's computer after the data was analysed and reported on. It was kept there in password-protected folders for five years before being totally erased.

3.10 Limitations

One limitation of this study was that it focussed on only collecting data from young women who were residents of the facility catchment area, excluding young women who were not residents of the facility catchment area. Given the small sample size and the qualitative nature of the study, findings are not generalisable to the entire Alfred Nzo population.

The researcher worked as a programme manager in the same study district, it was anticipated that some key informants may feel uncomfortable discussing the topic with the researcher. To overcome this possible limitation, key informants were assured of the confidentiality of the study and encouraged to give honest answers that reflected their true experiences and perceptions. Another possible limitation was that even though data was collected in isiXhosa as the mother tongue of the study participants, some concepts and names could not be translated; for example, contraceptive names. Care was taken to explain and simplify all concepts.

CHAPTER 4

FINDINGS

4.1 Introduction

This chapter presents the findings of the study. First, the characteristics of the participants are described, followed by a presentation of the findings, arranged according to four themes and their related sub-themes. Broadly, the key findings that emerged from the data showed that barriers to accessing SRH services were related either to the health system, the socio-cultural environment, the individual or geographical considerations – or a combination of these.

Although health policies and guidelines are geared towards improving access to SRH services, young women still identified critical aspects in the health system that acted as barriers to access. The Covid-19 pandemic worsened SRH service accessibility challenges. Waiting times became even longer, facilities closed owing to increased infections, pharmaceutical companies prioritised vaccine manufacturing over contraceptive commodities, and limited space had to be shared with Covid prevention and management activities such as screening, isolation and vaccination. Socio-cultural factors that influence young women's ability to access SRH services were related to the family structure, the parenting context and gender socialisation. Individual barriers included the young women's upbringing and lack of knowledge about SRH services. Geographically, the study facility presents a number of challenges of access. It is situated in a town, but the population it serves extends to remote rural areas, with poor road infrastructure making it nearly impossible for some young women from these areas to visit the health facility, especially in bad weather.

4.2 Description of the study participants

Participants in the study were sixteen young women aged between 18 and 24 years, both those who had experience in accessing SRH services and those that had none. The key informants were a programme manager, a SRH nurse, a clinic committee member and a peer educator.

Participants were purposefully selected as follows: Two were in Grade 12, ten had passed Grade 12, one had dropped out of school in Grade 11, two had degrees and one had a diploma. Seven participants had children and nine had no children. Of the sixteen participants, five were selected from the furthest communities. None of the participants was married.

Table 1: Participant characteristics

*Participant identification Code	Age	Educational status	Residing with
P1_D2_23	23 years	Degree	Parents and siblings
P2_G12_18	18 years	Grade 12	Parents and siblings
P3_D1_24	24 years	Diploma	Mother, sister and daughter
P4_G12_20	20 years	Grade 12	Mother, siblings and son
P5_G12_20	20 years	Grade 12	Mother and siblings
P6_G1_21	21 years	Grade 12	Parents, siblings and son
P7_G12_20	20 years	Grade 12	Mother, brother and daughter
P8_G11_19	19 years	Grade 11	Parents, siblings and son
P9_G12_12	22 years	Grade 12	Parents, siblings and son
P10_G12_22	22 years	Grade 12	Mother and siblings
P11_G12_19	19 years	Grade 12	Parents and siblings
P12_G12_20	20 years	Grade 12	Parents, siblings and daughter
P13_D2_23	23 years	Degree	Parents, siblings and daughter
P14_G12_22	22 years	Grade 12	Aunt and cousins
P15_G12_19	19 years	Grade 12	Mother, siblings and daughter
P16_G12_22	22 years	Grade 12	Mother, siblings and son

*Participant ID code: Participant number (P#), educational status (G12 = Grade 12, G11= Grade 11, D1 = Diploma, D2 = Degree), age

The key informants were selected in view of their experience in the field of sexual reproductive health, and in order to obtain a variety of perspectives from different levels and spheres.

4.3 Health system barriers to accessing SRH services

The study findings showed that participants experienced health system barriers to accessing SRH services. The study facility was a high-volume facility with long waiting hours, inconvenient operational hours, had infrastructural challenges and resource challenges and the participants complained about the negative attitudes of the health care providers. On the overall there was minimal support for the total SRH service package.

4.3.1 Long waiting times

Findings showed that the facility was a high-volume facility with 250 clients on average seen each day. This number excluded clients who came for Covid-19 vaccinations and those who came to collect medication from the Central Chronic Medicines Dispensing and Distribution (CCMDD) facility pick-up point. Experiences shared by participants revealed that from screening and registration to the time when the client left the facility, the average facility waiting time was four to five hours for clients who visited for SRH services, which is over the standard of not more than three hours. Waiting times were further extended by the newly introduced Health Patient Registration System (HPRS), which required the recording of all clients' data when they visited the facility for the first time. Clients were spending more than twenty minutes registering, as the administration officers would record all demographic, biographic and medical data in the patients' facility-retained cards.

Comments from participants reinforced the notion that waiting times were excessive.

> *'The long queues in the clinic make you think twice before going again.'* (P 1)

> *'It's always full when I visit the clinic … and at registration, its worse.'* (P 13)

Our data showed that Covid-19 regulations made waiting times longer than usual. Key informants cited that clients were required to go through Covid-19 screening, which would take about ten minutes, before they were allowed inside the health facility. Observation during the facility visit also revealed that queues were long, since Covid-19 regulations stipulated social distancing of two metres between clients. Consultations were stopped every two hours to allow

for deep cleansing of the consulting rooms. Participants confirmed that Covid-19 regulations in the facility were a significant challenge to accessing SRH services. It appeared from the interviews that most young women found the waiting times unacceptable and a hindrance to regular visits.

4.3.2 Facility operating times

The facility opens at 07h00 in the morning and closes at 16h30 in the afternoon from Mondays to Thursdays, and on Fridays, the facility closes at 13h00 in the afternoon. All participants, especially those who were scholars, cited the facility opening times as a challenge. Facility opening times coincide with their hours at school, and after school they either attend afternoon classes or have to get home to take care of household chores. Key informants concurred that facility operational times are a major hindrance to young women's access to SRH services. This aspect was complicated by the fact that parents and teachers were often not aware that young women had intentions to access SRH services. A participant mentioned that having to explain her attendance at the clinic was a deterrent.

> *'... going to the clinic is not easy at all. You have to ask for permission from the class teacher every time you have to go to the clinic. During the school holiday, my mother would ask where I have been'.* (P 7)

The following quotes from respondents show that there is a lack of communication and mutual understanding between the schools and the health facilities about young people's need to attend the clinic. As a result, young women were not aware that the facility had set side certain times for learners to access SRH services.

> *'We encourage them to come after lunch at 14h00 so that they can be given enough attention ... very few end up coming.'* (KI 2)

> *'It would be better if we had times just for us, even if it's after school.'* (P 2)

From the comments of participants, it appears that SRH services suffer from a lack of a multi-disciplinary approach. A multi-disciplinary approach would involve consultations with all stakeholders, including community leaders, parents, the youth, and relevant government departments. The lack of such an approach is evident in the unawareness that young women showed about the services on offer.'

As revealed by facility reports and interviews, facility operations and working times were disrupted during the first and second waves of Covid-19. Consultations and patient flow was delayed to allow for deep cleansing of the consulting rooms in the morning, after examination of a COVID 19 symptomatic client and in the afternoon. Daily working times were thus reduced significantly from the normal eight hours to about six hours. Increased infections amongst employees forced the facility to close for a few days every time a staff member became infected, in order for staff to self-isolate. A key informant explained how Covid affected the facility:

> *'The first wave was the worst. There were no clear guidelines of how to manage Covid-19 infections in facilities. Labour unions would force closure … NHLS was also overwhelmed with specimens, results took longer. Its better now that there is rapid antigen testing, as results are available immediately.'* (KI 1)

4.3.4 Infrastructural challenges

The health facility had experienced a fire accident in 2020 during which some consulting rooms collapsed. This left fewer consulting rooms to render services across all health programmes and streams; acute, chronic, HIV/Aids, maternal, child, women's health, SRH services and Covid-19 vaccination. It emerged from the interviews that because of the space shortages, all services were compromised.

> *'There is a serious space challenge in this clinic. The fire in 2020 made things worse ... eight consulting rooms were destroyed.'* (KI 2)

Covid-19 management and vaccination as a national health priority exacerbated space challenges in the facility. The facility was required to identify a minimum of four rooms for Covid;

screening, vaccination, post-vaccination observation and an isolation room for persons under Covid investigation. Our findings show that the relaxation of Covid lockdown restrictions resulted in facilities such as public halls and supermarkets formerly used for Covid vaccinations withdrawing their support. Public halls had to be prepared and used for the local government elections, and adjusted level 1 conditions meant that more shoppers were expected in the supermarkets. The clinic had no choice but to allocate space for community Covid-19 vaccinations.

> *'The facility had to allocate space for Covid vaccination and isolation of suspected cases.'* (KI 1)

Study findings also show that infrastructural challenges compromised privacy and confidentiality. Nurses in the study health facility shared consulting rooms, which meant that two clients would be consulted in one consulting room at any given time. It was therefore nearly impossible to maintain privacy and confidentiality for all clients. The fact that clients came from the same catchment area meant that many knew each other and were likely to feel uncomfortable sharing their personal and confidential health problems in front of one another. The excerpt below shows how some young women felt when forced to divulge their health problems in front of other clients.

> *'When it was my turn to be seen, yhoo! There was already an elderly woman inside. I thought the nurse would wait until she had left… but she didn't, she asked what my problem was. I was so embarrassed … I couldn't tell her [silence] … I told her I had a tummy ache. I left with my discharge ... My friend advised me to go to the chemist. I took my taxi fare and went to the chemist. That was the last time I went to the clinic until I came for child vaccination.' (P 8)*

> The excerpt indicates the serious negative effects of forcing clients to share consulting rooms simultaneously; in this case, the young woman opted to receive no treatment at all rather than divulge her condition. It is likely that others may have felt the same way; if they

did divulge their conditions, it is possible that they avoided giving much detail. This would not be conducive to receiving the kind of help they needed.

4.3.5 Resource shortages

Data collected and analysed showed that the highest reported resource challenges were a shortage of human resources and of contraceptive supplies. Many nurses above fifty-five years and those with comorbidities take early retirement, as was the case in this facility. The facility also lost two nurses who succumbed to Covid-19 complications. The facility had serious staff shortages, with a nursing personnel vacancy rate of 48%. When there is a shortage of staff, SRH services are not prioritised. Two key informants had this to say:

> *'We are short staffed … the facility lost two professional nurses during the second wave. Also, with severe symptoms experienced by those with comorbidities, most nurses, those above fifty-five years, decided to take early retirements.'* (KI2)

> *'The departmental moratorium clearly stated that there is no money to fill vacant posts. Most of the district coordinators have retired, very few are remaining. Programmes are coordinated by people taken from facilities to act.'* (KI 1)

Data findings showed that staff shortages inevitably mean constraints in the quality of services offered. In this case, the fact that retired or deceased nurses were not being replaced exacerbated the problem of staff shortage in the facility and compromised quality of care. Nursing personnel from facilities were seconded to act as coordinators, having to coordinate programmes at the sub-district and district levels. This increased the work burden for nurses who remained in the facilities, who were already overworked.

Stock shortages identified were mostly of contraceptives, particularly long-acting reversible and injectable contraceptives. Study findings reveal that the facility experienced a complete depletion of stock in the year prior to investigation, at times for three consecutive months. From interviews with the key informants, it emerged that all the reported stock-outs were due to the unavailability of essential SRH commodities and drugs at the central medical depo. The medroxyprogesterone

acetate injectable was out of stock nationally. Participants related that visiting the health facility only to be told that there was no stock was discouraging. In addition, there appeared to be no system in place for alerting clients when stock was available.

> *'Going to the clinic and being told after waiting that your contraceptive method is not available is a huge discouragement.'* (P 15)

> *'My friend told me that sometimes there are no injections in the clinic … that's why I don't bother going there.'* (P 5)

Key informants confirmed that there were stock-outs in some SRH commodities and drugs in the facility, and that these could be attributed to the Covid-19 pandemic. As revealed by the study findings, the pandemic had adverse effects not only on production but also on the transportation and storage of SRH commodities. SRH commodities such as pregnancy test kits, disposable vaginal speculums, medroxyprogesterone acetate injectable and Nuristerate were out of stock nationally. The national Department of Health issued a communiqué from Pfizer indicating their incapacity to produce medroxyprogesterone acetate injection as they were focusing on producing the Pfizer Covid-19 vaccine. The focus on Covid-19 infections in the central medical depo had therefore resulted in serious shortages of essential SRH commodities such as pregnancy test kits and vaginal speculums.

> *'We are currently out of stock in pregnancy test kits, disposable vaginal speculums, Depo and Nuristerate … this was worse in 2020 and 2021, especially with Depo. We were told from time to time that the medical depot was closed for decontamination.'* (KI 2)

> *'Pfizer issued a communiqué this year [2021] citing capacity challenges in producing MDPA [medroxyprogesterone acetate]as they are now focusing on Pfizer Covid vaccine production. I'm sure others [pharmaceutical companies] will follow, too.'* (KI 1)

4.3.6 SRH provider attitudes and behaviour

The majority of the young women who were interviewed stated that they and their peers had conflicting opinions about the SRH services they sought. The manner they were treated when utilising services at the health facility was cited as the main factor in both satisfaction and dissatisfaction. Respectful and empathetic treatment evoked a positive assessment of SRH services.

> *'I was happy with how sister treated me when I was in the clinic.'* (P 7)

> *'My friend said I must visit the clinic when there is that young nurse as she doesn't shout at us.'* (P 16)

Most participants reported that they preferred younger service providers, as they were usually informative and treated them with respect, so that the participants felt comfortable disclosing their health problems. Some commented that they felt that younger service providers understood their health problems as young people, since they themselves were young and may have had similar SRH experiences and challenges. As a result of this clear preference for younger nurses, a number of young women reported leaving the facility before consultation, or lying about the reason for their visit, once they discovered that a much older SRH provider was to attend to them.

Some young women had complaints about the general demeanour and conduct of healthcare professionals. They reported that the judgmental attitude and unprofessional behaviour of nursing staff was the reason for their dissatisfaction with the care they received. This comprised rude and aggressive behaviour as well as a lack of empathy.

> *'Let's just say … I would like to be treated with the same respect I give, to have someone explain to me the service that I want and its side effects. To be in a space that allows me to ask questions without feeling like I am a nuisance.'* (P 1)

> *'Some nurses in the clinic are just rude.'* (P 6)

Some young women reported being scolded when they visited the clinic and as a result were scared to visit the health facility for SRH services again. A twenty year-old participant shared how nervous she was about visiting the clinic after she had been mistreated by a nurse; partly as a result of her reluctance to visit the clinic again, she had fallen pregnant and thereafter had no choice but to attend the clinic for antenatal care services.

> *'After the nurse shouted at me, I was scared to go back again (to the clinic). When I wanted to try again, I was pregnant and had to visit for antenatal care.' (P 4)*

The findings showed that provider attitudes play a large role in determining whether young women seek SRH services or not. A positive attitude and friendly, respectful service encourages young women to ask questions, making them more likely to access the service again. Negative and unprofessional behaviour by the SRH provider discourages young women from asking questions, making them unlikely to access the services again.

4.3.7 Selective SRH service support and donor funding influence

Research findings revealed that the total SRH service package receives little support from donors. Key informants reported that supporting partners focused mainly on HIV/Aids and Covid-19, particularly in the areas of information, education, communication, health promotion, prevention and case management. Key informants also stated that support for SRH package components such as contraceptives, cervical cancer screening, pregnancy planning, antenatal care, postnatal care and gender-based violence was limited to technical support in a few district PHC facilities. The American President's Fund, for example, focused on HIV/Aids programmes.

> *'MatCH [the district supporting partner] is funded by the U.S. President's Emergency Plan for Aids Relief (PEPFAR) to support HIV/Aids prevention and management strategies. That is their priority.' (KI 1)*

> *'We have professional nurses employed by the supporting partner but they only deal with the HIV and TB programme.that do HIV counselling.' (K I 2)*

The study findings show that most participants were offered HIV/Aids testing when they visited the health facility and were not offered SRH services such as contraceptives, pregnancy planning and other aspects of SRH. The findings from the facility register confirmed that all clients were screened, and those found eligible were tested for HIV/Aids; however, contraceptives, pregnancy planning and cervical cancer screening was offered only at the request of the client. This was mostly because lay counsellors, employed by the district, were funded by HIV programmes and were available and trained to conduct HIV counselling and testing in the facility. The scope of practice of these lay counsellors did not allow them to offer other SRH services; instead, they had to refer clients in need of SRH or any other services to the professional nurses. Professional nurses hired by the supporting partner had daily HIV/Aids programme targets, which included number of clients initiated on anti-retroviral treatment and total number of clients enrolled on pre-exposure prophylaxis (PrEP). This placed pressure on these nurses to chase the set targets, resulting in poor integration of services. Also as a result, clients were not managed holistically and opportunities to offer the total SRH services package were missed. Two participants stated:

'*Yes, I was counselled [for HIV] and offered an HIV test but not contraceptives.'* (P 4)

'You are not helped in the clinic unless you do an HIV test first.' (P 16)

The study established that the majority of participants were knowledgeable about HIV/Aids, largely because of the high level of funding and staffing support for HIV/Aids-related services. From the interviews, it was established that participants gained information on HIV/Aids from a great variety of sources, including Life Orientation classes at school and nurses who visit schools; the clinic, both from nurses and from posters on the walls; and from media platforms such as TV, radio, internet and social media.

Furthermore, data showed that the facility was implementing strategies to improve their 90/90/90 HIV/Aids strategy. This included Phuthuma Nathi, the 'welcome back' strategy and 'Undetectable = Untransmittable' (U=U). All these programmes are designed to strengthen and improve HIV/Aids treatment adherence, to bring back treatment defaulters and to follow up

clients to the point where they receive ongoing care. In contrast, other SRH services receive far less attention and financing, and suffer from a lack of strategies to improve their uptake.

> *'As the facility we are implementing Phuthuma Nathi, we track and welcome back HIV and TB defaulters…we do not track women for missed contraception appointments.'(KI 2)*

4.4 Family structure and context of parenting

The majority of young women reported that they lived with either a mother or a grandmother, with the presence of a father or a father figure varying considerably. Few participants reported living with both parents, since fathers were frequently away for work. The study established that there was poor parent-child communication in many families, and clear gender socialisation, both of which acted as barriers to young women's access of SRH services.

4.4.1 Poor parent-child sexuality communication and education

The study findings showed that most participants had poor or no communication with their parents about sexuality and reproduction. In addition, in many households, the parent-child relationship was not amicable. Most of the young women interviewed said that they had never had discussions about sexuality with their parents. They recognised that cultural norms were the reason; culturally, sex is still a taboo topic between parents and children. Findings also show that adolescent girls generally preferred to remain quiet about their unmet sexual health needs, or to speak to friends who themselves were not well informed. To have consulted parents would have been seen as an admission of being sexually active, and such an admission would not have been acceptable to their parents, in their opinion.

The following participant's comment about sexuality and reproduction communication with her mother was typical:

> *'We do not talk about anything that has to do with sex, absolutely nothing! At 22 years, I still have to sneak out when I visit my boyfriend. She (my mother) never talked about sexuality at all, including natural things like menstruation …'* (P 10)

The quote was typical of many, and showed that the family set-up lacked transparency and did not facilitate communication on issues of sexuality between the adults and children in the household.

A twenty-four-year old participant described the authoritarian nature of her mother's relationship with her, which acted as a barrier to open discussion about anything related to sexuality. Her mother's refusal to entertain discussion shows a lack of transparency on matters pertaining to SRH.

> *'My cousin became pregnant and my mother scolded me, she told me that I must not fall pregnant as she won't take care of that baby … there was no discussion of anything, and that was that.'* (P 3)

The above quote shows a missed opportunity, where a mother could have used the situation to her own daughter's benefit by discuss sexuality and SRH services. Further findings from the interviews showed that opportunities for parents to educate young girls and prevent sexual health challenges were regularly missed. In some instances, sexuality and reproductive health discussions were conducted, but too late – as, for example, when the young woman was already pregnant. This was demonstrated by the words of a twenty-two-year-old mother of one.

> *'I was 16 years old and already pregnant when my mother told me about HIV/Aids and that my studies will be delayed because I'm pregnant.'* (P 9)

The study revealed that parents themselves lacked both the knowledge on sexuality and the skills for broaching the topic; this combination made them quite unable to help their daughters. A key informant seemed to exemplify the misunderstanding that many parents and older people have about educating young people about sex and sexuality:

'Telling young girls about sex and contraceptives might encourage them to be loose and not act in a dignified manner.' (KI 3)

One would expect that, someone interacting with adolescent girls and young women in a health facility in anyway had more knowledge and understanding that discussing sexuality with young girls equip them to make informed decisions. It would be expected that, such an individual is able to handle sexuality topics with parents and young girls.

4.4.2 Gender socialisation

The study found that young women were socialised differently from their male counterparts. Young women stated that society and parents' treatment of them was stricter and more conservative than for male children in the family. Participants reported that, as young women, they were expected not to engage in sex before marriage. In addition, they had to be at home before dark and take care of household chores such as cooking and washing dishes and clothes. Boys, on the other hand, were allowed to roam outside the yard even after dark, and their chores were limited to herding cattle in the veld. Two young women below stated:

> *'There are things that I'm just not supposed to do as a girl … simple things like spend time with friends … it's just like that.'* (P 8)

> *'Boys are treated differently. They are allowed some freedom to do whatever … I think the community expects women to be submissive and that is not cool at all. For me, I got some freedom at varsity.' (P 1)*

Societal expectations about gender and sexuality have in effect created a double standard that typically encourages sexual liberty amongst men and demands sexual constraint from women. This double standard places the bulk of responsibility for contraception on young women, who are not expected to explore their own sexuality. Double standards prevail in marriage, too. For example, married women are expected to be faithful to their husbands, while affairs with younger women are fairly common among married men. Many of these extra marital relationships produce children. In addition, a married woman is expected to have children, and if she cannot, the apparent infertility is generally blamed on her. The unfortunate result of this is that young women feel pressurised to test their fertility earlier on in life by falling pregnant, thus

showing to the world that they are healthy and fertile. The pressure leads to unsafe sexual practices.

Lastly, men are culturally socialised to be strong and visiting a health facility is viewed as a sign of weakness. Data in this study indicated that very few boys attended the facility for any health services. Boy-specific SRH services such as medical male circumcision (MMC) were seasonal and conducted out of the clinic as part of outreach campaigns. Boys were visited, assessed and screened in schools and communities and would be transported to the hospital as a group for the surgical procedure. This means that boys bypass the clinic. Only those with identified health problems are referred to the clinic.

4.5 Individual barriers

The study findings show that lack of knowledge about SRH services, personal SRH service provider preferences and feelings of shame and guilt act as individual barriers to accessing SRH services among young women.

4.5.1 Lack of knowledge about SRH services

Young women did not have adequate information about the total SRH services package. All young women knew about contraceptives, HIV/Aids prevention and STIs. Very few knew about cervical cancer screening, services for gender-based violence, HIV/Aids PrEP and youth zones. All participants knew about choice on termination of pregnancy (CTOP), but thought it was available only in private health facilities. In addition, many nurses in public health facilities disapprove of abortion and actively discourage young women from availing themselves of this service. Data also revealed that illegal abortion advertisements were displayed in town and illegal abortion services were readily available and accessible for young women.

> *'I heard (from a classmate) about pills and injectables … Nari and Depo, that are offered in the clinic to prevent pregnancy ... and also condoms.'* (P 18)

Participants derived their knowledge about termination of pregnancy from posters placed in town by illegal termination of pregnancy providers. No accessible advertisements or information

seemed to be available about termination of pregnancy offered by public health facilities in the district. Data showed that only two of seven district hospitals offered CTOP. The study facility referral hospital did not offer CTOP, and young women who needed the service were referred to another hospital, forty kilometres away, which had long queues. The following statement by a participant shows that knowledge about the service was typically vague.

> *'Abortion is done by doctors [referring here to illegal abortionists] in town … I think it's R500, I'm not sure.'* (P 13)

Further, research findings reveal that health information seeking behaviour was forced by circumstances, with SRH services sought only when the young women experienced health challenges such as pregnancy and sexually transmitted infections. Information seeking is thus reactional and not preventative. A 22 year-old mother of one said

> *'I learned about them [contraceptives] in maternity, all contraceptive methods are in a board on the wall, I read about them there … before that, I only knew about condoms, pills and two injections, one for people with kids and one for young girls with no kids.'* (P 12)

The SRH information that the participants had came from friends, peers, classmates, media and the internet. Very few participants reported receiving information from the health facilities and when they did, it was picked up during visits for other health services. The young women interviewed seemed to think that the clinic was a place one went to when sick; it was not a place that one went to for health-related information or other services. Not much is done to market the SRH services to young people. As showed by the data collected, young women were not aware of the total SRH package available for them, including SRH education.

> *'People visit the clinic for medication when sick … I don't think I can go to just ask questions.* (P 6)

> *'I got information (SRH) from friends who have received these services. Umm … and from the internet.'* (P 1)

Although all participants had some knowledge of SRH services, there were clear information gaps, misconceptions and myths that influenced their decisions with regard to accessing SRH services. The young women were not aware of departmental information hubs in the clinic, media and internet. Readily available information, education and communication in the public sphere appears to be selective and specifically targets HIV/Aids programmes, TB, and seasonal issues such as medical male circumcision and, recently, Covid-19 vaccination.

4.5.2 Personal SRH service provider preferences

Participants had distinct preferences when it came to the gender and age of the service provider. These it seems, were shaped by cultural values in the community. Most participants stated that they preferred a younger, female SRH provider who was respectful and friendly. They felt that being examined by a male SRH provider would be uncomfortable for them, especially if it involved their private parts.

> *'I prefer a female, bubbly person who will ask me questions, preferably a younger person. I think a younger nurse can understand my problems better … besides, I won't feel like I'm talking to my mother.'* (P 13)

> *'I wouldn't be comfortable being examined by a male nure) … no, it's just not right, for me anyway*.' (P 2)

Some stated that their main concern was age; they preferred a younger person and did not mind whether the person was male or female. What mattered was that they were respectful, listened well and would not shout at them. However, when pressed, even this group said that they preferred a female nurse to a male one.

> *'For me any gender is fine as long as they are young, friendly and respectful … I'm not sure about examination by a male though.'* (P 12)

Some participants were emphatic in their preference for private SRH providers, and preferred to go to pharmacy clinics than to attend public health facilities.

The characteristics of the individual SRH provider seemed to play considerable role in determining whether or not the young women would attend the facility for SRH services. Participants preferred younger SRH providers, with most of the participants preferring female SRH providers. The study findings further showed that the type of service required also influenced the SRH provider gender preference. If the service required examination of the private parts, participants preferred a female provider. Participants also viewed private SRH services as better than the services offered in the public clinics.

4.5.3 Feelings of shame and guilt

Based on observation, only two participants seemed comfortable talking freely during the interviews. Most had to be re-assured and encouraged frequently through non-verbal cues and active listening to express their views. Shyness was evident amongst participants. It appeared that they felt a sense of shame about being sexually active, even though none of the participants was under eighteen years of age. It was interesting to observe this sense of shame even amongst those that had children.

'Yhoo! Noo … it's not easy… [accessing SRH services]. It's better if you are sick with other things like headache or tummy ache.' (P 4)

'Telling someone about your sexual problems is never easy…' (P 7)

Findings showed that there was stigma associated with SRH services. It seemed, from anecdotes related, that young women who were known to have accessed SRH services in the community were labelled as promiscuous and a bad influence on their peers. Sexually transmitted infections were associated with having sexual intercourse with men from other areas, who came to the area as contractors, along with men of foreign nationality and men of other races. Sexual relationships with such men were unacceptable by community norms and standards. This led to young women feeling ashamed and guilty about accessing SRH services. A key informant expressed the idea that men from outside the community may be a source of sexually transmitted diseases.

'These children have relationships with men they do not even know where they come from. No one knows about diseases from other countries and other races and the diseases they carry.' (KI 3)

Cultural barriers that limit open discussion on sexuality and reproduction, especially between an older woman and younger woman, restrict young women's access to SRH services, as SRH service providers are more likely to be older women than young women. The cultural and community taboo with regard to discussing sexual issues forces this topic to remain under wraps and makes young women feel guilty and ashamed for seeking SRH services.

'*Telling a nurse that you had sex feels like telling the whole world … It's not easy.'* (P 14)

'Most of the young women who come to the clinic with sexually transmitted infection will say they have a headache, and you have to probe them to tell you the real reason for visiting the clinic. They usually claim that it's from dirty toilets.' (KI 2)

The guilt associated with engaging in sexual activities in the face of societal and parental expectations not to do so also makes young women to feel reluctant to access SRH services.

4.6 Geographical barriers in accessing SRH services

The health facility under review in this study serves communities that extend up to twenty-five kilometers away from the clinic. This meant that some women have to travel more than the WHO-recommended five kilometers to access SRH services. Participants sampled from the furthest villages cited distance as one of the barriers to accessing SRH services.

'The clinic is far from home and from school … it takes the whole day to walk to the clinic, wait in the queue and come back.' (P 5)

'I used to walk with my friend [to the clinic] from school … but never from home, it is just too far …' (P 11)

The study findings further identified that geographical challenges to accessing SRH services were intertwined with other barriers; not having taxi fare to go to the clinic, along with the community assumption that young women who visit the clinic with no obvious injury or illness are sexually active.

> *'When people see you in a taxi to the clinic, they assume that you are going to get contraceptives… and you are sleeping around.'* (P 11)

> *'I can't ask my mother for taxi fare to the clinic, she will know that I want to prevent [get contraceptives].'* (P 9)

Analysis of the Geographic Information Systems showed that distances from the catchment areas to the clinic were further increased by other geographical factors such as mountains, rivers and forests. Poor road infrastructure means that shorter routes are inaccessible and alternative longer routes are the only option, especially after heavy rains, storms and wind. It emanated from the interviews that sometimes roads were blocked by mud slides and fallen trees, and that some bridges had washed away.

4.7 Suggestions for improving access to SRH services

Young women and key informants were asked to suggest strategies that would improve access to SRH services. The main themes that emerged were the suggestion to implement youth-centred SRH services, an attitude change among service providers, the provision of outreach services in communities and schools, improved parent-child communication, and the use of social media platforms to disseminate information.

4.7.1 Health system changes

Participants provided the health system with a number of recommendations. Young women believed that SRH care providers should be kind and considerate of their needs, especially when they asked delicate questions concerning reproductive health issues. Also emphasised by young women was the need for facilities to take into account the gender and age of the service workers assisting them. The majority of respondents claimed that they preferred and would actively seek

out female care providers because they could openly discuss issues pertaining to their reproductive health with them and felt more comfortable around them. They recommended that SRH services intended for adolescents be provided at set hours, in a distinct location, and by nurses who are familiar with and skilled in working with young people. Participants believed that more young people would actually use the programs if time were set out to attend just to them after school.

> *'The service should be given at a separate place in the clinic where only youth can go and where they can feel comfortable. These services should be given by younger nurses because they are more understanding and less judgmental than the older nurses.' (P 13)*

> *'I think there must be time just for young people and students. Their time* [laughs] *and not adding other people.' (P 4)*

According to key informants, the government must give sufficient resources to enable the provision of educational material, equipment, and infrastructure, as well as the facilities needed to provide adolescents with proper SRH services. They also suggested that, particularly in light of the Covid-19 pandemic, staffing circumstances be made better and that the government spend money on training youth and adolescent SRH care providers to deliver the services required for adolescents.

> *'There is much that still needs to be done. Young nurses are from school so they need training, space is not enough for normal services and COVID-19 management and vaccination … temporary structures can assist.'* (KI 1)

> *'The issue of stock-outs has to be addressed urgently …'* (KI 2)

Ensuring enough stock availability was suggested by almost all participants. Participants suggested that the facility make sure that no young person leaves the facility without the service they came for, as lack of supplies was discouraging and would deter young people from visiting the facility again. One participant said:

'*There should be sufficient medication because going to the clinic and being told that your contraceptive method is out of stock is a huge discouragement. That also puts you at risk of falling pregnant and having an unplanned pregnancy whilst still studying.'* (P 1)

4.7.2 Outreach services in communities and schools

Participants were of the opinion that SRH services should be taken to where young women are; in the schools, and hard-to-reach and impoverished areas.

'The department must hire people to go around the schools and tell us about all these services, for us to know about them.' (P 16)

'I think, umh … they must go to schools, especially the under-privileged schools, as most teenage pregnancies are in those schools. I think more focus must be in those schools.' (P 2)

4.7.3 Improved parent-child communication

Young women placed a high value on parental education, good communication, encouragement and support. They felt that it would be easier for them to access SRH services if their parents educated and supported their decisions. One participant stated that good communication with her mother had equipped her with the knowledge to correct her peers occasionally.

'Yes, my mom tells me about sex, pregnancy, HIV/Aids, STI and contraceptives … and it's always good because it's my mom and I know her [smiling]*… I'm also able to correct my friends when we have our own discussions.'* (P 2)

Participants further suggested that parents be given enough information about SRH services, as they lacked the necessary knowledge to educate their children. This could be done through parent focus group discussions, community dialogues, community engagements through local leaders and collaborations with other departments and the municipality.

'Parents must be educated, too; it would be better if parents had more information about these issues [SRH] so as to tell their daughters before they are pregnant or, worse, HIV positive.' (KI 3)

4.7.4 Social media platforms to educate about SRH services

Data findings showed that all participants had access to media and most used it to access information about health issues in general. They also reported that their peers, too, used media such as television, especially for HIV/Aids, as well as the internet and social media. Key informants suggested that a reliable social media platform with accurate information ought to be advertised so that young women could access correct information. One key informant emphasised the importance of reliable media platforms:

'I think they know a lot of information about their sexuality and reproductive health, but, unfortunately it's not always accurate … they must be made aware of reliable government platforms like B-Wise … we need to market those.' (KI 1)

Young women had their own suggestions for improving communication and imparting knowledge through a social media platform:

'Nurses can create social media groups for the clinic where we can ask questions and can be answered by a knowledgeable person. We can also make suggestions on how we can be treated in the clinic [laughs] *and also report those who did not treat us well.'* (P 16)

4.8 Summary of findings

The findings show that young women face many barriers in accessing and utilising SRH services. The health system itself poses significant barriers. Long waiting times, inconvenient facility operating times, numerous infrastructural challenges, resource shortages and low programme support all translate to poor access and utilisation of SRH services. Findings also show that the family structure and the context of parenting plays a role in preventing young women from accessing SRH services. Individual barriers that contribute to poor utilisation of SRH services included lack of knowledge about SRH services, personal SRH service provider

preference and feelings of shame and guilt. Geographical barriers were the long distances between homes and the health facility, weather conditions and poor road infrastructure in the district.

CHAPTER 5

DISCUSSION

5.1 Introduction

This study set out to explore perceived barriers to accessing SRH services by young women in a rural clinic in Alfred Nzo, Eastern Cape, South Africa. The narratives of the participants showed that a significant proportion of young women were sexually active but did not take appropriate steps to prevent sexual reproductive health adversities. The literature and the primary data reviewed revealed that young women were vulnerable to unintended pregnancies that contribute to maternal morbidities and mortalities and sexually transmitted infections, including HIV/Aids (WHO, 2022). The findings of this study are discussed in relation to the socio-ecological model which recognises individual, interpersonal or family, social and organisational/health system factors that influence health seeking behaviour (Sallis, Owen & Fisher, 2008).

5.2 Individual-level barriers

Individual-level barriers identified were lack of knowledge about SRH services, personal SRH service provider preferences and feelings of shame and guilt.

5.2.1 Lack of knowledge about SRH services

This study found that lack of knowledge about SRH services was a key limiting factor to young women's utilisation of SRH services. Most of the study participants reported that they did not have access to accurate and relevant information about the types of SRH services available. Despite the availability of various government initiatives to inform young people about sexuality, reproduction and SRH services, findings showed that young people still lack knowledge about these services. The findings of this study concur with those of a study conducted in Lao People's Democratic Republic, where young people reported that they did not have enough information about SRH services. They stated that they obtained SRH information only when they specifically ask for it (Souksamone et al, 2019). The limited knowledge of young women in the current study highlights the need to focus on programmes that will equip them

with information and knowledge related to the various SRH package services. This would enable them to make informed decisions and improve their utilisation of the service. South Africa already has existing, ongoing and funded programmes that address SRH challenges, but they are clearly not having the desired impact. These programmes include the comprehensive sexuality component of the curriculum introduced in South African schools in 2019; other educational tools are the Integrated School Health Services policy (SRH&R Policy, 2019), B-Wise and the Life Orientation curriculum in schools. According UNFPA (2016), young people with knowledge about SRH services are more likely to access SRH services. If these programmes are to have the desired effect, there is an urgent need to review their implementation. Barriers to access, as revealed in this study, need to be addressed, especially when it comes to young women. Interventions need to be individualised and offered by skilled, sympathetic and non-judgmental nursing staff at public health clinics. Each person in need of these services presents with unique circumstances, which need to be taken into consideration.

5.2.2 Personal SRH service provider preferences

The study findings show that participants had distinct SRH provider preferences. Most young women in the study reported that they did not feel comfortable speaking to or being examined by a male SRH service provider. Nmandu (2017) concurred with this finding, stating that provider gender can be a barrier for women's access to SRH services. This may be attributed to cultural mores and gender socialisation.

The age of the service provider also emerged as a contributory factor to whether or not young women access SRH services. Young women tend to view older service providers as similar to their parents, and feel uncomfortable discussing such matters with them, since culturally it is considered disrespectful to discuss sexuality with one's parents. In addition, many older service providers tend to behave as chastising parents, displaying little empathy or respect for young female clients seeking SRH services. All participants stressed that what they wanted was health providers who are friendly, good listeners and non-judgmental. A study by Onukwugha et al. (2019) on the views of service providers and adolescents regarding SRH services had a similar finding; adolescent girls preferred service providers who respected them and their personal choices. The Adolescent and Youth Friendly Services policy requires all clinic committees to

include a young person representative, so that youth needs, views and ideas are heard and considered (National Youth and Adolescent Policy, 2017). However, compliance and implementation of the policy is still a challenge in most health facilities.

5.2.3 Feelings of shame and guilt

Many adolescents in the current study preferred to access services outside the health centres in order to overcome the feelings of shame and guilt associated with SRH services. Kambikambi (2014), whose study was conducted in Zambia, similarly found that fear of sitting in a waiting room with a group of strangers, with the possible stigma attached to SRH services, discouraged young people from accessing these services. A study conducted in Ethiopia by Temesgen and Tariku (2021) showed that adolescent and young women found it embarrassing and difficult to access services because they felt that use of the services was stigmatising. Adolescents and young women in the current study stated that advocacy activities needed to be stepped up in order to combat the ingrained social and cultural norms that induce stigmatisation of adolescents seeking SRH services. It has been demonstrated that culturally sensitive techniques can help teenagers who are experiencing prejudice and stigma related to their sexuality and reproduction. For instance, the Safeguarding Young People Programme in the districts of Alfred Nzo and O.R. Tambo aims to reduce the stigma attached to SRH services by collaborating across sectors and using a comprehensive, community-based approach. In order to foster healthy social norms, the program has developed relationships with important community stakeholders and the guardians of culture, including the district municipalities, the religious sector, civil society, and the business sector. This is accomplished by involving local leadership and fostering respectful conversations about issues pertaining to sexuality, reproduction, and SRH services. The Social Behaviour Change Program, which was implemented in Alfred Nzo in 2018, used tactics like involving different stakeholders, using media to spread important messages about adolescent health, holding parent workshops, and employing trained parent peer educators to educate and support parents in the community on issues related to sexuality and reproduction, including SRH services. The Sexual, Reproductive Health & Rights Policy (2020) and the Comprehensive Sexuality Education service package (2020) were also developed with the goal of boosting young people's self-assurance in obtaining medical care without feeling shame or guilt. All of these tactics are in line with the current legal framework in South Africa and are based on the

idea of "universal health for all." However, there is still more to be done because statistics indicate that the majority of young people do not access utilise SRH services.

5.3 Social barriers

In this study, a number of social norm-related themes were identified as factors affecting young women's access to and use of SRH services. Social norms can be broadly defined as "common practices and widely held views within a particular group" (Jiang & Marcus, 2015). Social identities serve as the foundation for social norms, which have an impact on young people's sexual behaviours and reproductive health (UNICEF, 2012). Family, community, and religious influences are a few of these. Social stigma is the social repercussion of deviating from recognised social norms (Schroeder & Graziano, 2015). Adolescent and young women's decisions on SRH services have been proven to be significantly influenced by social expectations and stigma (Smith, Turan, White, Stringer, Helova, Simpson & Cockrill, 2016).

5.3.1 Family-level barriers

The findings show that in the Alfred Nzo district, as in many districts across South Africa, communication and discussion between parents and children on matters related to sex are still regarded as taboo. Cultural norms and taboos around sexuality in the household and community remain a central barrier to more open dialogue between parents and young people. A study conducted in Thailand on gender norms and youth-friendly sexual and reproductive health services identified that culture prevented families from communicating openly about sexuality and reproduction with their children (Kolundzija & Marcus, 2019). The identified shift from the traditional extended family to the nuclear family means that the role of extended family members in educating young girls is left unattended. Parents have no support structure to ensure that information is passed from the old to the young, as has traditionally been the norm in most African cultures. There is a need to bridge this knowledge gap. The South African government recognises the importance of sexuality education, and various policies, strategies and guidelines have been developed on adolescent and youth health services in support of this notion (Department of Basic Education Comprehensive Sexuality Education, 2019). However, this study found that parents are reluctant to educate and inform their girl children. Parents believe that abstinence until marriage is the only acceptable choice. For them, sex is a taboo topic,

considered impolite and embarrassing to discuss. A study on parent-child communication about sexual and reproductive health by Wamoyi, Fenwick, Urassa, Zaba, and Stones (2010) conducted in Tanzania also revealed that parents believed it was culturally inappropriate to discuss contraceptive use with their children because doing so would encourage teenagers to have sex.

Numerous studies indicate that adolescent girl's decisions regarding their sexual and reproductive health are significantly influenced by the type and quality of their relationships with their parents. Teenagers are more likely to utilise SRH services if their parents create a warm, loving, and nurturing atmosphere (Cox, 2007). According to Cox's research from 2007, this is a position that can be filled by relatives, particularly those who have the same gender as the young person being educated, such as aunts and grandparents in the case of girls.

5.3.2 Gender socialisation

As shown in the study, gender socialisation contributes significantly to young women's decisions about whether or not to access SRH services. Gender SRH socialisation instils in young people ideas about who is responsible for reproductive health, when it is appropriate to use contraception and SRH services, and what methods are appropriate for young women. Families and communities recognise and reinforce gender-based ideas on the behaviours that are acceptable for young women and young men. Young women in this study believed that they were expected to respond to male sexual advances, and not the other way around. Gender norms prevent women from initiating sexual activity, as doing so is associated with promiscuity. The passive role that young women adopt leaves them open to being easily pressured into having sex at an early age. They are vulnerable to unsafe sexual practices, since all decisions about when, how and where to have sex depend on their male counterparts, with no allowance made for discussion. In this area, young women have little agency. A study was undertaken in Uganda by Kabagenyi et al. (2014) to look at the obstacles males face when accessing SRH services. They discovered that although the majority of males adhered to the gender stereotype that contraception is a woman's responsibility, when informed, they were open to taking a more active role. However, the prevalence of poor parent-child communication, revealed in this study, makes it unlikely that most young men have opportunities to become knowledgeable about SRH

services. Thus they are unable to make informed and safe sexual decisions, and leave the matter of contraception entirely to their female counterparts who know almost as little as they do.

Gender socialisation affects service providers, too. In Kenya, Godia et al. (2013) reported that health service providers were aware that they could not deny young people SRH services, but they were nonetheless reluctant to provide some SRH services to the opposite sex, particularly examinations of the private parts, as that is regarded as culturally unacceptable. Gender socialisation in the current study affected young women's preferences with regard to service providers; most were not comfortable with the idea of receiving SRH services from male nurses. It is unfortunate that gender socialisation compels males to take the lead in sex and reproduction decisions, and yet most South African adolescent and youth health strategies focus on the 'girl child'. This leaves the 'boy child' vulnerable to engaging in risky sexual behaviours with girls who are socialised into playing a passive and accepting role. They lack both the confidence and the knowledge to take control of their own sexuality and decisions relating to SRH.

5.3.3 Social and community norms

Young women in this study gave responses that suggested the community disapproved of them for using SRH services. Because of their concern of being labelled promiscuous, young women steered clear of using these services. This finding is akin to that of a study done in 2017 by Qolesa, which showed that teenage girls were scared to use SRH services because they were worried about being seen by their family and community. Young women thought that by seeking services that society did not support, they would be stigmatised. At the same time, the finding that some young women are eager to show themselves as fertile to combat the blame often heaped upon women in childless marriages played a role here. Many young women were pleased to show their communities that they were fertile, which is at odds with the social expectation that accessing SRH services carries a stigma.'

Our data further revealed that young women were also scared to ask permission to access SRH services from teachers, as most teachers were members of their own community. A study on young, unmarried Iranian women indicated that they felt ashamed to use SRH services due to the risk of being labelled promiscuous and facing discrimination from society (Mohammadi, 2016).

This was also evident in the current study, which discovered that a large number of participants were hesitant to acknowledge that they had previously used SRH services. But after being questioned and given assurances about privacy and anonymity, they admitted that they had previously visited the clinic in search of these services - in some cases, only to leave empty-handed. The Constitution of South Africa recognises the right of women to access health services as South African citizens. The National Health Act 61 of 2003 gives effect to this right, making access to all health services, including SRH services, a basic human right, which ought to be accessible without fear of discrimination. In addition, the Termination of Pregnancy Act 92 of 1996 allows young women from twelve years of age to terminate a pregnancy without their parents' consent. Similarly, the South African Children's Act 38 of 2005 allows young girls from twelve years of age to access health services without the consent of a parent. In light of these provisions made by the government, these services ought to be freely available, but societal expectations and the stigma attached to SRH services continue to pose a significant limitation to access of these services by young women in rural areas.

5.4 Health system barriers in accessing SRH services

The study findings show that the health system itself constitutes a significant barrier to access of SRH services for young women. This theme refers to the poor quality of SRH information and services rendered to young women. This is despite the National Adolescent and Youth Policy (2017), the Integrated SRH Policy (2019) and the Integrated Schools Health Policy (2012), all of which advocate for accessibility of SRH services and accurate SRH information for young people. Innovations such as the B-Wise programme strive to ensure that young people have access to adequate and accurate SRH information, and that every effort is made by health providers to debunk myths and misconceptions about SRH services. However, despite these enabling policies, the current study findings show that SRH services are still inaccessible to the majority of young women in the rural setting.

5.4.1 Long waiting times

Participants reported that long waiting times in the clinic made them unwilling to make use of the clinic's services. These findings are similar to those reported in the 'She Conquers' focus

group discussions conducted in Alfred Nzo in 2018, where adolescent learners reported that long queues in clinics hindered access to them. They stated that they preferred to buy over-the-counter medications from pharmacies, since the queues there are not long. They could not afford private doctors, and so skipped this step and often went straight to pharmacies for both diagnosis and cure. According to the National Core Standards for Health Establishments in South Africa (2011), reducing patient waiting times is the second of six national priorities. These health standards stipulate that health clients should not wait for more than three hours before they receive health services. The Alfred Nzo Annual Performance Review (2021/2022) and the peer review of Perfect Permanent Teams for Ideal Clinic Realisation and Maintenance (PPTICRM) (Q3 2021) state that long waiting times have been a problem for some time, but the situation was made worse by the government's non-pharmaceutical Covid-19 prevention strategy and management.

5.4.2 Inconvenient facility operating times

Facility operating times were a further health system barrier identified by young women in Alfred Nzo district. Despite statements made in the departmental Strategy for the Implementation of Adolescent and Youth Friendly Services (2017) and the implementation of Youth Zones (2018), clinic operating times are not youth centred. The clinic under review operated from 7h30 to 16h30, the hours when young girls are at school or work. The facility had set aside a 'youth zone' time to attend to young people, but no memorandum of understanding (MOU) had been signed by the clinic and local schools for proper alignment of the time with the school schedule, as per Integrated School Health Policy guidelines (2012). The PPTICRM monitoring system (2019) also requires that all PHC facilities have MOUs with other government department with which they directly interact for service delivery, management of clients, referral, follow-up and monitoring of clients. This stipulation was not being observed at the clinic under review. The need for Covid-19 management did not help the situation, as young people were in school for very few hours in order to allow for classroom decontamination; this left no time to visit clinics, many of which were closed for periods at the height of the pandemic because of infections amongst personnel.

5.4.3 Infrastructural barriers

Infrastructural challenges forced nurses to share consulting rooms in the facility. The fire that had earlier destroyed consulting rooms made things particularly difficult in the facility. Lack of adequate infrastructure in the facility severely compromised nurse-patient confidentiality and privacy. Confidentiality and privacy are important components of adolescent and youth friendly services and should be based on the needs of the youth and not on provider perceptions and preferences (National Adolescent and Youth Health Policy, 2017). According to UNICEF (2018), confidentiality assurances are associated with willingness to seek future health care for routine health needs. Souksamone (2019) concurs that young people are more likely to disclose sensitive information, including information related to sexual health, and increase the frequency of visits for medical intervention for sexual health challenges if they trust the provider to keep services related to their sexual health confidential. Internal and external Ideal Clinic Realisation and Maintenance assessments concluded that facility infrastructure seriously compromises privacy and confidentiality for clients during consultations, since more than one nurse would be consulting in a consulting room at any given time (PPTICRM, 2021).

5.4.4 Resource shortages

The findings of the study showed that lack of adequate resources for the provision of SRH services was a barrier to accessing SRH services for young women. These included staff shortages and drug stock-outs in the facility. The Covid-19 death rate amongst workers in Alfred Nzo district was reported to be 78 (Covid-19 Report, August 2021). Coupled with deaths, the Persal report (Quarter 3, 2021) states that a significant number of health workers decided to retire during the pandemic, as studies revealed that people above sixty years and those with core morbidities were at a high risk for severe Covid-19 symptoms, hospitalisation and death. This has left a huge vacuum in human resources to render health services, including SRH services.

The findings of a study conducted in northwest Nigeria showed that adolescents preferred to buy medications from the chemist, as public clinics often had no essential drugs (Nmadu, 2017). In the Alfred Nzo Stock Visibility Solutions (SVS) report generated for the first and second quarter of 2021/2022, 88% of the clinics reported stock-outs of intra-uterine contraceptive devices, 48% reported stock-outs of sub-dermal implants, 38% of clinics reported stock-outs of

medroxyprogesterone and 28% reported stock-outs of norethisterone acetate contraceptive. With Pfizer indicating capacity challenges in producing medroxyprogesterone while they focus on the Pfizer Covid vaccine, (NDoH, 2021), medroxyprogesterone contraceptive stock-outs have affected most Alfred Nzo PHC facilities, including the study facility.

5.4.5 SRH provider attitudes and behaviour

In this study, fear of the treatment they would receive from healthcare professionals was one of the main deterrents for young women from visiting the health facility. The study's young female participants believed that health professionals did not treat their information as confidential. This result was similar to that of a study done in Nepal, where the majority of the teenagers interviewed felt that when teens disclosed their sexually-related health issues to health providers, they did not act professionally and maintained confidentiality. (2010) Regimi et al.

In addition, some young women in the current study stated that they were treated badly by health workers when they accessed SRH services. Negative attitudes cited by young women included being shouted at, not being given an opportunity to explain themselves, and health workers adopting a judgmental approach.

Numerous studies have identified health professional's unfavourable attitudes towards young women as a barrier to adolescents and young women's access to SRH services. For example, a research among 55 teenagers in Kwazulu-Natal, South Africa, revealed the unwelcoming and hostile attitude of health professionals toward teenagers (Alli, 2013). The unprofessional attitude of healthcare workers prevented teenagers from using SRH services in developing countries, according to a review of the research on the attitudes of health workers toward adolescent SRH services (Chilinda, 2014). Chilinda (2014) suggested that health professionals must receive specialised training to be able to address the SRH needs of young women and adolescents.

In the current study, the warm and welcoming nature of some health professionals, empowered some adolescents and young women to utilise SRH services. They confirmed that they were well taken care of and pleased with the services they received, which made them want to return. The conclusion that positive attitudes among SRH professionals boosted service use was similar to

research done in India and Kenya, where it was discovered that positive health provider attitudes made it easier for teenagers to use SRH services (Godia, 2014; Mehra, Sogarwal & Chandra, 2013). Therefore, depending on the attitude they choose to adopt, health professionals can either help or hinder adolescents' access to and use of SRH services. Positive attitudes are more likely to inspire. Supportive attitudes tend to enhance teenage service use, whereas unwelcoming and hostile attitudes deter adolescent access to and use of SRH services.

5.4.6 Too little programme support for the total SRH services package

The majority of support and funding for SRH services is directed specifically to HIV/Aids. The budget allocated includes an HIV/Aids grant for the compensation of employees, goods, services, information, education and communication. In addition, the department allocates the United States President's Emergency Plan For Aids Relief (PEPFAR) to HIV/Aids district programmes. All this support is monitored and measured against HIV/Aids indicators and as a result, key informants in this study were aware of the targeted HIV/Aids monitoring strategies such as 90/90/90, but did not know the targets for the couple year protection rate, male urethritis syndrome and the cervical cancer screening rate. As reported by participants during interviews, young women are offered an HIV test in the clinic when they visit for other health problems, while other SRH package services are offered only on request. This was also identified as a problem in a baseline study conducted in Nelson Mandela Bay and Alfred Nzo, Eastern Cape, and in Uthukela district in Kwazulu-Natal, where participants reported having been offered HIV counselling and testing in the clinic when they visited for minor ailments, but not offered other SRH services (Southern Hemisphere, 2021). Lack of knowledge about the total SRH services package can be attributed to poor financial support for SRH services.

5.5 Geographical barriers to accessing SRH services

Geographical barriers to SRH services extend beyond long distances to the health facility and include other geographical characteristics of the area such rivers, forests, mountains and weather conditions. As identified in a study on the geographical aspect of access to SRH services for women in rural Africa (Yao, Murray & Agadjanian, 2013), although straight-line distances can be measured easily on a map, relying on this data can result in grossly underestimating the burden placed on women in accessing health services. Other geographical factors increase

distances to facilities significantly; for example, the presence of a mountain may compel people to walk around it or over it, hugely slowing down their journey. A study by Yasuoka (2015) on barriers to health services for pregnant women in rural villages in Cambodia found that long distances exacerbated by the presence of tropical forests in the area inhibited access. In the current study, weather changes such as heavy rains frequently made it impossible for anyone to access the clinic owing to flooded bridges and poor road infrastructure. WHO (2021) states that people should not have to travel more than five kilometres to access health services. The Covid-19 vaccine accessibility mapping showed that in Alfred Nzo, 389 communities have to walk more than five kilometres to their nearest health facility, with 38 of those communities living in national pressure areas, more than 20 kilometres from health facilities (Geographic Information Systems, 2021). Outreach services such as Mobile clinics, ISHP, WBPHCOT are some of the intervention that are rolled out to bring services to where people are. However, geographical barriers have a negative impact on the success of these interventions.

5.6 Implications on Policy and Practice

The current study findings affirms conclusions made by other studies that, barriers to accessing SRH services by young women are complex. The study showed that, SRH and youth policies should be designed such that they cater for all young women in their different contexts. Implementation guidelines should advocate for ntersectoral collaboration as the key intervention in improving uptake of SRH services by young women. There is a need for more research to be done to gain more insights on the barriers to accessing SRH services in the following areas:

1. A study to explore barriers to accessing SRH services by young males as they were excluded in the study.
2. A study to explore information and knowledge levels of adolescent and youth programme managers as policy advocates and implementation enablers.
3. A study to explore challenges in collaboration with other government departments e.g. health, basic education, social development and municipality to improve access to SRH services by young people.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

This chapter presents the conclusion and recommendations applicable in the Alfred Nzo context, based on the findings.

6.1 Conclusion

Although young women in this study had some information and knowledge about SRH services, few accessed these services regularly owing to a host of factors that included issues to do with the health system, the family structure and context, individual preferences and geographical barriers.

Generally, young women perceived SRH services as inaccessible to them. Critical shortages in the health facility, poor communication with parents, gender expectations within families and communities, individual factors and geographical challenges were all identified as barriers to accessing SRH services for young women. The Covid-19 state of disaster as declared by the state president has meant that resources have had to be redirected in favour of Covid management, leaving very little for preventative health programmes such as SRH services. The findings in this study confirm the findings of several studies conducted in this field, showing that young women in rural areas face deep-seated barriers to accessing SRH services. These require rigorous strategies to overcome. Although the national legal framework, policies and guidelines support and advocate for the accessibility of SRH services by young women, these national-level stipulations require additional resources, effort and inter-sectoral collaboration to be implemented and to yield any appreciable positive outcomes.

6.2 Recommendations

Based on the study findings and related literature, the following recommendations might be considered to improve young women's access to SRH services:

6.2.1 Inter-sectoral collaboration

The health district ought to make an effort to ensure that all relevant stakeholders are consulted when developing adolescent and youth services. The most important stakeholder is young women themselves. District SRH services should be designed with young women and not only for them. This could be done by ensuring that all facilities have youth representatives in their clinic committees and hospital boards. As outlined in the Youth Policy (2017) and Integrated School Health Policy (2012), every effort needs to be employed to engage community leaders, especially traditional leaders as custodians of community culture and norms. Parents must take the lead in advocating for SRH services. This can be achieved through community dialogues, parent focus group discussions, information, education and communication. Key government departments, such as the Department of Education, the Department of Social Development and the Department of Sports and Recreation, along with local municipalities, have a major role to play in facilitating community education through structured information programmes and platforms.

6.2.2 Outreach campaigns for adolescent girls and young women

The findings indicate that there is a need to disseminate information and educate young women on SRH services available to them. The implementation of comprehensive sexuality education in schools and the marketing of media platforms such as B-Wise can assist in addressing the knowledge gap in all young people. There is also a need for the health district to identify and collaborate with community-based youth organisations that can impart knowledge to young women and young men in their areas, as waiting for young people to visit the health facilities for information and services is not always possible. There is also a need to follow up on how the sexual education component of the Life Orientation curriculum is being implemented. Ensuing that this learning area is comprehensively covered would go a long way to ensuring that all young people, both girls and boys, have the necessary information to make informed and responsible choices.

6.2.3 Better quality SRH services in the health facilities

The Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) concept addresses all the quality issues that affect youth services offered in the public health facilities, PHCs, CHCs and hospitals. This concept is aligned with the AYFS policy and standards to ensure that youth services rendered in health facilities cater to the specific needs of adolescents and youth. The AYFS policy also advocates for knowledgeable, skilled and passionate service providers. There must be adequate resource provision in the facilities for them to be accessible. Resource availability should include information, education and communication materials in all the languages used in the district, along with skilled health providers, SRH package commodities, surgical sundries and essential drugs such as contraceptives and antibiotics to treat STIs. An effort should be made to ensure that facility operational times are flexible to accommodate the needs of young women. This could include opening before schools start and staying open for longer hours to accommodate girls' school hours and domestic chores.

6.2.4 A strengthened, reengineered PHC service

The reengineering of PHC in South Africa rests on three legs: District Clinical Specialist teams (DCSTs), Ward Based Primary Health Care Outreach teams (WBPHCOT) and the Integrated School Health Programme (ISHP). This concept was developed to facilitate the prevention of illness and the promotion of health rather than an approach based entirely on treatment. With young women residing far from the health facilities, WBPHCOTs and ISHP can ensure that health services are offered in schools and local communities, as per the policy, with the DCSTs providing clinical support, capacity building and governance. Taking services to young people is a strong recommendation; it would reduce the PHC headcount – essential while the country is still dealing with the Covid-19 pandemic – and be advantageous for communities where young women struggle to access SRH services.

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APPENDIX 1

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CONSENT FORM - *English*

Title of the Research Project: *Perceived and experienced barriers in accessing sexual and reproductive health services by young women (18 – 24 years) in Alfred Nzo health district, Eastern Cape, South Africa*

I have been given a written summary of the study in the language that I understand. My queries about the study have been answered, and my worries have been taken care of. I am aware of the potential repercussions of my engagement, and I freely and voluntarily elect to participate. I am aware that my identity will be kept confidential. I am aware that I am free to leave the study at any moment without having to give a reason or worry about negative consequences or loss of benefits.

___I agree to be **[**videotaped/audiotaped/photographed**]** during my participation in this study.

___I do not agree to be **[**videotaped/audiotaped/photographed**]** during my participation in this study.

Participant's name……

Participant's signature…….

Date……

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CONSENT FORM - *Isixhosa*

ISIHLOKO SEMFUNA-LWAZI: *Imibono ngemiceli mngeni ekufikeleleni kwinkonzo zempilo ngezesondo nenzala kumakhosikazi aselula aneminyaka elishumi elinesibhozo ukuya kumashumi amabini anesine eminyaka kwisithili sase – Alfred Nzo, Mpuma Koloni eMzantsi Afrika.*

Le mfuna-lwazi icacisiwe kum ngolwimi endiluqondayo. Imibuzo ebendinayo iphendulwe. Ndiyakuqonda ukuba ukuthatha inxaxheba kwam kubandakanya ntoni, kwaye ndivuma ndinganyanzeliswanga, ngokuthanda kwam. Ndiyakuqonda ukuba ukuthatha inxaxheba kwam kuyakugcinwa kuyimfihlo kungachazelwa namnye umntu. Ndiyakuqonda ukuba ndingayeka ukuthatha inxaxheba kule mfuna-lwazi ndinganikanga sizathu, nangeliphi ixesha, ngaphandle kwesohlwayo okanye ukuphulukana nenkonzo ekumele ndizifumane.

___ Ndiyavuma ukuba ndishicilelwe [ngevidiyo/iteyiphu/ndifotwe] ngexesha ndizibandakanye nale mfuna-lwazi.

___ Andivumi ukuba ndishicilele [ngevidiyo/iteyiphu/ndifotwe] ngexesha ndizibandakanye nale mfuna-lwazi.

Igama lomthathi-nxaxheba……..

Utyikityo lomthathi-nxaxheba…….

Umhla…….

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INFORMATION SHEET FOR YOUNG WOMEN – *English*

Project title: *Perceived and experienced barriers in accessing sexual and reproductive health services by young women (18 – 24 years) in Alfred Nzo Health district.*

What is the study about?

Patricia Noluthando Gwiji, a research student pursuing a Master's in Public Health at the University of the Western Cape, is the researcher on this project. You are a young woman between the ages of 18 and 24, which is the study demographic, and I'm encouraging you to take part in this research project. We will be very grateful for your involvement in the study, which will help us better understand the obstacles people face when trying to access sexual and reproductive health services. The information gathered during the project is also hoped to be shared with the policy makers and be considered in developing Sexual Reproductive Health policies that will address these barriers and make these services more accessible in the similar settings beyond Alfred Nzo district.

What will I be asked to do if I agree to participate?

As a participant, you will be requested to be interviewed for 45 to 60 minutes at the time convenient to you. You will be requested to respond to open-ended questions from an interview guide about what you perceive as barriers to accessing Sexual Reproductive Health services. With your permission, I will be recording the focus group discussion so as to make sure that I do not miss the important comments you make during the discussion. I will also be taking notes during the discussion but I may not be too fast to capture everything, hence with your permission

I will be audio recording the discussion. Recording will not be done if you do not agree and can be stopped at your request at any point. I have also attached the summary of the questions that you will be asked to respond to during the discussion.

Will my participation in this study kept confidential?

You won't be asked to identify yourself during the interview by name or last name in order to ensure anonymity. A "DO NOT DISTURB" sign will be posted at the door, and the interview will take place in a private area. Any identifying information will be deleted from all records, and names will be substituted with numbers. No healthcare practitioner employed by the healthcare institution will have access to any of the information that has been obtained, which will be kept in strict confidence. Additionally, all study reports and publications created about this project will not reveal your identify.

What are the risks of this research?

Talking about oneself or others and engaging in human interactions all carry some level of danger. Even so, we will take precautions to reduce these risks and will help you right away if you encounter any physical or psychological pain while taking part in this study. If a need arise appropriate referral for psycho-social management will be made to the social worker. To reduce the risk of Covid 19 transmission during data collection, safety regulations and protocols will be adhered to during the interview, these include wearing of three layered face mask that will cover both the nose and the mouth, sanitizing the hands before and after the interview, sitting 2 metres apart during the interview, opening the window and decontaminating the chairs and tables before the first interview and between interviews. Participants who show signs and symptoms of Covid 19 will be referred to the nearest facility for further management. Three layered face masks, hand sanitizers and disinfectant will be provided by the researcher.

What are the benefits of this research?

Although the results of this study won't directly benefit you, they might allow the researcher to understand more about the perceived obstacles to receiving sexual and reproductive health services. The knowledge I gained from the study will help me formulate recommendations and,

with any luck, persuade the decision-makers to increase the accessibility of Sexual and Reproductive Health services in the future.

Do I have to be in this research and may I stop participating at any time?

Your participation in this study is entirely optional. You have the option to participate in the study. If you decide to participate in this research, you may stop participating at any time. You won't incur any penalties or forfeit any advantages for which you are otherwise eligible if you choose not to participate in this study or if you decide to discontinue at any time.

What if I have questions?

This research will be conducted by Patricia Noluthando Gwiji, a student at the School of Public Health, Faculty of Community and Health Sciences at the University of the Western Cape, South Africa. My supervisor is Dr. Thubelihle Mathole of the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape, South Africa. . Her telephone number is +27 21 959 9384 and email: tmathole@uwc.ac.za and my Cell phone number is 073 247 4676 and email: 3908775@myuwc.ac.za

If you have any inquiries about this study or your rights as a research participant, or if you want to report any issues you've had with it, please contact:

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This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

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IPHEPHA LENKCUKACHA KUBATHATHI-NXAXHEBA ABANGAMAKHOSIKAZI ASELULA - *Isixhosa*

Isihloko semfuna-lwazi: *Imibono ngemiceli mngeni ekufikeleleni kwinkonzo zempilo ngezesondo nenzala kumakhosikazi aselula aneminyaka elishumi elinesibhozo ukuya kumashumi amabini anesine eminyaka kwisithili sase- Alfred Nzo.*

Ingantoni le mfuna-lwazi?

Le projekti yemfuna-lwazi yenziwa ngu Patricia Noluthando Gwiji ofunda kwidyunivesithi yaseNtshona koloni. Ndiyakumema ukuba uzibandakanye nale mfuna-lwazi ingokuphicotha imibono yakho njenge ntombazana okanye inkosikazi eselula eneshumi elinesibhozo ukuya kumashumi amabini anesine eminyaka ngezinto ezenza inkonzo zempilo ngezesondo nenzala ukuba zingafikeleleki lula. Ndiyakuvuyiswa kakhulu kukuthabatha kwakho inxaxheba ukuze ndifumane ulwazi nengqiqo ngesisihloko. Ulwazi oluqokelelwe kule mfuna-lwazi kuzakwabelwana ngalo nabasemagunyeni abathi benze imithetho kwezempilo ukuze imithetho iqinisekise ukuba inkonzo zempilo ngezesondo nenzala zifikelele kubo bonke abayidingayo e-Alfred Nzo nakwezinye izithili ezifanayo.

Yintoni elindeleke kum xa ndithabatha inxaxheba?

Njengomthathi-nxaxheba ulindeleke ukuba uthabathe inxaxheba kudliwanondlebe olungathabatha amashumi amathathu ukuya kumashumi amane anesihlanu emizuzu. Uzakulindeleka ukuphendula imibuzo gabalala ngemibono yakho ngezinto ezenza inkonzo zezempilo ngezesondo nenzala zingafikeleleki lula. Ndizakuthi ndibhale impendulo kwincwadi, kwaye ngemvume yakho ndiyishicilele ingxoxo ukuze ndifumane lonke ulwazi oyakuthi wabelane ngalo nam. Uvumelekile ukulumisa ushicilelo kwaye uvumelekile ukuba ungayeka

ukuthabatha inxaxheba nangaliphi ixesha ngaphandle kwesohlwayo okanye impatheko-mbi nangaluphi uhlobo. Ungazifundela isishwankathelo semibuzo ozakubuzwa ngayo. Ngokuvumelana nawe, oludliwanondlebe luzakubanjwa phakathi kwentsimbi yeshumi ukuya kweyesine emva kwemini.

Ingaba ukuthabatha kwam inxaxheba kule mfuna-lwazi luzakubayimfihlo?

Ukuqinisekisa ukuba abathathi-nxaxheba bagcinwa beyimfihlo, udliwanondlebe luyakubanjwa ekhusini kubekwe umbhalo othi 'UNGAPHAZAMISI' emnyango. Abathabathi-nxaxheba bayakuthi banikezwe inombolo abazakwaziwa ngazo ngexesha lodliwanondlebe, kushicilelo nakwinkcukacha ezibhaliweyo. Iziko lezempilo aluyi kunikezwa nkcukacha ngabathathi-nxaxheba okanye ngodliwanondlebe. Ingxelo ngemfuna-lwazi aziyi kudiza abathabathe inxaxheba.

Yintoni imingcipheko kule mfuna-lwazi?

Ingxoxo ngeenkonzo zempilo ngezesondo nenzala kungenza ukungaphatheki kakuhle nanjengoko ingumba okungelulanga ukuthetha ngawo. Xa kukho imfuneko, ungaziva kakuhle, ngemvume yakho uyakuthi ugqithiselwe kwiziko lezempilo ukuze afumane unyango. Ukwehlisa umngcipheko wolosuleleko ngentsholongwane I Covid 19, bonke abathathi-nxaxheba balindeleke ukuba banxibe izifosho, bahlambe izandla ngezibulali ntsholongwane, baqaqelane ngemitha ezimbini ubuncinane, kuvulwe iifestile kwaye kucocwe isitulo phambi kodliwano ndlebe lokuqala losuku nasemva kodliwano-ndlebe ngalunye yonke imihla. Bonke abathathi-nxaxheba abathe babonakalisa iimpawu zeCovid 19 bazakugqithiselwa kwiziko lezempilo elikufutshane. Izifonyo nesibulali zintsholongwane sizakuza nomphandi.

Yintoni engazuzwa kule mfuna-lwazi?

Le mfuna-lwazi ayinanjongo zakunceda mntu ngamnye, kodwa iziphumo zayo zingancedisa ekufumaneni ulwazi ngezithintelo ekufuneni inkonzo zempilo ngezesondo nenzala. Ndinethemba lokuba ingcebiso eziyakuthi zenziwe emva kwale mfuna-lwazi ziyakuthi zincedise ekumiliseni imithetho ezakwenza ukuba zifikeleleke lula ezinkonzo.

Ingaba kufuneka ndithabathe inxaxheba kule mfuna-lwazi kwaye ndingarhoxa nangeliphi ixesha?

Ukuthabatha inxaxheba akunyanzelekanga, ungakhetha ukungazibandakanyi nale mfuna-lwazi. Ukuba uthe wathabatha inxaxheba, ungarhoxa nangeliphi ixesha ngaphandle kwesohlwayo okanye ukungaphatheki kakuhle.

Xa unemibuzo?

Le mfuna-lwazi iqhutywa ngu: Patricia Noluthando Gwiji, ongumfundi kwiYunivesithi yase Ntshona Koloni kwisikolo sePublic Health, kwi-Faculty ye Community ne Health Sciences. Umlawuli wam ngu Gqirha Thubelihle Mathole wesikolo se-Public Health kwi-Faculty ye Community ne Health Sciences, kwi-Univesithi yase Ntshona Koloni, eMzatsi Afrika. Xa unemibuzo nge mfuna-lwazi ungaqhakamshelana no Gqirha Thubelihle Mathole kule dilesi: University of the Western Cape, School of Public Health, Private Bag X17, Belville 7535, South Africa; Umnxeba: +27 21 959 9384 and email: tmathole@uwc.ac.za okanye mna kule dilesi: No 81 Murray Street, Kokstad, South Africa, 4700. Umnxeba: 073 247 4676 i-email: 3908775@myuwc.ac.za

Xa uneminye imibuzo ngemfuna-lwazi, amalungelo akho, okanye ufuna ukubika ingxaki ohlangabezene nayo ngexesha lemfuna-lwazi ungaqhakamshelana:

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Lemfuna-lwazi ithe yavunyelwa ukuqhubeka yikomiti yeYunivesithi yaseNtshona Koloni iBiomedical Research Ethics Committee:

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INFORMATION SHEET FOR KEY INFORMANTS - *English*

Project title: *Perceived and experienced barriers in accessing sexual and reproductive health services by young women (18 – 24 years) in Alfred Nzo Health district.*

What is the study about?

Patricia Noluthando Gwiji, a research student pursuing a Master's in Public Health at the University of the Western Cape, is the researcher on this project. I'm encouraging you to take part in this research project as you have knowledge about sexual and reproductive health services. We will be very grateful for your involvement in the study, which will help us better understand the obstacles people face when trying to access sexual and reproductive health services. The information gathered during the project is also hoped to be shared with the policy makers and be considered in developing Sexual Reproductive Health policies that will address these barriers and make these services more accessible in the similar settings beyond Alfred Nzo district.

What will I be asked to do if I agree to participate?

As a key informant, you will be requested to be interviewed for 45 to 60 minutes at a time convenient to you in discussion with the researcher. You will be requested to respond to open-ended questions from an interview guide about what you perceive as barriers to accessing Sexual Reproductive Health services. With your permission, I will be recording the focus group discussion so as to make sure that I do not miss the important comments you make during the discussion. I will also be taking notes during the discussion but I may not be too fast to capture

everything, hence with your permission I will also be audio recording the discussion. Recording will not be done if you do not agree and can be stopped at your request at any point. I have also attached the summary of the questions that you will be asked to respond to during the discussion.

Will my participation in this study kept confidential?

You won't be asked to identify yourself during the interview by name or last name in order to ensure anonymity. A "DO NOT DISTURB" sign will be posted at the door, and the interview will take place in a private area. Any identifying information will be deleted from all records, and names will be substituted with numbers. No healthcare practitioner employed by the healthcare institution will have access to any of the information that has been obtained, which will be kept in strict confidence. Additionally, all study reports and publications created about this project will not reveal your identify.

What are the risks of this research?

Talking about oneself or others and engaging in human interactions all carry some level of danger. Even so, we will take precautions to reduce these risks and will help you right away if you encounter any physical or psychological pain while taking part in this study. If a need arise appropriate referral for psycho-social management will be made to the social worker. To reduce the risk of Covid 19 transmission during data collection, safety regulations and protocols will be adhered to during the interview, these include wearing of three layered face mask that will cover both the nose and the mouth, sanitizing the hands before and after the interview, sitting 2 metres apart during the interview, opening the window and decontaminating the chairs and tables before the first interview and between interviews. Participants who show signs and symptoms of Covid 19 will be referred to the nearest facility for further management. Three layered face masks, hand sanitizers and disinfectant will be provided by the researcher.

What are the benefits of this research?

Although the results of this study won't directly benefit you, they might allow the researcher to understand more about the perceived obstacles to receiving sexual and reproductive health services. The knowledge I gained from the study will help me formulate recommendations and,

with any luck, persuade the decision-makers to increase the accessibility of Sexual and Reproductive Health services in the future.

Do I have to be in this research and may I stop participating at any time?

Your participation in this study is entirely optional. You have the option to participate in the study. If you decide to participate in this research, you may stop participating at any time. You won't incur any penalties or forfeit any advantages for which you are otherwise eligible if you choose not to participate in this study or if you decide to discontinue at any time.

What if I have questions?

This research will be conducted by Patricia Noluthando Gwiji, a student at the School of Public Health, Faculty of Community and Health Sciences at the University of the Western Cape, South Africa. My supervisor is Dr. Thubelihle Mathole of the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape, South Africa. . Her telephone number is +27 21 959 9384 and email: tmathole@uwc.ac.za and my Cell phone number is 073 247 4676 and email: 3908775@myuwc.ac.za

If you have any inquiries about this study or your rights as a research participant, or if you want to report any issues you've had with it, please contact:

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This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee

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IPHEPHA LENKCUKACHA KUBATHATHI-NXAXHEBA ABANOLWAZI

OLUNGCONO - *Isixhosa*

Isihloko semfuna-lwazi: *Imibono ngemiceli mngeni ekufikeleleni kwinkonzo zempilo ngezesondo nenzala kumakhosikazi aselula aneminyaka elishumi elinesibhozo ukuya kumashumi amabini anesine eminyaka kwisithili sase- Alfred Nzo.*

Ingantoni le mfuna-lwazi?

Le projekti yemfuna-lwazi yenziwa ngu Patricia Noluthando Gwiji ofunda kwidyunivesithi yaseNtshona koloni. Ndiyakumema ukuba uzibandakanye nale mfuna-lwazi ingokuphicotha imibono nolwazi lwakho ngezinto ezenza inkonzo zempilo ngezesondo nenzala ukuba zingafikeleleki lula. Ndiyakuvuyiswa kakhulu kukuthabatha kwakho inxaxheba ukuze ndifumane ulwazi nengqiqo ngesisihloko. Ulwazi oluqokelelwe kule mfuna-lwazi kuzakwabelwana ngalo nabasemagunyeni abathi benze imithetho kwezempilo ukuze imithetho iqinisekise ukuba inkonzo zempilo ngezesondo nenzala zifikelele kubo bonke abayidingayo e-Alfred Nzo nakwezinye izithili ezifanayo.

Yintoni elindeleke kum xa ndithabatha inxaxheba?

Njengomthathi-nxaxheba ulindeleke ukuba uthabathe inxaxheba kudliwanondlebe olungathabatha amashumi amane ukuya kumashumi amahlanu emizuzu ngexesha elilungele wena eniyakuthi nivumelane ngalo nomphandi. Uzakulindeleka ukuba uphendula imibuzo gabalala ngemibono yakho ngezinto ezenza inkonzo zezempilo ngezesondo nenzala zingafikeleleki lula. Ndizakuthi ndibhale impendulo kwincwadi, kwaye ngemvume yakho ndiyishicilele ingxoxo ukuze ndifumane lonke ulwazi oyakuthi wabelane ngalo nam.

Uvumelekile ukulumisa ushicilelo kwaye uvumelekile ukuba ungayeka ukuthabatha inxaxheba nangaliphi ixesha ngaphandle kwesohlwayo okanye impatheko-mbi nangaluphi uhlobo. Ungazifundela isishwankathelo semibuzo ozakubuzwa ngayo.

Ingaba ukuthabatha kwam inxaxheba kule mfuna-lwazi luzakubayimfihlo?

Ukuqinisekisa ukuba abathathi-nxaxheba bagcinwa beyimfihlo, udliwanondlebe luyakubanjwa ekhusini kubekwe umbhalo othi 'UNGAPHAZAMISI' emnyango. Abathabathi-nxaxheba bayakuthi banikezwe inombolo abazakwaziwa ngazo ngexesha lodliwanondlebe, kushicilelo nakwinkcukacha ezibhaliweyo. Iziko lezempilo aluyi kunikezwa nkcukacha ngabathathi-nxaxheba okanye ngodliwanondlebe. Ingxelo ngemfuna-lwazi aziyi kudiza abathabathe inxaxheba.

Yintoni imingcipheko kule mfuna-lwazi?

Ingxoxo ngeenkonzo zempilo ngezesondo nenzala kungenza ukungaphatheki kakuhle nanjengoko ingumba okungelulanga ukuthetha ngawo. Xa kukho imfuneko, ungaziva kakuhle, ngemvume yakho uyakuthi ugqithiselwe kwiziko lezempilo ukuze afumane unyango. Ukwehlisa umngcipheko wolosuleleko ngentsholongwane I Covid 19, bonke abathathi-nxaxheba balindeleke ukuba banxibe izifosho, bahlambe izandla ngezibulali ntsholongwane, baqaqelane ngemitha ezimbini ubuncinane, kuvulwe iifestile kwaye kucocwe isitulo phambi kodliwano ndlebe lokuqala losuku nasemva kodliwano-ndlebe ngalunye yonke imihla. Bonke abathathi-nxaxheba abathe babonakalisa iimpawu zeCovid 19 bazakugqithiselwa kwiziko lezempilo elikufutshane. Izifonyo nesibulali zintsholongwane sizakuza nomphandi.

Yintoni engazuzwa kule mfuna-lwazi?

Le mfuna-lwazi ayinanjongo zakunceda mntu ngamnye, kodwa iziphumo zayo zingancedisa ekufumaneni ulwazi ngezithintelo ekufuneni inkonzo zempilo ngezesondo nenzala. Ndinethemba lokuba ingcebiso eziyakuthi zenziwe emva kwale mfuna-lwazi ziyakuthi zincedise ekumiliseni imithetho ezakwenza ukuba zifikeleleke lula ezinkonzo.

Ingaba kufuneka ndithabathe inxaxheba kule mfuna-lwazi kwaye ndingarhoxa nangeliphi ixesha?

Ukuthabatha inxaxheba akunyanzelekanga, ungakhetha ukungazibandakanyi nale mfuna-lwazi. Ukuba uthe wathabatha inxaxheba, ungarhoxa nangeliphi ixesha ngaphandle kwesohlwayo okanye ukungaphatheki kakuhle.

Xa unemibuzo?

Le mfuna-lwazi iqhutywa ngu: Patricia Noluthando Gwiji, ongumfundi kwiYunivesithi yase Ntshona Koloni kwisikolo sePublic Health, kwi-Faculty ye Community ne Health Sciences. Umlawuli wam ngu Gqirha Thubelihle Mathole wesikolo se-Public Health kwi-Faculty ye Community ne Health Sciences, kwi-Univesithi yase Ntshona Koloni, eMzatsi Afrika. Xa unemibuzo nge mfuna-lwazi ungaqhakamshelana no Gqirha Thubelihle Mathole kule dilesi: University of the Western Cape, School of Public Health, Private Bag X17, Belville 7535, South Africa; Umnxeba: +27 21 959 9384 and email: tmathole@uwc.ac.za okanye mna kule dilesi: No 81 Murray Street, Kokstad, South Africa, 4700. Umnxeba: 073 247 4676 i-email: 3908775@myuwc.ac.za

Xa uneminye imibuzo ngemfuna-lwazi, amalungelo akho, okanye ufuna ukubika ingxaki ohlangabezene nayo ngexesha lemfuna-lwazi ungaqhakamshelana:

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Lemfuna-lwazi ithe yavunyelwa ukuqhubeka yikomiti yeYunivesithi yaseNtshona Koloni iBiomedical Research Ethics Committee:

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INTERVIEW GUIDE FOR YOUNG WOMEN - *English*

Background information

I appreciate you taking the time to participate in this study. Please start by telling me a little bit about yourself:

1. Currently, what age are you?
2. Would you kindly tell me where you reside, how long you've been there, and who you share your home with?
3. Could you please tell me if you are currently enrolled in school, if not, whether you are working or staying at home, and how you are coping with this?
4. Could you briefly describe the kinds of things you do for leisure and on the weekends?

Health services

I would now like to ask you some questions about health services:

5. Have you ever visited a health facility and if yes can you tell me what was the reason for the visit *(probe whether she visited the facility to access health services or visited for any other reason)*
6. Tell me about the services that you accessed in the clinic? (If she has never accessed services) what health services does she think are offered in the clinic?
7. How did you feel after you received the services?

Sexual and Reproductive Health services

8. Tell me what you understand about SRH services?

9. How did you get information about these services?

10. Have you ever accessed these services? [If yes, how did you experience and feel about the service and would you access the services again and why? If no, tell me the reasons for not accessing the services, are you having any intentions to access the services in the future and why?

11. Tell me how would you like to be treated when you visit the clinic? *(Probe on the type of service she would like to receive including when, by whom, where etc.)*

12. Do you ever discuss sexual and reproductive issues with your parents, do you feel they give you enough information and how do you feel about that?

13. Tell me more about the information that you learn at school on sexual and reproductive issues (life skills)? *(Probe about information that she would like to be added in the information taught at school on sexual and reproductive health?)*

14. What information do you think your peers know about Sexual and Reproductive health services?

15. What are the challenges that you have experienced in the facility during this time of Covid 19?

16. Tell me what would make SRH services accessible. *[Probe on what she recommends for easy access of SRH services in the clinic and elsewhere]*.

Thank you so much for your time!

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ISIKHOKELO SODLIWANO-NDLEBE NAMAKHOSIKAZI ASELULA - *Isixhosa*

Ulwazi ngemvelaphi

Ndiyabulela kakhulu ngokuzibandakanya nale mfuna-lwazi, ndizakuqala ngokubuza imibuzo ngawe:

1. Ingaba uneminyaka emingaphi ngoku?
2. Ungandixelela ukuba uhlalaphi, unexesha elingakanani uhlala apho kwaye uhlala nabani?
3. Ingaba uyafunda, uyaphangela okanye uhlala ekhaya? Uziva njani ngalonto?
4. Ungakhe undixelele ukuba zintoni ozenzayo ukuzonwabisa?

Imibuzo ngenkonzo zesini nenzala

5. Wakhe waya kwiziko lezempilo? Ukuba ewe, ungandazisa isizathu sokundwendwela iziko elo.
6. Zeziphi inkonzo owazinikezwayo? Ukuba zange uye, zeziphi inkonzo ocinga ukuba zinikezwa abantu abatsha?
7. Waziva njani emva kokundwendwela elo ziko lempilo?
8. Wazintoni ngenkonzo zempilo zesini nenzala?
9. Walufumana njani ulwazi ngezinkonzo?
10. Wakhe wazifumana ezinkonzo [Ukuba ewe, ungandichazela ukuba waziva njani xa uzifumana ezinkonzo kwaye unazo na injongo zokufumana ezinkonzo kwakhona.
11. Ungathanda ukuphathwa njani kwiziko lezempilo? *(Buza ngenkonzo angathanda ukuzifumana, engazinikwa ngubani, kanjani).*
12. Ndixelele ngolwazi olufunde kwizifundo zeLife skills esikolweni? (Buza ngolunye ulwazi angathanda lwengezwe kwezizifundo).

13. Loluphi ulwazi ocinga ukuba abanye abalingana nawe banalo ngenkonzo zesini nenzala?
14. Ndichazele neengxaki ohlangabezene nazo ngelixesha le Covid 19 eklinikhi?
15. Ucinga ukuba zintoni ezingenziwa ukwenz ezinkonzo zifikeleleke?

Ndiyabulela ngexesha lakho.

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INTERVIEW GUIDE FOR THE PROGRAMME COORDINATOR – *English*

I appreciate you taking the time to participate in the study.

1. I would like you to tell me a little bit about yourself and your work
[Ask whether his or her role include SRH services].

2. At what time does the PHC facilities open and at what time do they close on which days of the week? *[Probe whether consultations start immediately after it is opened and remain operational until the closing time?]*

3. Tell me about the special arrangements that are made for adolescents and young people that visit the PHC facilities to access services?

4. Tell me about the health services that young women are supposed to receive in the facilities? *[Probe whether they receive all the services and why not?]*

5. Based on your experience and interactions with young women would you say they are well informed about their sexuality and reproductive health issues?

6. Which guiding documents are used in providing SRH services?

7. Tell me how SRH services are rendered in the facilities? (Are they rendered by one person? Are they integrated with other services?).

8. What do you think are the reasons for poor access of SRH services in this facility and in general?

9. What are the Covid 19 challenges to accessing and uptake of SRH services?

10. What strategies do you think would assist in improving accessibility of SRH services by young women?

Thank you for giving me time to interview you.

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ISIKHOKELE SODLIWANO-NDLEBE NOMLAWULI WENKONZO ZEMPILO - *Isixhosa*

Ndiyabulela ngokuba uzibandakanye nale mfuna-lwazi.

1. Ndicela undixelele gabalala ngawe nomsebenzi owenzayo? *(Buza ukuba umsebenzi wakhe uyaziquka na inkonzo zesini nesondo?)*
2. Ingaba ivula, ivale ngawaphi amaxesha iklinikhi? (*Ingaba unikezelo lwenkonzo luqala xa ukuvulwa luqhubeke kude kuvalwe?)*
3. Ingaba akhona amalungiselelo akhethekileyo enzelwe amakhosikazi aselula eklinikhi ukuze zifikeleleke inkonzo zesini kunye nenzala kuwo?
4. Zeziphi inkonzo zesini nesondo amele ukuzifumana eklinikhi amakhosikazi aselula?
5. Ngolwazi lwakho, ingaba amakhosikazi aselula analo ulwazi ngenkonzo zesini nenzala abangazifumana kumaziko empilo?
6. Zeziphi iincwadi ezisisikhokelo ngokunikezelwa kwenkonzo zesini nenzala?
7. Zinikezelwa njani ezinkonzo kwiklinikhi? (Ingaba zinikezelwa ngumntu omnye okanye ziyinxalenye yezinye inkonzo?)
8. Ucinga ukuba zeziphi izizathu ezenza ezinkonzo zingafikeleleki kumakhosikazi aselula kuleklinikhi?
9. Zintoni ingxaki zeCovid 19 ezenza amantombazana aselula angazifumani ezinkonzo zesini?
10. Zeziphi izinto ocinga ukuba zingenziwa ukwenza ezinkonzo ukuba zifikeleleke?

Ndiyabulela ngexesha lakho.

APPENDIX 11

UNIVERSITY OF THE WESTERN CAPE

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INTERVIEW GUIDE FOR THE NURSE – *English*

I appreciate you taking the time to participate in this study.

1. I would like you to tell me a little bit about yourself and your work
[Ask whether his or her role include SRH services].

2. At what time does the clinic open and at what time does it close on which days of the week? *[Probe whether consultations start immediately after it is opened and remain operational until the closing time?]*

3. Have you ever received training on SRH services? How long was the training and how does it assist you in your duties?

4. What services do you render for young women?

5. What has your experience been like in working with young women? [*Do they visit the facility more often; what kind of information are they interested in? who do they speak to when they come in to the health facility? What other services are provided to adolescent girls and young women in this health facility?]*.

6. Based on your interactions with teenagers would you say teenagers are well informed about their sexuality and reproductive health issues?

7. Tell me about the guiding documents that you use when rendering SRH services. *[Probe about SRH policies, guideline, standard operating procedures]*.

8. Tell me how SRH services are rendered in the facility? (Are they rendered by one person? Are they integrated with other services?)

9. Can you please tell me about your perception broadly regarding SRH services?

10. What do you think are the reasons for poor access of SRH services in this facility and in general?

11. What are the challenges that you have experienced in the facility during this time of Covid 19?

12. What strategies do you think would assist in improving accessibility of SRH services by young women?

Thank you for giving me time to interview you.

APPENDIX 12

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ISIKHOKELO SODLIWANO-NDLEBE NOMONGIKAZI – *Isixhosa*

Ndiyabulela ngokuba uzibandakanye nale mfuna-lwazi

1. Ndicela undixelele gabalala ngawe nomsebenzi owenzayo? *(Buza ukuba umsebenzi wakhe uyaziquka na inkonzo zesini nesondo?)*
2. Ingaba ivula, ivale ngawaphi amaxesha iklinikhi? (*Ingaba unikezelo lwenkonzo luqala xa ukuvulwa luqhubeke kude kuvalwe?)*
3. Wakhe walufumana uqeqesho ngenkonzo zesini nesondo? Yayiluqeqesho lwexesha elingakanani? Lukuncedisa njani oluqeqesho kumsebenzi wakho?
4. Zeziphi inkonzo zempilo ozinikezela amakhosikazi aselula?
5. Athini amava akho ngokusebenza namakhosikazi aselula? (Ingaba beza rhoqo eklinikhi? Loluphi ulwazi abanomdla kulo? Badla ngokuthetha nabani xa befika eklinikhi? Ingaba zikhona ezinye inkonzo abazinikezwayo xa beze eklinikhi?).
6. Ngamava akho okunikezela inkonzo kumakhosikazi aselula, ingaba banalo ulwazi ngenkonzo zesini nenzala?
7. Yeyiphi imibono yakho gabalala ngenkonzo zesini nenzala?
8. Zeziphi iincwadi ezisisikhokelo ngokunikezelwa kwenkonzo zesini nenzala?
9. Zinikezelwa njani ezinkonzo kwiklinikhi? (Ingaba zinikezelwa ngumntu omnye okanye ziyinxalenye yezinye inkonzo?)
11. Ucinga ukuba zeziphi izizathu ezenza ezinkonzo zingafikeleleki kumakhosikazi aselula kuleklinikhi?
12. Zintoni ingxaki zeCovid 19 ezenza amantombazana aselula angazifumani ezinkonzo zesini?
13. Zeziphi izinto ocinga ukuba zingenziwa ukwenza ezinkonzo ukuba zifikeleleke?

Ndiyabulela ngexesha lakho.

APPENDIX 13

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INTERVIEW GUIDE FOR THE CLINIC COMMITTEE MEMBER – *English*

I appreciate you taking the time to participate in this study.

I would like you to tell me a little bit about yourself:

1. Can you tell about your role in clinic committee?
2. How long have you been a member of the clinic committee and what are the challenges of this role?
3. In your role as the member of the clinic committee, I take it you have engaged with adolescent and young women, what concerns regarding SRH services in the clinic did they raise with you?
4. In your opinion, do you think they are aware of the services available in the clinic for them as young people? (Probe on the SRH services they are aware of)
5. Can you please tell me about your perception broadly regarding SRH services? [Probe on what she knows about the service].
6. In your view, what do you think prevent young women from accessing SRH services?
7. What are the challenges that you have experienced in the facility during this time of Covid 19?
8. As the member of the community and the clinic committee, what do you think can be done to improve access to SRH services in the facility and community at large.

Thank you for giving me time to interview you.

APPENDIX 14

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ISIKHOKELO SODLIWANO-NDLEBE NELUNGU LEKOMITI YEKLINIKHI - *Isixhosa*

Ndiyabulela ngokuba uzibandakanye nale mfuna-lwazi, ndingathanda ukubuza imibuzo ngawe:

1. Ingaba yintoni umsebenzi owenzayo kulekomiti yeklinikhi?
2. Unexesha elingakanani ulilungu lalekomiti?
3. Njengelungu lekomiti yeklinikhi ndiyakuqonda ukuba uyanxulumana namakhosikazi aselula, yeyiphi imiba abathi bayiphakamise ngenkonzo zesini nenzala?
4. Ngoluvo lwakho, ingaba amakhosikazi aselula ayazazi inkonzo ezinikezwayo zesini nenzala apha eklinikhi? (Buza ngenkonzo zesini nenzala acinga ukuba ayazazi amakhosikazi aselula).
5. Ingaba luthini uluvo lwakho ngenkonzo zesini nenzala?
6. Ngolwazi lwakho zintoni ezenza amakhosikazi aselula ukuba angezi eklinikhi ukuza kufumana inkonzo zesini nenzala?
7. Zintoni ingxaki zeCovid 19 ezenza amantombazana aselula angazifumani ezinkonzo zesini?
8. Njengelungu lekomiti yeklinikhi, zintoni ocinga ukaba zingenziwa ukuze zifikeleleke inkonzo zesini nenzala?

Ndiyabulela ngexesha lakho.

APPENDIX 15

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INTERVIEW GUIDE FOR A PEER EDUCATOR – *English*

I appreciate you taking the time to participate in this study.

I would like you to tell me a little bit about yourself:

1. Can you tell about your role in clinic and the community?
2. How long have you been a peer educator and what are the challenges of this role?
3. In your role as a peer educator I take it you interact with adolescent girls and young women, tell me your experiences about the engagements?
4. In your opinion, do you think they are aware of the SRH services available in the clinic for them as young people?
5. Can you please tell me about your perception broadly regarding SRH services? [Probe on what she knows about the service].
6. In your view, what do you think prevent adolescent girls and young women from accessing SRH services?
7. What are the challenges that you have experienced in the facility during this time of Covid 19?
8. As a young person, what do you think can be done to improve access to SRH services in the facility and community at large?

Thank you for giving time to interview you.

APPENDIX 16

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ISIKHOKELO SODLIWANO-NDLEBE NOSELULA OFUNDISA ABANYE - *Isixhosa*

Ndiyabulela ngokuba uzibandakanye nale mfuna-lwazi

1. Ungandixelela ngenxaxheba okanye umsebenzi owenzayo apha eklinikhi?
2. Unexesha elingakanani ufundisa abanye abaselula?
3. Njengofundisa amakhosikazi aselula, yeyiphi imiba athi axoxe ngayo?
4. Ngokubona noluvo lwakho, bayazazi inkonzo ezifumanekayo zesini nenzala eklinikhi?
5. Ungandixelela ngemibino yakho ngenkonzo zesini nenzala?
6. Ngoluvo lwakho, zintoni ezenza amakhosikazi aselula angezi eklinikhi ukuzofumana inkonzo zesini nenzala?
7. Zintoni ingxaki zeCovid 19 ezenza amantombazana aselula angazifumani ezinkonzo zesini?
8. Njengomnye oselula, zintoni ocinga ukuba zingenziwa ukuze inkonzo zesini nenzala zifikeleleke kumakhosikazi aselula?

Ndiyabulela ngexesha lakho.

APPENDIX 17

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E-mail: soph-comm@uwc.ac.za

The Chief Director Clinical Health Programmes
Miss M. Nokwe
Eastern Cape Department of Health
Private Bag X 0038
Bisho
5605
Tel No: 040 608 1118
Fax No: 040 608 1117

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN A PRIMARY HEALTH CARE FACILITY

Dear Miss Nokwe

My name is Patricia Noluthando Gwiji, and I am currently enrolled in the University of Western Cape's Public Health program in Cape Town. I have to undertake a research project as part of my master's degree requirements. In a rural primary health care institution, I want to explore the perceived and actual hurdles that young women have while trying to get services for sexual and reproductive health. Dr. Thubelihle Mathole, from the University of the Western Cape in South Africa, will be in charge of overseeing the project.

In light of the foregoing, I respectfully ask your excellent office to grant me permission to contact the Alfred Nzo district and Mount Ayliff Gateway clinic in order to secure volunteers for this research project.

Along with a copy of the approval letter I obtained from the University of Western Cape Bio-Medical Research and Ethical Committee, I've attached a copy of my research proposal, which also includes copies of the consent and assent forms to be used in the study (BRMEC).
I agree to deliver a bound copy of the whole research report to the Department of Health after the study is finished. If you require any further information, please do not hesitate to contact me on 073 247 4676 and 3908775@myuwc.ac.za.

Thank you for your time and consideration in this matter.
Yours sincerely,

Patricia Noluthando Gwiji
Student Number: 3908775
University Western Cape

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: 021 959 4111
E-mail: research-ethics@uwc.ac.za

APPENDIX 18

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Private Bag X 17, Bellville 7535, South Africa
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The District Director
Mrs D.N. Mtonjana
Alfred Nzo Health District
No 81 Murray Street
Kokstad
4700
Tel No: 039 727 6072
Fax No: 039 727 1044

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN A PRIMARY HEALTH CARE FACILITY

Dear Mrs Mtonjana

My name is Patricia Noluthando Gwiji, and I am currently enrolled in the University of Western Cape's Public Health program in Cape Town. I have to undertake a research project as part of my master's degree requirements. In a rural primary health care institution, I want to explore the perceived and actual hurdles that young women have while trying to get services for sexual and reproductive health. Dr. Thubelihle Mathole, from the University of the Western Cape in South Africa, will be in charge of overseeing the project. In light of the aforementioned, I respectfully ask your good office to grant me permission to contact Mount Ayliff Gateway clinic in order to recruit participants for this research study.

Along with a copy of the approval letter I obtained from the University of Western Cape Bio-Medical Research and Ethical Committee, I've attached a copy of my research proposal, which also includes copies of the consent and assent forms to be used in the study (BRMEC).

I agree to deliver a bound copy of the whole research report to the Department of Health after the study is finished.

If you require any further information, please do not hesitate to contact me on 073 247 4676 and 3908775@myuwc.ac.za.

Thank you for your time and consideration in this matter.

Yours sincerely,

Patricia Noluthando Gwiji

Student Number: 3908775

University Western Cape

Biomedical Research Ethics Committee

University of the Western Cape

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APPENDIX 19

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The Clinic Supervisor
Mr M. Patela
Mount Ayliff Gateway Clinic
No 8 Ntsizwa Street
Mount Ayliff
4735
Tel No: 039 254 0324
Fax No: 039 254 0245

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN A PRIMARY HEALTH CARE FACILITY

Dear Mr Patela

My name is Patricia Noluthando Gwiji, and I am currently enrolled in the University of Western Cape's Public Health program in Cape Town. I have to undertake a research project as part of my master's degree requirements. In a rural primary health care institution, I want to explore the perceived and actual hurdles that young women have while trying to get services for sexual and reproductive health. Dr. Thubelihle Mathole, from the University of the Western Cape in South Africa, will be in charge of overseeing the project.

In light of the foregoing, I respectfully ask your good office to grant me permission to contact the Alfred Nzo district and Mount Ayliff clinic in order to recruit participants for this research study.

Along with a copy of the approval letter I obtained from the University of Western Cape Bio-Medical Research and Ethical Committee, I've attached a copy of my research proposal, which also includes copies of the consent and assent forms to be used in the study (BRMEC).
I agree to deliver a bound copy of the whole research report to the Department of Health after the study is finished. If you require any further information, please do not hesitate to contact me on 073 247 4676 and 3908775@myuwc.ac.za.

Thank you for your time and consideration in this matter.
Yours sincerely,

Patricia Noluthando Gwiji
Student Number: 3908775
University Western Cape

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville

APPENDIX 20

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

05 May 2021

Mrs PN Gwiji
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM21/03/02

Project Title: Barriers in accessing sexual and reproductive health services by young women in a rural clinic in Alfred Nzo health district, Eastern Cape, South Africa.

Approval Period: 09 April 2021 – 09 April 2024

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

FWA BEC Registration Number: BMREC-130616-030

FROM HOPE TO ACTION THROUGH KNOWLEDGE

APPENDIX 21

Province of the

EASTERN CAPE

HEALTH

Enquiries: Ywnæ Gixela Tel no: 079 074 0859

Enwil: Yvonne.Gixela@echealth.gov.za / ygixela@gmail.com

Date: 12 May 2021

RE: Title: Barriers in accessing sexual and reproductive health services by young women in a rural clinic in Alfred Nzo health district. Eastern Cape, South Africa.(EC_202105_003)

Dear Mrs P.N. GwiJi

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

APPENDIX 22

Province of the
EASTERN CAPE
HEALTH

81 Murray Street • Koksnd • 4700
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Tel.: +27 039 727 4462 • Fax +27 (0)39 727 1044 • Website
www.ecdoh.gov.za
vironmentalHmlth Sevices - EHS
Enquiries: Mr. Mkhalane Cdl: 060 557 9753 Date: 31 May 2021
Fmail• mat 1 mkalan«ôømailrom

To Whom It May Concern

Research Approval - EC_202105_003 (P.N. Gwiji)

Kindly be advised that the Health District, Alfred Nzo, has no objection in allowing the study "Barriers in accessing sexual and reproductive health services by young women in a rural clinic in Alfred Nzo Health Distirct., Eastern Cape, South Africa. The Study is approved based on Eastern Cape Health Research Committee Approval.
The Department, however, is wishing you all the best in conducting the study, you are also requested to give feedback to the District Manager for implementation of recommendations thereof:

Also be advised to maintain Ethics and Participant Consent should there be any clinical trials. The Department will NOT be held responsible for any adverse events pertaining the study.

Regards,

Mkhalane M

31/5/21

Mkhalane
Research Coordinator