Sexual and Reproductive Health Services: Experiences and views of young adults and providers in Soshanguve

by

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Declaration

I, **Naum Mahlatse Maeko,** student number: **2019827324**, hereby declare that this dissertation is submitted in compliance with the requirements of the Master of Health Systems Studies degree at the University of the Free State is my own independent work and has not been previously submitted by me for a qualification at another institution of higher learning. Further, all academic sources have been acknowledged in-text and in the reference list. I furthermore cede copyright of this dissertation in favour of the University of the Free State.

Signature: Date: 09/10/2024

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Abstract

Background

Despite efforts to educate young people about healthy sexual behaviours and the availability of sexual and reproductive health (SRH) services, risky sexual behaviour (RSB) outcomes such as unplanned pregnancies, unsafe abortions, and sexually transmitted infections (STIs) among youth in South Africa persist. Efforts have been made to implement SRH interventions aimed at addressing RSB outcomes through targeted clinic SRH services tailored for young people. However, implementation discrepancies continue, necessitating improvements in service delivery strategies and policy guidelines. These discrepancies stem from various barriers such as insufficient knowledge, education gaps, myths, misconceptions, family dynamics, socio-cultural elements, and systemic health issues. To comprehensively analyse these challenges, this study adopted the Socio-Ecological Model (SEM) proposed by McLeroy et al. (1988). The SEM framework acknowledges the multi-layered influences on human behaviour; that is, the *individual, interpersonal, community, institutional* and *policy-level factors.*

Main research question

How do socio-ecological factors influence young adults and SRH providers' experiences and views regarding SRH services in Soshanguve, South Africa?

Aim

The aim of the study was to explore how socio-ecological factors influence the experiences and views of young adults and SRH providers regarding SRH services in Soshanguve.

Methodology

The research project utilised an interpretive paradigm. A qualitative approach was employed by using an exploratory research design to explore the personal views and experiences of young adults and SRH providers regarding SRH services at clinics. The study was conducted in three purposively selected local clinics in Soshanguve. The sample consisted of fifteen young adults, comprising of seven females and eight males, selected through convenience sampling. Five SRH providers were selected through purposive sampling. They were collected through in-depth interviews (IDIs) with young adult participants, in addition to key informant interviews (KIIs) with SRH provider-participants. All interviews were audio-recorded and transcribed for analysis by applying Thompson's (2022) eight-step abductive analysis, which allowed the blending of inductive and deductive reasoning. Data from young adults and SRH providers was

triangulated. Ethical considerations focused on informed consent, confidentiality, privacy, and respect throughout the research.

Findings

Both young adults and SRH providers identified key challenges across the SEM that affected their views and experiences of clinic SRH service in Soshanguve. At the *individual level*, knowledge, attitudes and beliefs about SRH were crucial determinants. At the *interpersonal level*, both groups perceived parent-child and peer communication as the critical factors influencing young adults' knowledge, attitudes, and behaviours towards SRH. *Community-related* factors hindering and facilitating young adults' access to and utilisation of clinic SRH services such as societal attitudes, religious beliefs, and cultural norms emerged as significant barriers contributing to stigma and discrimination for both groups. Both groups perceived similar *institutional-related* barriers and facilitators such as limited clinic operating hours, overcrowding, and lack of confidentiality. However, young adults expressed greater concerns about SRH providers' judgemental and gender-bias attitudes, while SRH providers were concerned with the impact of the clinic booking system, especially for the abortions. At the *policy level*, both groups emphasised the need for guidelines that could support comprehensive education, youth-friendly services, and mobile SRH services to address systemic issues and enhance access for young adults.

Conclusion

The findings revealed the views and experiences of both young adults and SRH providers regarding young adults' access to and utilisation of clinic SRH services in Soshanguve, thus underscoring the necessity for a multi-layered SEM approach. Addressing the identified SEM factors through targeted interventions and policies can assist in bridging the gaps in service delivery and the utilisation of resources to promote better SRH outcomes among young adults.

Key terms: Sexual and Reproductive Health services, Risky Sexual Behaviour, Socio-Ecological Model, young adults, SRH providers

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Abbreviations and Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
IDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
DBE	Department of Basic Education
DoH	Department of Health
DSD	Department of Social Development
GDoH	Gauteng Department of Health
HIV	Human Immunodeficiency Virus
HTEI	Higher Tertiary Education Institution
IDI	In-depth Interview
ISHP	Integrated School Health Policy
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LGBTIQA+[1]	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual
NGO	Non-Governmental Organisation
NSHP	National School Health Policy
NSP	National Strategic Plan
PLH	Parenting for Lifelong Health
PHC	Primary Health Care
PrEP	Pre-Exposure Prophylaxis
RSB	Risky Sexual Behaviour
SANAC	South African National AIDS Council
SEM	Socio-Ecological Model
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
SRHI	Sexual and Reproductive Health Intervention

[1] The symbol '+' encompasses gender identities and sexual orientations beyond those specifically denoted by the acronym LGBTIQ (University of Technology Sydney, 2024).

SRHR	Sexual and Reproductive Health Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organization
YFSRHS	Youth-Friendly Sexual and Reproductive Health Service

Terms and Definitions

Abortion: Refers to the termination of pregnancy before the foetus can survive outside of the uterus. It can occur naturally (miscarriage) or can be induced through medical or surgical procedures (WHO, 2004).

Clinic SRH Services: Refers to healthcare facilities that offer a range of services related to SRH including family planning, contraception, prenatal care, STI testing and treatment, sexual health education, and counselling.

Comprehensive Sexuality Education: According to the National Department of Health (NDoH), this refers to "the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgemental information about sex and relationships. Sexuality education provides opportunities to explore one's values and attitudes and to build decision-making, communication, and risk-reduction skills about many aspects of sexuality" (NDoH, 2019: viii).

Experiences: In the context of health care this refers to the subjective encounters and interactions that individuals have within the healthcare system, which encompasses their personal encounters with healthcare providers, the healthcare environment, and the overall care received (Lee et al., 2020).

Health System: Refers to the "total of all the organisations, institutions, and resources whose primary purpose is to ensure delivery of quality services to all people, when and where they need them (NDoH, 2019a, p. ix). The WHO identifies six core components or 'building blocks' of a health system: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance" (WHO, 2007).

Healthcare Provider: Refers to an individual who is trained and licensed to provide medical care and treatment to individuals. They may work in various settings such as hospitals, clinics, private practices, community health centres, and other healthcare facilities (Lee et al., 2020). In this context, the healthcare providers are SRH providers. SRH providers are healthcare professionals who specialise in delivering family planning, contraception, prenatal care, STI testing and treatment, sexual health education, and counselling to individuals.

HIV/AIDS: HIV is a virus that attacks the immune system, and AIDS is the advanced stage of HIV infection. HIV is primarily transmitted through sexual contact, sharing of needles, or from mother-to-child during pregnancy, childbirth, or breastfeeding. HIV/AIDS weakens the immune system, making individuals more vulnerable to infections and illnesses. HIV/AIDS can be managed through antiretroviral therapy (ART) which can control the virus and improve quality of life, but there is no known cure (WHO, 2004).

Reproductive Health: "Reproductive health implies that people have the capability to reproduce, and the freedom to decide if, when, and how often to do so. Implicit in this, are the rights of all people to be informed, and to have access to safe, effective, affordable, and acceptable methods of contraception of their choice, as well as to safe termination of pregnancy. People have the right to access appropriate health-care services that will enable women to journey safely through pregnancy and childbirth and to provide couples with the best chance of having a healthy infant" (NDoH, 2019: ix).

Risky Sexual Behaviour (RSB): Refers to actions that put individuals at a higher risk of contracting sexually transmitted infections (STIs), unplanned pregnancies, and other negative sexual health outcomes (Tolera, 2019). These behaviours include unprotected sex, having multiple sexual partners, engaging in sex with high-risk individuals, and substance abuse before sexual activity (Tolera, 2019).

Safe abortion: Refers to the termination of a pregnancy by a trained healthcare provider, using an approved method, performed in a suitable clinical setting (WHO, 2004).

Sexual and Reproductive Health (SRH): Refers to a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction. SRH encompasses issues that affect the lives of both men and women, including but not limited to reproductive health and menopause. (WHO, 2004).

Sexual and Reproductive Health Interventions (SRHIs): Refers to programmes or services designed to promote healthy sexual behaviours, prevent STIs and unplanned pregnancies, and promote safe and responsible sexual practices (WHO, 2004) such as sex education in schools, access to contraception, counselling and testing for STIs, outreach programmes, youth-friendly health services, and social marketing.

Sexual and Reproductive Health Rights (SRHRs): SRHRs encompass a wide range of rights related to sexual health, reproductive health and the ability to make autonomous decisions

about one's own body. These rights are grounded in principles of human rights and are essential for achieving gender equality and overall wellbeing (NDoH, 2018).

Sexual Health: "Sexual health requires a positive and cautious approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (NDoH, 2019: x).

Sexually Transmitted Infection (STI): Refers to an infection transmitted from one person to another through sexual contact (WHO, 2004).

Unplanned pregnancy: Refers to when a woman gets pregnant but did not intend to become pregnant or was not trying to conceive. An unplanned pregnancy can occur due to failure of contraceptives, lack of contraceptive use, or sexual violence (WHO, 2004).

Unsafe abortion: Refers to termination of pregnancy performed by unskilled or untrained practitioners, and in an environment that does not meet medical standards. An example of this is when a pregnant woman undergoes an abortion from an untrained or unlicensed practitioner, such as a traditional healer or someone who lacks proper medical training (WHO, 2004).

Views: Refers to the perspectives and opinions held by individuals, including young adults and healthcare providers regarding healthcare practices, interactions, and the overall healthcare system (Lundvall et al., 2020).

Young Adults: This refers to individuals within a specific age group, from late adolescence to early adulthood who are characterised by unique healthcare needs and challenges. Young adults often encounter distinct healthcare experiences and have specific views on healthcare practices and interactions, which are influenced by their developmental stage, social context, and personal circumstances (Gokhale et al., 2020).

Youth-friendly health services*:* Health facilities that cater to the specific health needs of young people and offer a safe and non-judgemental environment where young people can access SRH services (WHO, 2004).

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

The provision of Sexual and Reproductive Health (SRH) services is crucial in promoting the overall health and well-being of populations, particularly among vulnerable groups like young adults. Globally, SRH services are designed to reduce the incidence of sexually transmitted infections (STIs), unintended pregnancies, and maternal mortality, while also promoting sexual health education and rights (World Health Organization [WHO], 2004). However, significant challenges persist in ensuring equitable access to these services, especially among young adults who often engage in risky sexual behaviour (RSB). Unmet SRH needs among youth have far-reaching consequences, contributing to high rates of unplanned pregnancies, unsafe abortions, and the continued spread of infections such as Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (WHO, 2004).

Unplanned pregnancy also remains a major public health issue, with up to 80 million unplanned pregnancies occurring annually (Adamu et al., 2022). WHO has advocated for comprehensive sexuality education, improved family planning services, and access to safe abortion as key strategies to address these global challenges (WHO, 2004). Nonetheless, in many regions, these services remain less utilised due to stigma, inadequate healthcare infrastructure, and socio-economic disparities (Adamu et al., 2022).

Studies in various African contexts highlight the persistent engagement of young people in RSB, despite high awareness of its risks. For example, a Nigerian study found that while many young people were aware of the negative consequences of RSB, they tended to ignore them, continuing to engage in risky practices (Ajayi et al., 2018). Similarly, in Ethiopia, Keto et al. (2020) reported that 76.5% of secondary school students were knowledgeable about the adverse effects of RSB. Despite this awareness, a significant portion of the students continued to engage in RSB, with 22.7% having had sexual experience and 61.7% of these individuals reporting multiple sexual partners. Moreover, only 20% of sexually active students consistently used condoms, while 58% reported never using condoms during intercourse (Keto et al., 2020). This highlights the gap between knowledge of SRH risks and actual behaviours, a challenge seen across many regions.

Beyond individual behaviour, several social and structural factors contribute to adolescents' and young adults' reluctance to seek SRH services. Social norms within social networks such as family and peers play a significant role in shaping behaviour. A study conducted in California found that family expectations and peer influences could either discourage or promote the use of SRH services (East et al., 2021). Similarly, in Sub-Saharan Africa, the absence of social support and feelings of isolation were identified as key barriers to accessing essential services, including HIV care (Sidamo et al., 2023). This is further exacerbated by interpersonal barriers such as cultural and linguistic differences, as noted in the U.S.A., where these factors limit adolescents' access to healthcare (Garney et al., 2021).

In South Africa and Nigeria, additional barriers to SRH service utilisation include misconceptions about contraception, fear of side effects, and stigma associated with sexual health services. Studies by Ngwenya et al. (2020) in South Africa and Ezenwaka et al. (2020) in Nigeria found that fear and misinformation often deter young adults from seeking contraceptive services, further increasing their risk of unintended pregnancies and STIs.

Alarmingly, in Cambodia, some young people believe they are immune to the risks of unprotected sex, leading to continued RSB despite being aware of the dangers (Rizvi et al., 2020). This perception, combined with a gap between the implementation of SRH services and their real-world effectiveness, contributes to the persistent engagement in risky behaviours (Rizvi et al., 2020). Furthermore, a study in Kenya revealed a significant unmet need for contraception among young people, indicating that existing SRH services do not adequately address their specific needs (Ochako et al., 2015). Stigma and fear of judgment from healthcare providers also contribute to young adults' reluctance to seek SRH services, as reported by the Joint United Nations Programme on HIV/AIDS [UNAIDS] (2021).

In Sub-Saharan Africa, the region most affected by the HIV/AIDS pandemic, SRH services are especially critical. Despite advancements in treatment and prevention, adolescents and young adults continue to face elevated risks of contracting STIs, including HIV (Murewanhema et al., 2022). According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2021), adolescent girls and young women aged 15-24 account for a disproportionate number of new HIV infections in Sub-Saharan Africa, with approximately 6,000 young women becoming infected every week. This highlights the urgent need for targeted interventions that address both the structural drivers of HIV transmission and the unmet need for sexual and reproductive health services, such as access to contraceptives, HIV testing, and treatment services. The

intersection of these challenges places young women at the centre of the HIV epidemic in the region, requiring multifaceted responses that prioritize their sexual health and rights (UNFPA, 2020).

This underscores the importance of strengthening SRH services, especially for marginalised youth populations. Many countries in the region, including South Africa, have developed policies aimed at improving SRH outcomes, yet barriers persist at both the community and healthcare system levels (Adeniyi et al., 2020).

In South Africa, the SRH of young adults remains a pressing public health concern. Despite the government's implementation of national strategies such as the National Adolescent SRH and Rights Framework Strategy (2014-2019) and the National HIV, AIDS, and STI Strategic Plan (2017-2022), the prevalence of RSB among youth continues to result in adverse health outcomes, including unplanned pregnancies, STIs, and HIV transmission (National Department of Health [NDoH], 2015; South African National AIDS Council [SANAC], 2017). Young people in South Africa, particularly those from underserved communities, face multiple barriers to accessing SRH services, including socio-cultural taboos, stigma, and a lack of comprehensive sexual education.

The township of Soshanguve, located in northern Gauteng, reflects many of these challenges. Youth in the area represent a significant proportion of the population and are at heightened risk of unmet sexual health needs. Studies show that factors such as stigma surrounding sexual health, insufficient educational outreach, and infrastructural deficiencies prevent many young people from seeking SRH services (Bhengu, 2021). Healthcare providers in Soshanguve, like those in other South African townships, grapple with overburdened health systems, resource limitations, and personal biases that further complicate service delivery.

The COVID-19 pandemic exacerbated these challenges by disrupting routine primary health care (PHC) services, including SRH. Pillay et al. (2021) found that government-imposed lockdowns and protocols during the pandemic significantly hindered access to critical health services, including contraception, early pregnancy care, and STI testing. Filip et al. (2022) also highlighted the pandemic’s devastating effects on maternal and neonatal health, noting increased mortality rates as a result of delayed care. Similarly, Heunis et al. (2023) observed a decline in the utilisation of SRH services in the Free State, where teenage pregnancies and HIV care access suffered. Alarmingly, Save the Children (2021) reported a 60% rise in teenage pregnancies in South Africa during the pandemic, with the Gauteng Department of Health

documenting over 23,000 births to girls under 18 between April 2020 and March 2021 (Bhengu, 2021).

The current state of SRH in South Africa underscores the importance of evaluating SRH policies and programmes at the community level. Efforts to improve SRH outcomes must consider the real-life experiences and perspectives of both young adults and healthcare providers. This study will explore the specific challenges faced in Soshanguve, aiming to provide insights that can inform more effective strategies for improving access to and quality of SRH services for young people in township settings.

1.2 PROBLEM STATEMENT

Studies have indicated that despite SRH programmes aiming to educate South Africans about healthy sexual behaviours, young people continue to engage in RSB, leading to unplanned pregnancies, unsafe abortions, and STIs (Srahbzu & Tirfeneh, 2020; Mthembu, Maharaj & Rademeyer, 2019). Across Gauteng and other parts of South Africa, many young people fear judgment from healthcare providers when seeking services like contraceptives or STI treatment. This fear results in reduced uptake of preventive measures such as condoms (Mthembu et al., 2019; Ngwenya et al., 2020; Boitumelo et al., 2023). The gap between awareness and action is a major factor in the persistent high rates of unplanned pregnancies and STIs (Mthembu et al., 2019). Reluctance to seek SRH services, coupled with misconceptions about contraception side effects, leaves many at risk of unintended pregnancies and infections like HIV and other STIs (Boitumelo et al., 2023).

In South Africa, research focusing on university students aged 18-24 used in-depth interviews and focus group discussions to explore young people's sexual behaviours (Mthembu et al., 2019). The findings revealed that although students were aware of the risks of unprotected sex, multiple sexual partners, and alcohol use, these behaviours persisted. The study also noted a decline in condom use among the youth, attributed to negative attitudes toward condoms and lack of preparedness during first sexual encounters. Inconsistent condoms use and the influence of alcohol were identified as significant contributors to ongoing RSB, despite awareness of the consequences (Mthembu et al., 2019). These factors continue to pose challenges in reducing unplanned pregnancies and STIs among young people (Baker et al., 2023).

Efforts to expand and improve HIV prevention and SRH services, including contraception access, should be revisited and re-implemented in South African clinics (Jonas et al., 2020).

There is also a need for better SRH programmes that are freely accessible to young people (Ngidi et al., 2018). Improvements in SRH services should focus on providing effective information channels and safe, affordable preventive SRH services, particularly in areas where such services are lacking (Isaacs et al., 2024).

In Soshanguve, significant local challenges hinder the effectiveness of SRH services in addressing issues like unplanned pregnancies and STIs. Poverty, overcrowded clinics, and limited healthcare access create barriers to consistent use of SRH services by young people (Oyedele et al., 2013). Despite awareness of the risks associated with unprotected sex and multiple sexual partners, behavioural patterns like inconsistent condom use persist, driven by fear of judgment, misconceptions about contraception, and negative attitudes toward preventive measures such as condoms (Mthembu et al., 2019; Boitumelo et al., 2023). This gap between awareness and action remains a major contributor to high rates of unplanned pregnancies and STIs (Mthembu et al., 2019).

In response to these challenges, the National Department of Health (NDoH) implemented youth-friendly SRH clinic-based services across Gauteng, including Soshanguve (NDoH, 2020). These services formed part of broader efforts to enhance access to SRH resources for adolescents and young adults (NDoH, 2020). The goal was to provide non-judgmental, confidential, and age-appropriate care, with a particular focus on increasing access to contraception, STI prevention, and HIV testing (Baker et al., 2023). The implementation involved training healthcare workers to deliver youth-sensitive care, redesigning clinic spaces to be more welcoming, and creating outreach programmes to raise awareness about the availability of these services (Obiezu-Umeh et al., 2021).

Despite the prioritization of SRH by the National Department of Health, significant gaps remain in service delivery and accessibility (NDoH, 2020). Clinics often struggle to provide confidential, non-judgmental care tailored to the needs of adolescents and young adults (Baker et al., 2023). Systemic inefficiencies, such as poor booking processes, long waiting times, and limited staff capacity, further restrict young people's access to these essential services (Boitumelo et al., 2023).

Considering the above challenges, interventions that engage broadly with identified young people in conjunction with community SRH providers, will assist in understanding their real narratives. Hence, this study could provide rich data on the barriers to and facilitators of SRH

services' effectiveness, specifically on what works and what does not work in mitigating unplanned pregnancies, unsafe abortions, and STIs.

1.3 CONCEPTUAL FRAMEWORK: AN OVERVIEW

This study applied the Social-Ecological Model (SEM) to unpack the experiences and views of young people regarding SRH services and SRH providers. The SEM was conceptualised by Bronfenbrenner in the 1970s and adapted by McLeroy, Bibeau, Steckler, and Glanz in 1988 (McLeroy et al., 1988). The SEM model is a framework that examines multifaceted influences on human behaviour and decision-making that acknowledges the diverse levels of influence on such behaviours and decisions-making (Sidamo et al., 2023). It maintains that behaviours are not solely determined by individual factors but are also shaped by multiple layers of influence: *individual, interpersonal, community, institutional* and *policy* levels (Rizvi et al., 2020). This complex set of factors interplay to mould the behaviours and decision-making of individuals. The SEM thus offers an integrated approach for understanding and addressing intricate health issues by recognising the numerous strata of influence on individuals' health and behaviours.

1.4. RESEARCH AIM, OBJECTIVES AND MAIN QUESTION

1.4.1 Aim

The aim of the study was to explore the socio-ecological influences on the experiences and views of young adults and SRH providers regarding SRH services in Soshanguve clinics.

1.4.2 Objectives

- To explore knowledge and awareness of RSB and SRH issues and individual-related influences on young adults' use of clinic SRH services.
- To explore young adults and SRH providers' views and experiences of the interpersonal-related influences on the use of clinic SRH services.
- To explore young adults and SRH providers' views and experiences regarding community-related hindrances in facilitating access to and utilisation of clinic SRH services.
- To investigate the perspectives of both young adults and SRH service providers regarding institutional-related barriers and facilitators access to clinic SRH services.
- To explore views of young adults and SRH service providers regarding the SRH related rights and strategies for improving access to and utilisation of clinic SRH services.

1.4.3 Research Question

How do socio-ecological factors influence young adults and SRH providers' experiences and views regarding SRH services in Soshanguve?

1.5 JUSTIFICATION FOR THE STUDY

Despite the implementation of various SRH programmes, studies shows that young people continue to engage in RSB, resulting in high rates of unplanned pregnancies, unsafe abortions, and STIs, including HIV (Ngidi et al., 2018; Jonas et al., 2020). These persistent issues suggest that existing SRH services are not adequately addressing the needs of young people, particularly in under-resourced settings like Soshanguve areas.

This study aimed to explore the experiences and views of both young adults and healthcare providers in Soshanguve regarding SRH services, identifying key challenges and potential areas for improvement. Understanding the real-life barriers from the views of these two critical groups is essential for developing more effective interventions that are responsive to the specific needs of young people in this context.

To understand the factors contributing to the ongoing engagement in RSB and the views of young adults and SRH providers SRH clinic services, this study applied the SEM. The SEM is a widely recognised framework that allows for the investigation of the multiple levels of influence on health behaviours, making it ideal for investigating complex, multi-layered public health issues like those related to SRH.

The research findings will contribute to bridging the gap between SRH policy and practice, by providing valuable data that can inform future programmatic and policy decisions. Ultimately, the goal is to contribute to reducing the high rates of unplanned pregnancies, STIs, and other negative sexual health outcomes among South African youth, particularly in marginalised and underserved areas like Soshanguve.

1.6 LAYOUT OF DISSERTATION

Chapter 1: Introduction

The chapter serves as an overview of the study which includes the background, problem statement and significance of the study pertaining to SRH issues and services, as well as the research question, aim and objectives. It also establishes a foundational framework for the entire study. It outlines the social and contextual nature of SRH concerns by highlighting the

prevalence of RSB and challenges related to utilisation of clinic SRHIs. The research question, aim and objectives provide clarity regarding the study's purpose and scope, guiding the subsequent inquiry and analysis. The conceptual framework briefly describes the theoretical lens (SEM) underpinning the study.

Chapter 2: Literature Review

This literature review chapter encompasses various aspects related to the views and perspectives of young people and healthcare providers regarding RSB and SRH services in South Africa and globally. By dissecting existing literature, the chapter provides insights into, not only the perspectives of key stakeholders, but also into the policies and guidelines implemented for young adult SRH services in South Africa. It also discusses the SEM framework as a theoretical framework, thus providing a comprehensive understanding of the multifaceted influences on the experiences and views of both young people and SRH providers. The SEM framework considers factors at multiple levels, including the *individual*, *interpersonal*, *community*, *institutional* and *societal* levels, which are regarded as being essential for incisively analysing the dynamics of RSB and access to SRH service provision.

Chapter 3: Research Design and Methodology

This chapter explains the research methodology employed to ensure the reliability and validity of the findings. It describes the research paradigm including the design, setting, population and sampling, instrument development, participant selection procedures, data gathering techniques, and analysis methods.

Chapter 4: Findings

This chapter presents the findings from the interviews conducted with young adults and SRH providers. An overview is provided of the participants' demographics and the qualitative data gathered through semi-structured interviews. The findings are structured according to five SEM levels of influence (*individual, interpersonal, organisational, community and policy levels*). The chapter contains tables that display the key issues which include barriers and facilitators of SRH uptake among young adults from both young adults and SRH providers' perspectives. The chapter also includes direct quotes from both young adults and SRH providers concerning their experiences and views of clinic SRH services based on the five SEM levels of influence.

Chapter 5: Discussion

This chapter discusses the findings on the factors influencing the experiences and views of young adults and SRH providers of clinic SRH services among young adults. The discussion includes the implications of these findings. Moreover, it critically compares these findings with existing literature to identify commonalities, disparities, and areas requiring further exploration.

Chapter 6: Conclusions and Recommendations

This chapter provides an in-depth interpretation of the findings, suggests recommendations, and emphasises the relevance of the study in relation to its aim, objectives, and research question. It also outlines the implications of the SEM on the experiences and views of young adults and SRH providers regarding clinic SRH services.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

Reproductive health issues among adolescents are concerning, particularly regarding exposure to knowledge about contraception and consequences of unprotected sex (Netshikweta, Olaniyi & Tshitangano, 2018). This concern is exacerbated by the high incidence of early sexual debut, for example 74,4% in South Africa in 2021 and 67.6% in Tanzania in 2023, often occurring with the onset of menarche (McClinton et al., 2021; Millanzi, Osaki and Kibusi, 2023). This early exposure to sexual activity puts young people at the risk of unplanned pregnancies and STIs. Other risk factors regarding participating in early sexual activity include low school integration, inadequate maternal monitoring, and low self-esteem (Ngcobo, 2021). Lamentably, Netshikweta et al. (2018) found that one of the reasons for early sexual activity emanated because of being previously raped, while some adolescents claimed that they had planned it with their partners, felt compelled to do it out of curiosity, and pressured by peers. This emphasises the urgent need for providing sexual health education to young people to promote healthy sexual development and reduce negative outcomes of RSB (Netshikweta et al., 2018).

This chapter reviews relevant literature on the challenges faced by young people that contribute to RSB, strategies for addressing these challenges, and assessments of the current state of SRH services in South Africa regarding accessibility, and affordability. Additionally, the chapter assesses relevant policies and initiatives designed to enhance these services, specifically for young people. The literature review critically dissects the experiences and views of young adults and SRH providers by employing the SEM constructs. The focus is on understanding the factors that influence young people's utilisation of SRH services, including a comprehensive examination of the barriers and facilitators encountered by both individuals seeking services and those providing services. This literature review aims to highlight current issues in SRH services. By offering detailed insights, the review also informs the research design, methods, and discussion of the results.

2.2 YOUNG PEOPLE'S SRH SERVICES: POLICIES, UTILISATION AND CARE

Studies have emphasised the importance of policy recommendations and guidelines to improve the implementation and quality of SRH services (Ninsiima et al., 2021). For instance, the Adolescent and Youth Friendly Services (AYFS) framework has been widely promoted in

various African countries, including South Africa, focusing on equitable, accessible, and culturally sensitive SRH services (Ninsiima et al., 2021; Nyaga, Ongombe, & Mwangi, 2023).

Policies like the WHO's Strategic Approach to strengthening SRH programmes advocate for training healthcare providers and engaging youth in these programmes (Rashid et al., 2017). For example, in Migori County, Kenya, challenges in implementing youth-friendly services highlighted the necessity for better youth involvement and provider training. In South Africa, similar policies are being adopted to tackle the health and social risks associated with early sexual activity (Nyaga, Ongombe, & Mwangi, 2023). These policies and guidelines prioritise youth-friendly services, address cultural and religious considerations, and promote inclusivity which are meant to create an enabling environment for SRH providers to deliver comprehensive and quality care for all young adults at clinics (Ninsiima et al., 2021; Alomair et al., 2020).

2.2.1 Public Healthcare Systems in South Africa

According to the *National Adolescent Sexual Strategy and Reproductive Health and Rights Framework,* SRH care in South Africa is primarily provided through the public and private healthcare systems (NDoH, 2019b). The public healthcare system, funded by the Government, offers free or low-cost reproductive healthcare services to citizens and legal residents (Davids et al., 2020, Nkosi et al., 2019). This serves as a crucial facility for much of the population (49 million people or 83% of the total population) (Ngobeni, Breitenbach & Aye, 2020). However, private healthcare facilities, while offering SRH services, may pose challenges in terms of accessibility and affordability (Davids et al., 2020).

The reliance on the public (state-funded) system for SRH services in South Africa is high which indicates that young people are aware of and are maximally utilising these services (Davids et al., 2020). In 2016, the contraceptive use rate among sexually active women aged 15-49 was reported to be 67.9%, indicating a substantial level of access to contraception (NDoH, 2020). In 2019, 69.7% of pregnant women had accessed pregnancy services, and in 2020 approximately 68% of pregnant women accessed pregnancy services in the public healthcare sector, further revealing the high utilisation of SRH services (StatsSA, 2022). However, there are still significant challenges regarding access to contraceptives, as only 30% of adolescents (15-19 years of age) and young women (20-24 years of age) access them (NDoH, 2019). In 2019, approximately 3.1% of young women aged 15-44 accessed abortion services with the

public sector providing 20% of these services (NDoH, 2019). These challenges include long waiting times at healthcare facilities, a lack of youth-friendly services, and the fear of being judged by healthcare providers (Ngidi et al., 2018; Jonas et al., 2020; Ngwenya et al., 2020). Additionally, misconceptions about the side effects of contraceptives further discourage young people from using them consistently (Ngwenya et al., 2020). For instance, many young women avoid using certain contraceptive methods due to widespread beliefs that they may cause infertility or other long-term health issues, despite a lack of scientific evidence supporting these claims (Ngidi et al., 2018)

2.2.2 Constitutional Framework and SRH Rights

In South Africa, SRH rights are enshrined in *Section 27* of the *Constitution* (Republic of South Africa [RSA],1996), stipulating that everyone has the equal right to access healthcare services, including reproductive health care. These rights aim to assist adolescents and young people in accessing family planning, contraceptives, safe abortion and STI services, and addressing obstacles such as gender discrimination and inequalities in health services (SANAC, 2022).

The *Choice on Termination of Pregnancy (CTOP) Amendment Act 1 of 2008* (RSA, 2008) represents a critical policy shift by recognising women's reproductive rights, including reducing unsafe abortions. The amendment addressed legal inconsistencies, improved clarity, and enhanced the effectiveness of regulations related to pregnancy termination. The CTOP Act, as amended, allows abortions from the age of 12 but up to 12 weeks into pregnancy, and up to 20 weeks in critical circumstances such as when the pregnancy would put the health of the mother at risk and/or if the pregnancy is the result of incest, rape, or would affect the socio-economic wellbeing of the mother or her family (Kaswa & Yogeswaran, 2020).

Updated guidelines, such as the *South African National Contraception and Fertility Planning Policy and Service Delivery Guidelines* (2019), prioritise comprehensive SRH services, including counselling, education, and follow-up care, while emphasising dual protection and the engagement of men in SRH (Kassebaum et al., 2016; NDoH, 2019). These guidelines aim to enhance access to diverse contraceptive methods and support for making informed choices for individuals seeking contraception. Contraception is highlighted as a powerful public health tool which provides women (including young women) with access to safe and effective options to empower them in making correct decisions about their fertility (Kassebaum et al., 2016). Since women empowerment contributes to improved economic and social empowerment

opportunities, it also promotes birth-spacing for the wellbeing of children (Kassebaum et al., 2016).

2.2.3 Youth-Centric Policies and Recent Developments

In 1999, South Africa's Department of Basic Education (DBE, 1999) introduced the *National Policy on HIV and AIDS for Learners and Educators* followed by the implementation of the *HIV and AIDS Life Skills Education Programme* in 2000 which was revised in 2009 (DBE, 2012). This programme was integrated into the Life Orientation subject in secondary schools as a preventive strategy to combat the spread of HIV/AIDS among young people. The programme was implemented to ensure that young men and women aged 15 to 24 have access to information, education, and services necessary to develop life skills to reduce their vulnerability to HIV infection, including peer education programmes in schools (George et al., 2020). The DoH and DBE (2012) believed that by enhancing learners' knowledge, it would empower them to make responsible decisions regarding their sexual behaviour to prevent the transmission of HIV among them. However, challenges persisted, including the decision of determining the appropriate age for comprehensive SRH education (Rasesemola, Matshoge & Ramukumba, 2019; George et al., 2020).

In addressing SRH challenges especially among adolescents and young people, South Africa launched its *National School Health Policy* (NSHP) in 2003 (NDoH, 2019). The NSHP was implemented as a health promotion and preventive initiative for youth. However, it faced hindrances such as inadequate service provision, impractical nurse-to-school ratios, and a lack of referral services which led to gaps in facilitations at sub-district and school levels (Dibakwane & Peu, 2018). In response to these challenges, the *Integrated School Health Policy* (ISHP) was introduced in 2012 (DoH and DBE, 2012; Rasesemola, Matshoge & Ramukumba, 2019). The ISHP not only addressed immediate health problems of learners but also focused on the sub-district level, thus ensuring easier access to health facilities. A key aspect of the ISHP was collaboration between the DoH, DBE and Department of Social Development (DSD), which led to a comprehensive approach to learners' health (Rasesemola, Matshoge & Ramukumba, 2019).

In 2015, NDoH introduced the *National Adolescent SRH and Rights (NASRH&R)* framework to promote comprehensive sexuality education, free contraception, youth-friendly health services, evidence-based information-dissemination, and youth participation in SRH programmes and policies (NDoH, 2015). In 2019, it implemented the *National Adolescent and*

Youth Friendly Services Guideline to improve SRH services through policy updates, addressing challenges, and strengthening the overall effectiveness of the health system (NDoH, 2019).

The timeline of the policies outlined in Table 1 (below) represents ongoing commitments to achieving universal SRHR in South Africa.

Table 1: South African Policies Informing the National Adolescent SRH and Rights Framework Strategy

Act/Programme/Guidelines/Policy/Strategy/Plan/	Purpose
Choice on Termination of Pregnancy (CTOP) Act 1 of 2008	The main purpose of this policy is to regulate the termination of pregnancy in South Africa.
Youth Friendly Services Programme, Department of Health 2006	This programme aims to provide young people with access to friendly and non-discriminatory healthcare services, including SRH services.
Revised HIV and AIDS Skills Education Programme 2009	The purpose of this programme is to provide education and skills related to HIV and AIDS, aiming to prevent the spread of the disease and promote healthy behaviours.
Department of Basic Education (DBE) Guidelines for the Implementation of Peer Education Programmes for Learners in South African Schools 2011	These guidelines aim to implement peer education programmes in schools to address various health issues, including HIV, STIs, and TB among learners.
Integrated School Health Policy 2012	This policy aims to integrate health promotion, disease prevention, and curative services in schools to promote the health and wellbeing of learners.
Department of Health Integrated Strategy on HIV, STIs and TB 2012-2016	This strategy aimed to integrate efforts to address HIV, STIs and TB within the healthcare system, focusing on prevention, treatment, and care.
Health Sector HIV Prevention Strategy 2016	This strategy focuses on preventing the spread of HIV through various interventions, including behavioural, biomedical and structural approaches.
National Adolescent and Youth Health Policy 2016-2020	The purpose of this policy was to address the specific health needs of adolescents and youth, including needs related to SRH, mental health, and substance abuse.
National HIV Testing Services (HTS) Policy 2017-2022	This policy outlined the guidelines and strategies for HIV testing services to ensure widespread and accessible testing for HIV.
National Strategic Plan for HIV, TB and STIs, 2017-2022	The purpose of this plan was to provide a comprehensive framework to address HIV, TB and STIs including prevention, treatment, and support services.
DBE National Policy on HIV, STIs and TB	These policies aim to address HIV, STIs and TB within the schools by providing guidelines for prevention and management.
National Policy on the Prevention and Management of Learner Pregnancy in Schools	These policies aim to address pregnancy within the school environment by providing guidelines for prevention and management.
The South African National LGBTI HIV Plan, 2017-2022	This plan focused on addressing HIV within the LGBTI community, which included targeted prevention and support services.

Sources: RSA (2008); DBE (2012); NDoH (2019); SANAC (2022).

Another notable initiative within the sub-Saharan African public sector is the *Youth-friendly Sexual and Reproductive Health Services* (YFSRHS) initiative designed explicitly for young adults which aimed to create a safe and confidential environment by offering accessible and thorough care to promote sexual and reproductive wellbeing (Ninsiima, Chiumia & Ndejjo, 2021). The YFSRHS addressed the unique requirements of young people by providing information, counselling, and services related to contraception, STIs, HIV/AIDS, pregnancy prevention, and reproductive health education.

2.2.4 SRH Services Progress Evaluation

Progress Evaluation is a method used to assess the effectiveness and impact of interventions, policies or programmes, mostly within sub-Saharan African countries (Erasmus, Jordaan & Stewart, 2020). The evaluation involves comparing predetermined goals with actual outcomes to measure progress and identify areas for improvement. Evaluations from various nations, including South Africa, Ethiopia and Ghana, exposed the challenges and lauded the successes related to providing SRH services to young adults. Also, other factors such as community reactions, societal norms or beliefs towards SRH, and characteristics of the health system significantly influenced young adults' access to and utilisation of SRH services (Jonas et al., 2020).

In addition to *Progress Evaluation*, the *Right to Health Approach* emphasised that individuals and communities were entitled to the highest attainable standard of health as a fundamental human right outlined in international human rights law (WHO, 2004). In sub-Saharan Africa, this approach underscores the importance of *Availability, Accessibility, Acceptability, and Quality* (AAAQ) in the provision of SRH services (Jacobs et al., 2023). These elements are crucial for ensuring comprehensive and equitable healthcare services, including those related to SRH. *Availability* ensures that there are sufficient functional health services, while *accessibility* ensures that services are non-discriminatory, physically and economically reachable, and that information is easily accessible (WHO, 2023). *Acceptability* relates to respect for medical ethics, services that are culturally appropriate and sensitive to gender including health facilities, services and programmes that are people-centred and cater to the specific needs of diverse population groups in accordance with international standards of confidentiality and informed consent (WHO, 2023). *Quality* refers to underlying determinants of health; for example, effectiveness, safety, and client-centredness including that health facilities and services should be scientifically and medically approved (WHO, 2023).

The assessment of these AAAQ elements is crucial in shaping the delivery and utilisation of SRH services, as they focus on people' values, and acceptable health services and preferences of the target population. Studies conducted in sub-Saharan Africa have assessed these elements and identified factors that impact them in facilitating the utilisation of SRH services among diverse populations (Tilahun et al., 2021; Abdurahman et al., 2022; Jacobs et al., 2023).

Tilahun et al. (2021) conducted a study in western Ethiopia which assessed SRH services regarding access and utilisation among adolescents and youth. Factors such as age, sexual history, awareness of SRH services, and visits to health facilities for other services were identified as influencing accessibility and utilisation. In this regard, Jacobs et al. (2023) in Zambia, found challenges in the accessibility and utilisation of SRH services among young people, particularly in higher tertiary education institutions (HTEIs). Also, Abdurahman et al. (2022) investigated SRH service utilisation among Ethiopian adolescents in secondary schools which identified socio-cultural norms and fear of community judgement as significant barriers.

Similarly, in South Africa, multiple studies have been conducted to evaluate different aspects of SRH service provision and utilisation. For example, Geary et al. (2014) investigated the barriers to and facilitators of providing youth-friendly health services in rural South Africa that identified unmet needs in delivering SRH services to young adults. For instance, nurses reported the lack of youth-friendly training among staff, and the absence of a prescribed space to consult with young individuals. Also, some healthcare providers may not fully uphold the right of adolescents or young people to access health care independently, thus leading to potential breaches in confidentiality regarding young people's health; for example, they would reveal confidential information to their (young adults') parents (Geary et al. 2014). This means that understanding the specific needs and behaviours of the targeted population is crucial to ensure the accessibility and acceptance of SRH services, particularly in areas like Soshanguve. By addressing these concerns, healthcare providers and policymakers can teamwork towards providing comprehensive and equitable SRH services in sub-Saharan Africa.

2.3 THEORETICAL FRAMEWORK

This study adopted the SEM approach which was initially conceptualised by Bronfenbrenner (1979) and adapted by McLeroy et al. (1988). Bronfenbrenner (1979) emphasised reciprocal influences between individuals and their social contexts which encompassed family, school, community, and society. Building upon this foundation, McLeroy et al. (1988) tailored the

SEM specifically for health promotion programmes which recognised the intricate interplay among factors influencing health behaviours at various levels.

The application of the SEM model in SRH research, particularly in the sub-Saharan African context, is widely recognised as being valuable for understanding the multifaceted influences on SRH outcomes (Sidamo et al., 2023). The SEM model provides a comprehensive approach to examine the interplay of *individual*, *interpersonal*, *community*, *institutional*, and *policy-level* factors that impact SRH (Sharma et al., 2022). This model has been effectively utilised in public health studies to explore the nuanced factors that influence health outcomes, many of which exist externally to the individual (Spencer, 2022).

Particularly in sub-Saharan Africa, SEM model has been applied to understand the challenges and influences on adolescent contraceptive decision-making (Harrington et al., 2021), as well as to explore the impact of the COVID-19 pandemic on malaria and public health in the region (Heuschen et al., 2021; Amu et al., 2022). Furthermore, the SEM model has been applied in the USA and globally to conceptualise the effects of the COVID-19 pandemic on individuals with opioid use disorder which demonstrates its versatility in addressing diverse health issues (Cowan et al., 2021). The SEM model was also employed in the city of Plovdiv, Bulgaria, to examine the impact of the acoustic environment on university students' self-rated health during COVID-19 home quarantine, which emphasised its relevance in understanding environmental influences on SRH (Dzhambov et al., 2021). Additionally, the model has also been utilised in South Asia to explore young women's menstruation-related challenges (McCammon et al., 2020). This indicates its applicability in addressing SRH issues, especially its accessibility.

By utilising the SEM approach, this research uncovered not just individual factors, but also how the five elements of influence interact with each other. The insights gained by using this model provided a deeper picture of how these multiple and interactive factors impact the effectiveness of SRH services. In other words, the SEM framework serves as a comprehensive guide for understanding the determinants of health behaviours and designing effective health promotion interventions, particularly within the context of SRH. This is illustrated in Figure 1 below:

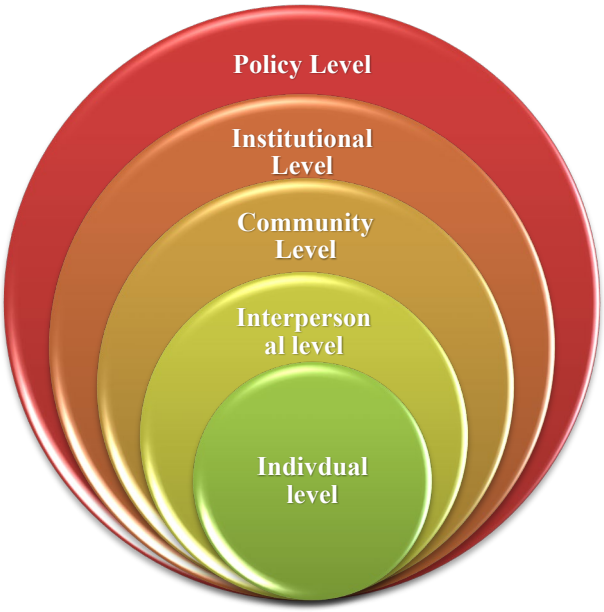

Figure 1: The Socio-Ecological Model

Source: McLeroy et al. (1988).

At the *individual level* factors such as age, knowledge, attitudes, beliefs, and self-efficacy play an important role in shaping SRH-related behaviours (McLeroy et al., 1988). For instance, these factors assist in determining whether young people engage in RSB and are free to access and utilise SRH services.

According to Garney et al. (2021), the *interpersonal level* involves relationships with family and peers which are crucial in understanding SRH. The support from parents, guardians or elders is essential for young individuals in navigating SRH-related activities. In a USA study, Pampati et al. (2020) found that family and peer relationships influence young people's knowledge, attitudes, and behaviour towards the use of SRH services. However, the yearning to fit into social group identities and adopt the normative behaviours of peers can strongly influence SRH choices and practices, thus adding a layer of social dynamics to their decision-making processes in this critical aspect of their lives.

At the *community level,* the focus is on the collective experiences, cultural norms, and resources within a specific community or neighbourhood (McLeroy et al., 1988). A Nigerian study found that these factors integrate to influence adolescents' access and the use of contraception (Ezenwaka, et al., 2020). Adolescents are vulnerable to misconceptions about contraceptive risks, particularly related to future fertility concerns rooted in gender and social norms (Harrington et al., 2021).

At the *institutional level,* the focus is on the impact of organisations, institutions, and structures on health-related behaviours (McLeroy et al., 1988). Based on a study conducted in Bulgaria, these entities can include systems such as schools, workplaces, healthcare organisations, and non-governmental organisations (NGOs) (Dzhambov et al., 2021). According to a South African study by Ngwenya et al. (2020), individuals are interconnected with these systems such that their behaviours and health status are shaped by features such as the youth-friendliness, trustworthiness of healthcare officials, and the policies implemented by these institutions.

Lastly, at the policy level, a South African study found that broader societal and political factors have influence on SRH services, including SRH laws, regulations and public health policies, strategies, legislation and guidelines that are developed to guide the implementation of services. These factors not only shape the availability and accessibility of these services but also affect the quality of care and the rights of individuals seeking SRH services, thus playing a critical role in clinic SRH outcomes (Ngwenya et al. 2020). According to a global systematic review, such measures could be implemented at the local, regional and at national healthcare and institutional levels (Hu et al., 2021). Institutions must therefore align their services with these policies, guidelines, and legislations to ensure consistency with the Government's objectives (Ezenwaka et al., 2020). This alignment is necessary for delivering effective services which can positively impact institutions and individuals' access to resources and opportunities for health promotion (Hu et al., 2022).

2.4 YOUNG ADULTS' EXPERIENCES AND VIEWS OF SRH SERVICES

In South Africa, especially the youth, face challenges related to discovering sex and sexuality which puts them at risk of contracting STIs and experiencing unplanned and early pregnancies (Mbatha, 2021). Factors such as poverty, poor parent-child communication, peer influence and early sexual debut contribute to these challenges. It is crucial to educate young people about condom use, contraceptives, STIs, HIV and AIDS, and other reproductive health issues to enable them to make informed decisions about their SRH (Mbatha, 2021).

Access to SRH services is therefore important to expeditiously identify the factors that influence adverse SRH outcomes to investigate them comprehensively (Obasanjo & Tlou, 2021). By targeting specific factors or barriers, interventions can be tailored to meet the specific needs of young people to improve their SRH outcomes.

This following section discusses through the SEM approach young adults' experiences and views of SRH services, both globally and nationally, by considering factors influencing the utilisation of services, including barriers encountered when seeking SRH-care.

2.4.1 Individual-Level Factors

Knowledge and awareness

In many South African communities, inadequate SRH knowledge has been identified as a major impediment contributing to early and unprotected sexual practices among adolescents (Murudi, Mashau & Ramathuba, 2020). Ajayi, Ismail and Akpan (2019) conducted a self-administered survey to identify factors associated with consistent condom use among students in Nigerian universities which included attitudes and perceived self-efficacy in negotiating condom use; they found that positive attitudes towards condom use and high levels of self-efficacy in negotiating condom use significantly increased the likelihood of consistent condom use among students. This implies that interventions aiming to promote consistent condom use should enhance students' confidence in their ability to negotiate condom use and foster positive attitudes towards condom use.

In South Africa, young people may have some awareness about specific contraceptives, but their knowledge about the various SRH services offered in health facilities remains limited (Siegfried et al., 2019). Mwamba et al. (2022) focused on assessing the SRH knowledge of postgraduate students at the University of Cape Town by offering valuable information on the understanding of SRH issues; the results revealed that respondents demonstrated knowledge about STIs or HIV/AIDS, including awareness of breast examination and the significance of Papanicolaou smear (Pap smear) in SRH. However, half the number of participants (49%) indicated that they did not require additional information regarding contraceptives.
Moreover, the study identified lecturers as one of the primary sources of information on SRH, indicating that the university setting plays a crucial role in providing students with essential SRH-related knowledge.

Further, Alomair et al. (2020) indicated that sexually active Muslim adolescents in 22 Islamic countries lacked an understanding of contraception, and the risk of pregnancy associated with their initial sexual experiences. These authors indicated that a significant number of adolescents reported that they were unaware of contraception methods and did not use any form of contraception during their first sexual intercourse.

In a study conducted by Bongongo and Govender (2019) in South Africa, it was found that some women lacked sufficient understanding of their fertility period, and when pregnancy is most likely to occur. Adolescent women aged 15-19 generally demonstrated limited knowledge of ovulation and were more likely to report unplanned pregnancies compared to older women.

Multiple researchers have found that educating women and young people on contraception significantly reduces the practice of unsafe sex and risky abortions (Alomair et al., 2020; Bongongo & Govender, 2019). Bongongo and Govender (2019) also report that woman-empowerment is crucial in reducing unwanted pregnancies and the rate of abortion in South Africa. By providing comprehensive SRH information, individuals can make informed decisions and avoid misinformation, myths, and the stigma surrounding SRH issues (Alomair et al., 2020). Greater education and information drives in health and educational settings could address the knowledge gaps to provide accurate and comprehensive SRH knowledge to young people (Siegfried et al., 2019).

Myths and Misconceptions

Jonas et al. (2020) conducted a study to explore the perceptions of contraception services among adolescent girls and young women in South Africa. They found that young people commonly cited myths and misconceptions as barriers to accessing contraception services. One of the misconceptions reported by young people was the belief that the injectable contraceptive affects body weight and shape which led to negative judgements and gossiping from others. This perception was influenced by social norms surrounding body weight, in addition to some young people expressing unfounded concerns related to the negative effects of contraceptive use on fertility. Hence, many feared that it could prevent them from having children in the future.

Lastly, in South Africa, the fear of being seen at the clinic for contraception services was mentioned by young girls as an additional barrier (Ngwenya et al., 2020). They expressed difficulty in visiting the clinic for these services due to the fear of being judged, stigmatised, and not afforded the protection of privacy (Ngwenya et al., 2020).

Self-Efficacy

The decision of a young person to engage in RSB may be influenced by the belief in the ability and self-efficacy to negotiate safer sex including the use of contraceptive methods (Tolera et al., 2019). In support, a Nigerian study identified perceived self-efficacy in negotiating condom

use as a significant factor (Ajayi, et al., 2019). These authors established that the level of an individual's self-efficacy determines his or her confidence in the relationship which should allow for discussion of sexual boundaries without the fear of rejection or feeling embarrassed.

Moreover, Ngcobo (2021) conducted a study in KwaZulu-Natal which revealed that high self-efficacy strongly influenced consistent condom use which prevented young people to engage in risky sexual activities when in a relationship. According to Tolera et al. (2018), high self-efficacy in Ethiopian young adults ensured transparency in sexual partnerships which included informing each other about their HIV/AIDS status and sexual boundaries. It also encouraged young people to confidently seek SRH services such as family planning without the fear of being judged. Conversely, young people with low self-efficacy were perceived as being diffident and reluctant to openly negotiate sexual boundaries, the use of contraceptives in intimate relationships, and freedom to visit healthcare facilities for SRH services (Tolera et al., 2019).

Low self-efficacy could stem from various factors, including a lack of comprehensive sexual education, societal norms and beliefs about gender roles and sexuality, and limited access to resources such as contraceptives (Tolera et al., 2019). For example, if a young person has received incomplete or inaccurate information about contraceptive methods, he/she may not feel confident in using them correctly (Ajayi, Ismail & Akpan, 2019). Lastly, if they have been socialised to believe that initiating conversations about safer sex or contraception is primarily the partner's responsibility, they tend to feel less empowered to advocate for their own needs (Tolera et al., 2019).

Nonchalant Attitude/Behaviour

A nonchalant attitude, as defined by Smith, Johnson and Brown (2018) refers to a lack of concern or indifference towards certain behaviours which results in risky decision-making without necessary precautions or consideration of potential risks. For example, individuals who are nonchalant may engage in substance or alcohol abuse and risky behaviours such as unprotected sex, without considering the risks involved (Francis et al., 2019). The more one indulges in substance-abuse, the more one's behaviour changes, leading to the increased likelihood of casual hasty sex and 'one-night stands' with strangers (Ajayi et al., 2018; Francis et al., 2019).

The attitude and behaviour of young individuals towards safe life practices also influence their likelihood of engaging in RSB (Ngwenya et al., 2020). In Nigeria, Ezenwaka et al. (2020) reported that young people are nonchalant about getting accurate information and utilising contraceptive services, even when such services are provided for free. Another Nigerian study by Ajayi at al. (2019) demonstrated that positive attitude toward condom use was significantly linked with consistent condom use. Students who held positive beliefs and attitudes towards condom use were thus more likely to engage in safe sex. The influence of perceived traditional cultural norms on condom use was also hindering safe sex practices (Ajayi at al., 2019). However, in another study also conducted in Nigeria, individuals reported feeling embarrassed to purchase or carry condoms, thus leading to the practice of not protecting themselves against STIs/HIV and unplanned pregnancies (Ezenwaka et al., 2020).

Financial Position

In South Africa, many women rely heavily on their male partners for financial support due to their poor socioeconomic conditions such that this dependency creates a weakened negotiating power for women to advocate for condom use during sexual intercourse (Hlongwa et al., 2020). The situation is exacerbated when women are less educated, unemployed, and reside in traditional rural areas. These situations further expose women to new HIV infections due to men's hesitancy of undergoing HIV testing.

Due to their poor financial position, some South African young people choose sex partners deliberately for material gain (Khuzwayo & Taylor, 2018). Handa et al. (2017) reveal that 80% of Kenyan young participants reported engaging in unprotected transactional sex because they were poor. Transactional sex is when young girls have sexual relationships with older men (and young boys with older women) for financial gain to acquire basic needs, improve their lifestyles, and overcome harsh economic conditions (Ranganathan et al., 2017). The younger one in this type of relationship has no power, especially in condom use. These results corroborate with other relevant literature studies reviewed in Ghanian and South African studies which expose imbalances in relationships regarding decision-making. This amounted to reduced reproductive autonomy and contraceptive negotiation which all could lead to unplanned pregnancies (Challa et al., 2018; Francis et al., 2019).

2.4.2 Interpersonal-Level Factors

Influence of Peers, Mass, and social media

During adolescence, social relationships become paramount as individuals focus on creating their identities (Landry et al., 2017). Given the importance of these relationships and adolescents' limited ability to fully control impulsive behaviours, concerns arise about the role of social media in their lives. Indonesia's University of Brawijaya reported platforms such as texting and social networking which provided opportunities for self-expression, intimacy, and privacy which allowed adolescents to shape their identities and cultivate intimate relationships (Fevriasanty et al., 2021). Additionally, a USA study emphasised that social media platforms are channels for acquiring health information; however, concerns exist regarding the quality and relevance of such information as related to health promotion and disease prevention (Landry et al., 2017). The belief in online privacy can lead to discussions about sensitive topics like drinking, sex, perversion, violence, suicide, and bullying, often with reduced parental oversight (Landry et al., 2017).

In South Africa, adolescents were reportedly influenced by peer pressure, concerns about social rejection, and the desire for popularity (Narker, 2021). Research indicates that adolescents are highly motivated by the prospect of peer approval and an elevated social status, often adjusting their behaviour to meet peer expectations (Narker, 2021). For example, a study conducted in the Netherlands found that most adolescents who discussed sexual matters with peers and discovered others were engaging in sexual activities, might feel encouraged to follow suit (Silva et al., 2019). Similarly, research by Challa et al. (2018) revealed that Ghanaian adolescents were more likely to engage in sexual activities if their peers exhibited increased sexual activity and approval.

A systematic review in the USA highlighted that adolescents involved in excessive texting or social networking were more prone to engage in risky behaviours, including early sexual activities (Landry et al., 2017). Furthermore, minorities, young people with less-educated parents, and single-parent households showed a higher likelihood of participating in risky online behaviours such as sexting (Landry et al., 2017).

Partner Support

In their study conducted in South Africa, Jonas et al. (2020) pointed out that the absence of support from male partners was recognised as a barrier to contraceptive use. Also, the role of male partners in family planning and contraceptive use was explored and found to be significant. In a study by Kriel et al. (2019) in KwaZulu-Natal, it was identified that social support, adequate information, and shared responsibility were pathways through which male

partners could positively influence family planning and contraceptive use. For instance, some young girls did not reveal their use of contraceptives to their partners due to their (boyfriends') lack of support, their misconceptions surrounding contraception, concerns about future infertility and decreased libido (Jonas et al., 2020).

In rural Uganda, Sileo et al. (2015) found a positive correlation between perceived partner attitudes and family planning advocacy, thus highlighting the importance of male support in promoting family planning. The study also indicated that women's perceived need for family planning was influenced by their partner's responsible attitudes on sexual matters (Sileo et al., 2015). Moreover, in urban Senegal it was found that couples who discussed family planning had a higher likelihood of using contraception as compared to couples who did not discuss it (Grabert et al., 2021). This emphasised the importance of couples that communicate in promoting contraceptive use. Additionally, in Angola, it was found that women who recently communicated with their husbands about family planning increased their odds of current contraceptive use (Weidert et al., 2016). This highlights the influence of male partners on women's contraceptive use while suggesting that involving men in family planning promotion efforts can be effective. In sum, understanding the barriers presented by male partners can help implement appropriate strategies to improve family planning policies and service delivery programmes (Kriel et al., 2019).

Poor Parental Communication

In an article on factors influencing young people's sexual activities written by Inanc et al. (2020), it was articulated that positive parent-child connectedness determines the sexual decisions of an individual. This article concurred with Muchimba's (2019) findings in South Africa which focused on predictors of risky sexual behaviour among young adults. It was reported that young adults who reported having a positive relationship with their parents, used condoms consistently and showed a greater intention to seek SRH services in the future (Muchimba, 2019). This is consistent with the findings of Massarwi et al. (2022), who demonstrated the effectiveness of a parenting-intervention, and *Parenting for Lifelong Health* (PLH) in reducing stress among parents of adolescents aged 12-18 in South Africa. Maina et al. (2020) emphasised the importance of parent-child communication regarding sexuality and HIV/AIDS in sub-Saharan Africa, underscoring the benefits of education in discussions about the potential derailment of adolescents' future goals due to risky sexual endeavours (Maina et al., 2020).

Additionally, positive relationships between adolescents and their parents have also been associated with improved interaction and important conversations about sensitive topics. Gumede et al. (2022) who investigated opportunities and barriers to DREAMS (*Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe*) concerning adolescents with grandparent caregivers in rural KwaZulu-Natal, found that they are disproportionately affected by the HIV epidemic. It must be noted that DREAMS is a public-private partnership aimed at reducing new HIV infections among adolescent girls and young women in sub-Saharan Africa.

Furthermore, according to some South African research findings, young adults reported not being comfortable communicating with elders, including their parents, about sexual relationships, condom use, and any other issues related to SRH (Ngidi et al. 2016; Narker, 2021; Duby, Verwoerd & Isaksen, 2022). Instead, they felt free to communicate and seek sexual advice from their peers (Ngidi et al., 2016). Even though some of the information they access could be misleading (Duby, 2022), some adolescents feel that being in a peer group liberates them because that is where they are comfortable and confident to converse (Ngidi et al., 2016). However, their behaviour and decisions differ according to the values of their peers. Having sound and ethical peer role-models who exhibit healthy behaviours could limit risky behaviours (Inanc et al., 2020).

Further studies revealed that some adolescents avoided speaking to their mothers about issues related to sex out of concern that they may assume they (youths) are sexually active (Narker, 2021). If they were to admit to being involved in a romantic relationship or simply ask their mothers questions about sex, parents would usually be angry and even criticise them (Duby, Verwoerd & Isaksen, 2022). As a result, adolescents avoid seeking advice from their parents due to the fear of causing conflicts or being judged.

In another South African study, adolescents mentioned that parents are also not comfortable discussing sexual topics with their children because it is a cultural taboo to talk about sex with teenagers (Ngidi et al., 2016). In Nigeria, parents confessed to being shy to communicate with their children about SRH issues - so teenagers hear it from their peers which can be mostly inaccurate information (Ezenwaka et al., 2020). A Tanzanian study found that whenever parents communicate about SRH topics with their adolescent children, they conceal some information that creates misunderstandings and often contradicts what was learnt from peers and from social media information (Mcharo, Mayaud and Msuya, 2021). Common reasons were that communicating about sexual issues, contraceptives, and condoms could ruin their

children's innocence (Duby et al., 2022). Further, these adolescents could perceive such conversations as approval to engage in sexual activities, thus encouraging promiscuity, having multiple partners, and risk-taking behaviour.

2.4.3 Community-Level Factors

Cultural and Social Norms

In Ghana, cultural and religious norms are associated with abstinence from premarital sex, the lack of comprehensive sex education, and limited access to quality SRH care (Challa et al., 2018). In a study's focus group discussion, South African adolescent girls reported that they were often viewed as wayward when seeking SRH services; hence, it was observed that adolescent girls were less likely to seek sexual advice until they became older because they developed feelings of shyness and embarrassment (Ezenwaka et al., 2020).

Stigmatisation and discrimination by the community were also cited as causes of discouraging young people from accessing SRH services in South Africa (Bohren et al., 2022). Young people reported that in their communities, visiting public clinics for any healthcare service was often associated with tuberculosis, HIV, and other STIs (Bohren et al., 2022). Among young South Africans, this stigmatisation was even more pronounced when accessing SRH services which led to rumours which deterred young people from using SRH services (Ezenwaka et al., 2020).

Cultural factors such as stigma surrounding sexuality can also influence policy development related to SRH. For instance, Nigerian studies revealed that some cultures view premarital sex as taboo which resulted in limited openness about comprehensive sexuality education limited awareness of available contraceptive methods that increased teenage pregnancy rates (Adedini et al., 2014; Ezenwaka et al., 2020).

Gendered Social Norms

In South Africa, gendered roles and inequalities still prevail, thus fostering ignorance, naivety and timidity among adolescent girls, as well as limiting their likelihood to access information about contraception and other SRH services (Ezenwaka et al., 2020). Similarly, Kenyan adolescents' contraceptive decision-making was also influenced by social factors such as stigmatisation of female sexuality, pregnancy and contraceptive use, and unequal power dynamics in sexual relationships (Harrington et al., 2021).

Siegfried et al. (2019) and Agu et al. (2022) compared the effects of social norms and GBV (gender-based-violence) which affected girls in South Africa and Nigeria - it was found that young men have complete control over sexual-related activities and decisions. These gendered norms contribute to the expectation that adolescent girls should abstain from sex until they are older, completed schooling, and have found the right partner (Siegfried et al., 2019). These beliefs ultimately deprive young women of their rights to sexual autonomy which undermines their ability to be in control of their bodies, and lives (Siegfried et al., 2019).

Similarly, in Uganda, a substantial majority of respondents (73%) agreed with the social norm that adolescent girls should not have access to contraception, reflecting a prevailing cultural belief that potentially aims to protect adolescent sexuality (Bukuluki et al., 2021). This restrictive attitude was more common among those currently or previously married. However, respondents who believed that sexually active girls could use contraception to prevent unwanted pregnancies, and that either married and unmarried women or girls should have access to contraception, were more supportive of adolescent girls' access to these services. Additionally, significant regional differences were observed, with the restrictive view being widespread across all studied countries, highlighting the need for localized interventions to address these cultural norms and promote reproductive health rights (Bukuluki et al., 2021).

Religious Norms

In South Africa, various religions view pre-marital sexual intercourse and the utilisation of contraceptives among unmarried adolescents as taboo, immoral, and sinful, thus leading to limited discussions about SRH issues and contraceptives (Pillay et al., 2020; Ezenwaka et al., 2020; Ngwenya et al., 2020). One church leader, a participant in the study conducted by Ezenwaka et al. (2020), opined that it is Biblically wrong to tell a young person that whenever they want to have sexual intercourse, they must consider using condoms to protect themselves from STIs or unplanned pregnancies. In a study conducted in Nigeria, adolescents indicated that according to religious norms, hugging, touching and kissing were inappropriate for unmarried individuals, and that pre-marital, casual, transactional, and age-disparate sex activities were viewed as unacceptable (Ezumah et al., 2021). Such perceptions can hinder sex education efforts to promote safe sexual practices and contraceptive use (Agu et al., 2022). Lastly, it could also hinder parental involvement in HIV prevention or SRH involving adolescents (Agu et al., 2022).

2.4.4 Institutional-Level Factors

Poor service-provider competency

A Nigerian study revealed that inefficient provider competency, scolding adolescents, and reluctance to provide quality services hinder the utilising of SRH services (Ezenwaka et al., 2020). South African young people reported that they would appreciate healthcare providers who take their time to discuss in detail SRH issues such as contraceptive methods, lauding those who make them feel comfortable to choose their preferred method (Jonas et al., 2020). This personalised approach helps them understand the differences between contraceptive options and other SRH alternatives without feeling embarrassed (Jonas et al., 2020). Unfortunately, inadequate counselling for young people, complaints about the process of providing quality services, and the physical environment conditions were identified as major barriers to quality of care in Gambian SRH clinics (Lowe et al., 2021). Jonas et al. (2020) noted that expeditious and efficient service encourages young people to return for future visits, especially when seeking preventive measures.

Confidentiality and Privacy

A narrative review on privacy, confidentiality, and healthcare provider bias meted out to young people in low and middle-income countries found that there were significant barriers to young people's access to health care (Corley, Sprockett & Montagu, 2020). Ngwenya et al. (2020) cautioned that the absence of privacy and confidentiality in South African public healthcare systems erodes self-confidence and trust among young adults, thereby affecting the utilisation of SRH services. In Canada it was found that most young people felt that their relationships with SRH providers lacked the feelings of comfort and trust, indicating the need for enhancement in the quality of health care (Lys et al., 2019). Similar experiences were documented in a global systematic review South Africa, which revealed that SRH providers did not respect confidentiality, in addition to providing inappropriate information to young people (Bohren et al., 2022).

Similarly, the study conducted in the USA found that there was the lack of privacy and confidentiality among young adult males when accessing SRH (Steiner et al., 2019). These young adult males reported feeling uneasy about obtaining condoms or STI tests in public health facilities in the presence of adults seeking health care. This uneasiness underscores the need for healthcare facilities to ensure that there are private consultation and treatment spaces,

in addition to following stipulated guidelines on confidentiality to better serve young people seeking SRH care.

Accessibility of Services

Studies conducted in sub-Saharan Africa showed that young people harbour negative attitudes about government or public healthcare facilities because of bitter experiences (Onokerhoraye & Dudu, 2017; Abuosi & Anaba, 2019; Sidamo et al., 2023). Young people mentioned that government/public health facilities are characterised by long waiting times and inconvenient hours which further discouraged them from accessing SRH services (Sidamo et al., 2023). In support, Onokerhoraye and Dudu (2017) agree that in Nigeria adolescents were appalled at overcrowded facilities with long queues. They further mentioned that if long waiting periods continue, they might stop using the SRH services.

Other studies focusing on adolescent healthcare access and utilisation in Ghana and South Africa highlighted the issue of inconvenient clinic hours. Young people, especially students, faced challenges such as attending clinics which have restricted hours of operation, thus leading to the under-utilisation of essential SRH services (Abuosi & Anaba, 2019; Hlongwa, Tlou & Hlongwana, 2021). In support, a qualitative study by Ouma et al. (2021) explored contraceptive decision-making among youth in different countries including Kenya, Nigeria and Uganda which identified barriers such as inconvenient facility hours, long waiting times, stigmatisation from the family and community members, and providers who deterred youth from accessing various contraceptive methods.

Also, the cost factor can also be a constraint as some young people (mainly the unemployed and students) may not be able to afford the services (where applicable) and may feel uncomfortable seeking financial assistance from friends or family (Mengesha et al., 2017). Lastly, distant SRH facilities, coupled with limited and costly access to transport, act as a barrier to reach service providers (Mulaudzi, 2023).

Healthcare Providers' Behaviours

Most young people mentioned that accessing public healthcare facilities, particularly for services such as SRH and HIV/STI testing and treatment, often led to judgemental behaviour and unfriendly attitudes from SRH providers (Smith et al., 2018). Young people mentioned that nurses shout at them, humiliate them, ask embarrassing and personal questions, and make cynical comments in front of others at the clinic (Jonas et al., 2020). Other South African

participants reported poor services from SRH providers including yelling, scolding, and embarrassing them by disclosing their contraceptive needs to other healthcare workers (Ngwenya et al., 2020; Ezenwaka et al., 2020). Conversely, some young people lauded the healthcare providers' positive attitudes in facilitating access to contraception services (Jonas et al., 2020). According to them, positive and welcoming attitudes at the clinic encourage them to continue seeking contraception services (Jonas et al., 2019). The pleasure they feel when nurses are happy to see them coming for contraceptives further motivates them to utilise these services (Jonas et al., 2019).

Shortage of Contraceptives and Other Supplies

Hlongwa et al. (2021) who addressed the challenges faced by adolescent girls in accessing modern contraceptives in South Africa, found that over 60% of the respondents cited the unavailability of contraceptives as a primary reason for poor contraception usage. Another study conducted in various sub-Saharan countries like Ethiopia, Zambia, Uganda and Kenya exposed how out-of-stock items hinder young people from seeking SRH services (Sidamo et al., 2023). Young people mentioned that sometimes when they asked for contraceptives or pills or condoms in clinics, the nurses would say that such items were unavailable (Sidamo et al., 2023). This situation often led to frustration resulting in young people not fully utilising SRH services.

2.4.5 Policy-Level factors

Integration of SRH services

The Ministry of Health has implemented an SRH programme that offers integrated services, comprehensive sexuality education, and information tailored to the age and needs of children, adolescents, and young adults (DoH, 2019). The SRH service integration refers to different varieties of SRH and HIV/AIDS services or holistic operational programmes that can be combined to address the diverse needs of individuals to maximise collective positive health outcomes (DoH, 2019; UNAIDS, 2010). The aim was to ensure that individuals are enabled to access all necessary services in one location, thus reducing barriers to health care to improve SRH outcomes (Smit et al., 2012).

In Limpopo Province (South Africa), the integration of SRH services with routine medical care is crucial for addressing the needs of young people to ensure easy access to comprehensive health care (Mulaudzi, 2022). This integrated approach aligns with the preferences of young people who value convenience and the multiple 'one-stop' services which saves them time and

effort. In a sub-Saharan African systematic review, Nkhoma, Sitali and Zulu (2022) praised the integration of services like contraception, post-abortion care, and HIV services under one roof such that young adults were able to receive comprehensive SRH care discreetly, and all at once. This approach saved their time, reduced the need for multiple appointments at different clinics or clinic sections, and ensured that individuals could access necessary services without fear of stigmatisation or privacy breaches (Nkhoma, Sitali & Zulu, 2022).

This is in line with what UNAIDS (2010) emphasised at the 26th Programme Board Meeting; namely, that the combination of SRH and HIV services should prioritise 'people-sense' by acknowledging that health systems must cater for individuals at one site. However, Kabakian-Khasholian et al. (2020), Mulaudzi (2022) and Mengesha et al. (2017) found that despite the benefits of integrated SRH services, there were still accessibility barriers that young people faced including the location of SRH services, the level of privacy offered by such facilities, and the age and gender of clinic employees.

Programme Territorialism

Territorialism is when healthcare providers or organisations establish and maintain restricted control over specific populations such as the disabled and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Asexual (LGBTIQA+) youths or geographical areas such as remote villages which limit access to comprehensive SRH services - a violation of their human rights (Afulani et al., 2018) A report compiled by the Guttmacher Institute in 2020 criticised territorialism as it restricts access to SRH services, which leads to delays in care and increased health risks for individuals seeking these services (Lindberg, Bell & Kantor, 2020).

A systematic review on pro-equity legislation, health policy, and utilisation of SRH services by vulnerable populations in sub-Saharan Africa found that social health inequalities persisted among subgroups of women, indicating that certain populations may face additional barriers in accessing SRH services (Feroz et al., 2021). Gender is another key factor to consider, especially in terms of developing youth-friendly programmes/policies (Jacobs & George, 2023). Gender inequality and power dynamics shape the experiences and behaviours of young people regarding SRH services. Dominant discourses in policy documents often reflect fixed, categorical identities of gender which may overlook the specific needs and challenges faced by the LGBTIQA+ youths (Jacobs & George, 2023). It is thus critical to stipulate and follow gender equality principles in policy development to ensure that the needs of all young people are met.

Furthermore, physical inaccessibility to SRH services can exclude young adults from poor backgrounds, including disabled ones seeking contraceptive services (Feroz et al., 2021). These challenges are multifaceted and include physical, attitudinal, and informational barriers. For instance, women with disabilities face difficulties in accessing maternal health care due to staff insensitivity, negative attitudes, and the lack of health information specific to their needs (Ganle et al., 2016). Individuals with disabilities in rural areas of South Africa encounter barriers to accessing PHC due to distance and unreliable public transport, which contributes to their non-use of healthcare services (Tshaka et al., 2023). This highlights the importance of addressing infrastructural concerns for easy access to SRH services such as adequate qualified staffing, physically comfortable environments, and smooth service delivery processes to ensure equal access and enhanced services for all young people in sub-Saharan Africa.

Restrictive Law

National and local policies in South Africa should be all-encompassing to ensure access and quality of SRH services. Before the CToP was enacted in 1996, unsafe abortions were a major cause of maternal deaths (Kaswa & Yogeswaran, 2020). This law decriminalised abortion which ensured that abortion-related deaths significantly decreased, thus highlighting the positive impact of legalised abortion. However, despite the promulgation of this law, young adults in South Africa still encounter obstacles in accessing safe abortion services (Kaswa & Yogeswaran, 2020). This could be because abortion is a time-restricted health service. The CTOP Act provided restrictive pregnancy times which could make it challenging for young people to seek legal abortions. Legal abortions are only available up to 20 weeks of pregnancy, or in the case of rape, financial hardships, incest, reasons related to the health of the mother, or when the pregnancy has severe abnormalities that threaten the pregnant mother's life (Lince-Deroche et al., 2019).

Also, certain public healthcare sectors establish daily quotas for abortions, leading to patients being turned away once the limit is reached, thus creating barriers to legal abortion services (Kaswa, 2021). The law allows SRH providers to refuse abortion based on personal or religious beliefs but mandates referring patients to willing providers (Kaswa & Yogeswaran, 2020). Consequently, some young people may opt for unscrupulous illegal providers due to easier access and less perceived judgement.

School-Based Programmes

Adekola and Mavhandu-Mudzusi (2023) and Jonas et al. (2020) indicate that some young South African people expressed the idea that it would be beneficial if contraception and other family planning services were available within school premises. They believed that having nurses available at school would make it convenient for students to access contraceptives without leaving their homes or asking their parents to go to the clinic (Adekola & Mavhandu-Mudzusi, 2023). Moreover, they felt that this could be helpful for adolescents who are hesitant to go to clinics or face challenges in discussing contraception with their parents (Jonas et al., 2020).

Similar research findings emanated from research in other countries; for instance, Papineau et al. (2021) evaluated student pharmacists' attitudes and perceptions of hormonal contraception prescription in Indiana, USA. The study found that most females had a history of using hormonal contraceptives and believed that the availability of contraception services within schools would be beneficial. In the Netherlands, young people expressed dissatisfaction with the quality of sex education they receive in high schools as they rate their sex education as being mediocre and believed that more comprehensive and ongoing sex education is needed throughout their school years (Cense et al., 2020).

Yau et al. (2021) examined the prevalence and correlates of contraceptive use among vocational school adolescents in Northern Thailand which exposed the need for up-to-date knowledge of influencers and barriers to contraceptive use because vocational school students have been reported to engage in unprotected sex due to having negative perceptions of condom use (Yau et al., 2021). In South Africa, the school initiative seems beneficial; however, cultural taboos surrounding discussions about sexuality still exist, particularly in the Limpopo Province (Munyai et al., 2023). Traditionally, sexuality is discussed in hushed tones and is considered a topic reserved for adults, thus making it difficult for modern programmes and other SRH intervention strategies to succeed (Munyai et al., 2023).

2.5 SRH PROVIDERS' EXPERIENCES AND VIEWS OF YOUNG ADULTS' SRH SERVICE PROVISION

This section examines SRH providers' experiences and views on SRH services at both the global and national levels. It explores through the SEM approach various aspects such as providers' attitudes, knowledge, and communication practices concerning the sexual health needs of young adults.

2.5.1 Individual-Level Factors

SRH providers' experiences and views of SRH services are influenced by their personal beliefs, attitudes, and knowledge. A study in California found that SRH providers' negative attitudes towards adolescent or the LGBTI group acted as barriers to providing comprehensive and inclusive care (Decker et al., 2021). In a study by Jonas et al. (2019) which explored the beliefs and views of South African nurses regarding adolescents' SRH services, there was a conflict between their personal beliefs and their professional code of conduct. Some nurses had strong feelings against certain components of SRH services for adolescents, such as the use of family planning and termination of pregnancy (ToP). These feelings were associated with their personal beliefs, which may be against the ToP. Nurses also recognise their professional duty to provide these services regardless of their personal beliefs, as it is part of their professional code of conduct. While most nurses understood this responsibility, some still struggled to provide ToP services to adolescents or adults due to their personal beliefs, despite their professional obligation (Jonas et al., 2019).

Similarly, Hlongwa et al. (2021) investigated SRH providers' knowledge and perceptions regarding the use of modern contraceptives among adolescent girls in KwaZulu-Natal, South Africa. The findings revealed that nurses may act in an unfriendly manner toward adolescent girls seeking SRH services because of their perceptions of adolescent girls' sexual activity. For instance, some nurses reported that providing girls with contraceptives or family planning services would promote promiscuous sexual activity; hence, they legitimise their unfriendly manner (Hlongwa et al., 2021).

2.5.2 Interpersonal-Level Factors

Interpersonal factors such as communication practices as well as relationships between SRH providers and patients also play a crucial role in influencing the quality of SRH services (Napit et al., 2020). Positive and supportive provider-patient relationships could enhance patient satisfaction and improve access to healthcare (Napit et al., 2020). In other words, when SRH providers establish a trusting and empathetic relationship with their patients, it can enhance patient satisfaction and their healthcare experience (Davies et al., 2020). Patients who feel heard, respected, and involved in their aspects of healthcare are more likely to be satisfied and have better health outcomes (Davies et al., 2020).

Ndayishimiye et al. (2020) found that trust between healthcare providers and patients is critical for understanding and addressing patients' needs, especially in sensitive areas such as SRH. In

other words, communication that is open, respectful, and free of judgement can help in identifying and resolving issues that might otherwise remain neglected (Ndayishimiye et al., 2020). Conversely, poor communication can lead to misunderstandings, distrust, and dissatisfaction which may prevent patients from seeking necessary SRH services (Engelen et al., 2019).

A review of sexual health communication between healthcare professionals and adolescents in Western countries found that both patients and professionals perceive sexual health as a taboo topic and thus feel uncomfortable discussing it (Engelen et al., 2019). According to these authors, personal and practical barriers also hindered discussing sexual health. In addition, healthcare professionals at some point felt uncertain about how to approach the topic of sexual health with young adults, particularly those with chronic conditions. This discomfort and uncertainty could lead to the avoidance of discussions about sexual health, thus negatively affecting patients' overall wellbeing (Engelen et al., 2019).

2.5.3 Community-Level Factors

Community factors including social norms and cultural beliefs significantly impact SRH providers' perspectives and practices related to serving young people (Rizvi et al., 2020). Socio-cultural norms and taboos surrounding adolescent sexual health often led to fear, shame, and restricted access to healthcare services (Salehin et al., 2020).

Salehin et al. (2020) conducted a global systematic review which revealed that SRH providers' attitudes and practices were mostly influenced by community norms regarding topics like contraception, abortion, and premarital sex. In communities where these issues are stigmatised and referred to as taboo, providers would exhibit judgemental attitudes jeopardising the quality of health care among young people.

Also, South African SRH providers' religious beliefs on specific SRH services such as abortion, further contribute to challenges in healthcare service delivery (Hlongwa et al., 2021). Jim et al. (2023) maintain that South Africa healthcare providers involved in abortion services face significant stigmatisation by being labelled with derogatory names like ‘baby killer’ or ‘murderer’, thus reflecting societal prejudices not only against young females seeking abortions, but also against the providers themselves.

The above studies highlight the urgency to address and solve challenges emanating from communities to enhance the delivery of SRH services for young people. In this regard,

interventions must transcend merely enhancing SRH providers' knowledge and skills – they must also change mind-sets ingrained in traditional sociocultural norms and attitudes within communities to create a more supportive and non-judgemental environment for young individuals seeking SRH services.

2.5.4 Institutional-Level Factors

At the global institutional level, SRH providers' experiences and perspectives on SRH services are profoundly influenced by different variables. In sub-Saharan Africa, it was found that structural and logistical barriers such as shortages of trained staff and dedicated spaces for specific populations posed significant challenges (Ninsiima et al., 2021). According to these authors, inadequate training and limited resources hinder providers from offering youth-friendly services and addressing the specific needs of certain populations, including adolescents and gender expansive[2] youth.

Studies have pointed out that SRH providers, particularly nurses, face substantial time pressure, which affects the quality of patient care in South Africa (Jonas et al., 2019). This pressure results in rushed provider-patient interactions that limit attention and information-sharing. Shortages of clinic staff and essential equipment exacerbate the challenges which leave nurses feeling that the healthcare system does take them seriously as it prioritises quantity over the quality of services (Maphumulo & Bhengu, 2019).

Additionally, the lack of ongoing training among SRH providers in South Africa remains a major barrier which leads to nurses delivering sub-standard family planning services, or they leave for greener pastures (Hlongwa et al., 2020). Also, the lack of institutional support, funding constraints, and inadequate equipment including educational materials, further constrain the public health sector's ability to effectively address healthcare challenges (Malakoane et al., 2020). In Nigeria, institutional factors affecting access to SRH services include insufficient funding, scarcity of trained SRH providers, and the absence of comprehensive SRH services in certain areas (Ezenwaka et al., 2020). A Simmons College systematic review reported that training programmes have emerged as a potential solution, which aims to enhance nurses' knowledge, attitudes, beliefs, and confidence in discussing sexual health topics with patients (Fennell & Grant, 2019). These programmes are essential to

[2] Gender expansive is used to describe individuals whose gender identity, expression or experience does not align with what is typically associated with the sex they were assigned at birth. In other words, gender expansive refers to individuals who are non-cisgender, including individuals who identify as binary, non-binary or transgender (McKay and Watson, 2019).

bridge the knowledge gap among SRH providers to improve the quality of health care, especially in SRH departments.

A study in Nigeria revealed that many facilities lacked a comprehensive range of SRH services, especially for adolescents (Envuladu et al., 2023). Facilities that did provide such services primarily focused on adult health care, which did not meet the unique needs of young people (Envuladu et al., 2023). This limited availability of adolescent centred SRH services could lead to their under-utilisation by young individuals. Similar barriers were found to exist in Nepal which included insufficient knowledge about SRH services, community obliviousness to such services, and limited peer-counselling at healthcare centres (Adhikari & Adhikari, 2021). In Ethiopia, service providers identified barriers like the lack of information, negative attitudes toward SRH, insufficient parental and social support, and inadequate implementation of SRH programmes, which hindered youth friendly SRH services (Habtu, Kaba & Mekonnen, 2021).

2.5.5 Policy-Level Factors

This section describes existing findings on policy-related factors affecting the effectiveness of SRHR policies governing the provision of SRH services and education.

Dilemmas Faced by Health Service Providers

While there are inclusive policies being implemented, including the South African *National Integrated SRHR Strategy on Service Delivery Guidelines* and the *Adolescent and Youth Health Policy* (NDoH, 2020), their effectiveness is questionable. Although these policies aim to ensure that adolescents and young adults have access to quality SRH services and education, healthcare providers often encounter a dichotomy between their personal beliefs and their professional responsibilities (Davids et al., 2020; Corley et al., 2022). For instance, some South African providers may have reservations about providing contraception or abortion services to young people due to personal or religious beliefs (Sidibé et al., 2022). This creates a dilemma as they must subtly circumvent these personal beliefs while upholding the rights of individuals to access SRH services (Davids et al., 2020).

Further, community stigmatisation associated with adolescent SRHR exacerbates the phenomenon under investigation. Health service providers sometimes exhibit judgemental attitudes towards young people seeking SRH services which can deter patients from accessing the necessary healthcare service (Bohren et al., 2022). These attitudes can be attributed to both

traditional societal norms and the lack of adequate training for providers on youth-friendly care services (Bohren et al., 2022).

The South African context also requires that regular updated knowledge and sensitivity-training be prioritised in ensuring that providers offer non-judgemental supportive care that aligns with both policy guidelines and the rights of young individuals (NDoH, 2020; Sidibé et al., 2022). Moreover, policymakers must consider the on-the-ground challenges to revise guidelines that bridge the gap between policies and practice (Sidibé et al., 2022).

Lack of Funding and Resources

Financial difficulties and under-funding of SRH clinics were identified as key barriers to accessing SRH services (Lince-Deroche et al., 2019). This lack of funding was noted in crisis settings such as among Syrian refugees in Jordan, where there is a lack of national coordination, inadequate logistical support systems, and insufficient funding for SRH services which severely impacted the delivery of comprehensive SRH services (Lince-Deroche et al., 2019).

A study conducted in Ethiopia found that the COVID-19 pandemic had exacerbated the dire challenges such that health systems' resilience and SRH service adaptation became overwhelmed due to the lack of external support and funding (Chekol, Muluye & Sheehy, 2023). Also, funding constraints hinder opportunities for linkages between SRH and HIV/AIDS programmes, thus affecting service delivery systems particularly in sub-Saharan Africa (Ng'andu et al., 2022). In an African scoping review, it was found that the lack of funding hinders the advancement of sound reproductive health on humans, especially when SRH receives a lower proportion of requested funds compared to other health sectors (Adu et al., 2022). This lack of funding not only affects the availability of services, but also the quality and accessibility of SRH care, which ultimately hinders the provision of adequate SRH services in South Africa (Maphumulo et al., 2019).

School-based and Community Education Approaches

Studies confirm the existence of programmes and initiatives like School-Based and Community Education Approaches which were implemented in South Africa to improve SRH outcomes among young people to enhance their knowledge (Mavhandu et al., 2022). In Tanzania, an evaluation of sex and HIV education programmes among young people in schools and community settings by Mcharo et al. (2021) found that such programmes were likely to have a positive impact on delaying sex, reducing the number of sexual partners, and increasing

condom and contraceptive use. In South Africa, Mavhandu et al. (2022) monitored the implementation of a school-based sexuality education programme and confirmed that sex education is crucial in promoting positive sexual health outcomes among learners.

Moreover, Ngabaza (2023) emphasised the need for South African young people to be taught skills to manage their sexuality, with schools being identified as the best place to provide accurate information. The benefits of sex education included the aspects of sexual awareness, self-respect, and motivation to maintain positive sexual health outcomes. However, another South African study by Mavhandu et al. (2022) identified barriers such as the lack of proper integration of the SRH programmes into the school systems due to inadequate implementation into existing educational frameworks and policies. Adekola and Mavhandu-Mudzusi (2023) identified another major barrier – the lack of well-trained sexuality education teachers. The authors found that some teachers provide basic information on abstinence and avoid sensitive topics such as sex, contraception, and gender identities. This can result in underprepared teachers who lack confidence in facilitating sex education lessons.

Furthermore, a negative attitude towards sex education among learners and teachers can also hinder its effective implementation (Adekola & Mavhandu-Mudzusi, 2023). Adekola et al., (2021) notes that some rural participants expressed concerns that sex education may motivate learners to engage in sexual activities. Such perceptions may lead teachers to skip certain aspects of the sex education curriculum, such as contraception fearing that learners may interpret the lessons as freedom to engage in sexual activities. Thus, it is crucial to provide continuous professional training and mentoring, in addition to integrating sex education pedagogy into teachers' pre- and in-service training to enhance their skills and knowledge. Muremela et al. (2023) pointed out that efforts should be made to attract and retain qualified teachers in the social sciences subjects in South African rural schools to ensure the provision of quality sexual health education.

Ngabaza (2023) exposed the tension between policy expectations and personal/community values which could impact on how learners and educators approach sex education. This author referenced the #LeaveOurKidsAlone hashtag movement as an example of adult voices resisting the sex education curriculum in schools which reflected that adults' resistance weakened the rolling-out of the comprehensive sexuality education programme in schools.

In sum, contradictory messages from South Africa schools and the taboo of discussing sexuality with young people in certain cultures can pose challenges to sex education programmes (Adekola & Mavhandu-Mudzusi, 2023). It is thus important to change cultural mind-sets to ensure that sexuality education is delivered in a way that is sensitive to and respects diversity. To address these challenges, it is important to promote open and honest communication channels regarding sexual health by involving parents, educators, learners, and the community in discourses about sexual education (Munyai et al., 2023).

2.6 SUMMARY OF THE CHAPTER

Since the *Constitution of South Africa* (1996) enshrines SRH as a basic human right, the Government has introduced measures to provide access to SRH through both the public and private healthcare systems. However, despite the awareness of RSB and knowledge of SRH care provision, there are still significant challenges in accessing and utilising SRH services for young people, particularly those faced with socioeconomic and socio-cultural barriers, including the practice of ridicule and stigmatisation. Hence, efforts should be directed at mitigating these challenges to promote youth friendly SRH quality services that foster young people's autonomy to enable them to make informed reproductive health choices throughout their lifetime. Importantly, enhancing SRH services can positively impact the overall health and wellbeing of young people in South Africa which will mitigate the risks of STIs, unplanned pregnancies, and unsafe abortions. Therefore, the SEM approach served as the theoretical framework for unpacking the determinants of RSB, as well as the experiences and views of young people and providers regarding SRH services. The literature reviewed also emphasised the need to address myths and misconceptions surrounding contraception to provide accurate information about its side effects and impact on fertility. It also advocated the need for support from parents and male partners to promote contraceptive use among young people. In addition, the perusal of SRH policies reveals both positive and negative aspects on youth wellbeing, hence a revision of these documents is imperative to enhance SRH provision. Overcoming most hurdles requires continuous professional training, cultural sensitivity, and open communication. These efforts will contribute to a more holistic and accessible SRH landscape for the youth in South Africa.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the philosophical stance underpinning the study by following Cresswell's (2013) and Denzin and Lincoln's (2011, 2018) models of conducting research. Philosophy involves the use of abstract ideas and beliefs that shape the research process. The research process guided by Denzin and Lincoln (2018) demonstrates that a philosophical stance influences how we dissect the research problem and formulate research questions including the selection of methods to seek answers. The selected qualitative approach includes an explanation of the research design and paradigm. According to Bless, Higson-Smith and Sithole (2013), research methodology is the general approach the researcher pursues in conducting a research project, including the procedures or step-by-step processes that are followed by the researcher. This chapter also addresses ethical considerations, detailing the clearance and approval process, and provides an explanation of the study's trustworthiness, reporting, and reflexivity.

3.2 PARADIGM

A paradigm is a framework or a set of beliefs, concepts, values and practices that define how a particular study understands and interacts with the world (Cresswell, 2013). Paradigms present a worldview which shapes how knowledge is perceived and created, reflecting the researcher's worldview, constructing the research questions, data collection techniques, data analysis procedures, and the interpretation of results (Widigdo, 2020). In other words, it shapes how problems are approached, how research is conducted, and how knowledge is interpreted and communicated (Creswell, 2013).

This study selected the interpretivism paradigm which holds that reality is socially constructed when individuals attempt to grasp the subjective meanings others assign to their experiences (Pervin and Mokhtar, 2022). The study embraced the notion that there is no singular, objective reality; but rather multiple subjective realities influenced by dynamic interactions between individuals and their environments (Kurukulaarachchi, Siriwardhana & Wesley, 2022). Thus, the interpretative viewpoint assisted the researcher to deeply delve into what the concept of SRH services means to young adults and SRH providers. It also explored how participants experienced and perceived the use of and access to SRH services through utilising the SEM framework to examine Soshanguve healthcare facilities.

3.2.1 Ontology

Ontology is concerned with ways of attaining knowledge which are referred to as methodology (Widigdo, 2020). Research is all about being amazed at the world around us, and the steps we take to understand this world. It concerns how we think the social world is constructed or what we think the world is which shapes the way we believe in knowing the world (Creswell, 2013). In the context of SRH services in Soshanguve, ontology involves qualitatively understanding the factors influencing young adults' access to these services and views of SRH providers regarding SRH services for young adults. The interpretivism ontology assumes that there are multiple realities shaped by different factors such as social, cultural and historical contexts (Cresswell, 2013).

When studying individuals, researchers often strive to report multiple realities (Denzin & Lincoln, 2011). Evidence of multiple realities includes the use of various forms of data in themes by quoting the verbatim words of different individuals while presenting different perspectives (Denzin & Lincoln, 2011). This study explored how young adults and SRH providers attached meanings to their perceptions and experiences regarding SRH services in different ways. In exploring the SEM's multifaceted influences on SRH services among young adults in Soshanguve, verbatim excerpts from interviews with young adults and SRH providers were provided to inform diverse realities and personal narratives, thus offering a rich understanding of their perspectives. Detailed multiple case studies of individual participants lead to incisive insights about their specific contexts which influence their actions and views.

Triangulation through the utilisation of multiple sources (young adults and SRH providers) in the current study was ensured through data validation, repetitive readings, and member-checking information across participants. Phenomenological analysis dissected the lived-experiences of young adults and SRH providers to detect recurring themes and the personal views concerning SRH services. Concurrently, contextual analysis played a crucial role in exploring how SEM factors facilitated the understanding of the accessibility and delivery of SRH services in clinics of Soshanguve.

3.2.2 Epistemology

Epistemology guides how knowledge about the world is acquired and helps the researcher to understand the relationship between the researcher and what is being studied (Cresswell & Poth, 2018). Epistemology presents how researchers look at the world, and how the methods they use assists in seeing what they intended to see (Cresswell, 2013). Interpretive

epistemology focuses on understanding subjective meanings and social constructions which individuals attach to their experiences and interactions (Cresswell, 2013). *Subjective meanings* refer to personal interpretations and narratives of individuals involved in these interactions (Denzin & Lincoln, 2018). For instance, the researcher was interested in understanding how interpersonal factors such as the interactions between young adults, healthcare providers, and parents shaped their experiences and views on SRH issues. This led to the realisation of the importance of the quality of these interactions, whether supportive or negative, and how they influenced young adults to make decisions to behave in certain ways towards SRH care.

Social contexts recognise that social/cultural norms that shape individuals' attitudes and behaviours towards SRH, thus emphasising the importance of understanding contextual factors to grasp the broader sociocultural dynamics affecting SRH service delivery. For this study, the researcher explored *community factors* (cultural and religious norms) in Soshanguve that influenced young adults' perception and utilisation of SRH services, in addition to how SRH providers viewed young adults with related SRH issues.

3.2.3 Axiology

Axiology refers to the researcher's values and how they influence the research processes, findings, and interpretations (Cresswell, 2013). The axiological assumptions acknowledge that researchers bring their values into the study, and that these values shape the research process and outcomes (Cresswell, 2013). In this study, the researcher acknowledged her own values, biases, and perspectives. While the researcher's personality and beliefs did not significantly influence the interview process, it reflected on how background and personal values might have shaped the designing of interview questions and the presentation of findings. However, biases emerged during data interpretation especially regarding the narratives of young adults' and service providers' experiences with SRH services. For instance, some young adults expressed frustration over perceived dismissive attitudes from providers, while service providers highlighted challenges in meeting the unique needs of this demographic, leading to a skewed understanding of the overall effectiveness of the services offered. During the review of data collection documents, the researcher became mindful of how her values influenced decisions regarding consent and participant wellbeing, so she openly discussed these ethical dilemmas and her approach to navigating them in the context of studying sensitive topics such as SRH.

3.2.4 Methodology

Research methodology is a structured approach used to conduct research and collect data to address research inquiries or explore a particular issue (Cresswell et al., 2011). Crowe et al.

(2011) pointed out that methodology provides an approach for conducting research to ensure that the research is organised, rigorous, and aligned with the aim and objectives. This study adopted the qualitative research approach which involves studying phenomena in their real-world settings, where the researcher does not attempt to manipulate the proceedings but allows the research processes to unfold naturally (Braun & Clarke, 2020). Qualitative research attempts to make sense of or interpret the phenomenon in terms of the meanings people attach to them (Bless, Higson-Smith & Sithole, 2013). This study explored the first-hand experiences of young adults and SRH providers regarding SRH services in Soshanguve. It adopted a non-invasive approach to understand these lived experiences authentically without any prejudice or biases. This approach aligns with how the interpretative paradigm aims to understand phenomena within their specific contexts (Widigdo, 2020; Bless, Higson-Smith & Sithole, 2013).

3.3 RESEARCH DESIGN

Research design refers to the structured plan that outlines the methodology for conducting a study to establish a step-by-step framework for data collection (Bless, Higson & Sithole, 2013). There are three broad categories of research designs: exploratory, explanatory, and descriptive studies - each serving a different purpose and each employing unique methodologies (Bless, Higson & Sithole, 2013). This study adopted an exploratory design to investigate the experiences and views of young adult patients and SRH providers in Soshanguve.

The exploratory research design is utilised mainly to familiarise researchers with a topic or phenomenon that is not well understood (Babbie et al., 2020). This design was useful in this qualitative study because of its flexibility that allows researchers to adjust their approach as new insights emerge during the study (Shiyanbola et al., 2021). This flexibility is crucial when investigating under-researched topics because it enables the study to evolve in response to new data and findings (Shiyanbola et al., 2021). In the context of SRH clinic services, this design enabled an all-inclusive exploration of the complex issues faced by both young adults and healthcare providers. Also, exploratory research is effective in generating new ideas and identifying areas for future research, thus contributing to the broader body of knowledge on the topic (Bless, Higson & Sithole, 2013).

3.4 SETTING

The study was conducted in three clinics (Clinic A, B and C) in Soshanguve which is a semi-rural area located north-west of Pretoria in the Gauteng Province of South Africa. Soshanguve

falls under the City of Tshwane Metropolitan Municipality and was established on trust land in 1974 near the former Bantustan border of Bophuthatswana. The name *Soshanguve* is derived from the languages spoken in the area; namely, Sotho, Shangaan, Nguni, and Venda (Mashigo, 2015). With a total population of 906,000 in 2024, a 1.57% increase from 2023, Soshanguve exhibits a diverse demographic profile (Macrotrends, n.d.). Notably, 17.1% of the population is comprised of young individuals aged 0-14 years, while the majority constituting 75%, falls within the working-age bracket of 15-64 years. The elderly aged 65 years and above comprise 7.9% of the total population (Macrotrends, n.d.).

According to Macrotrends (n.d.), the community comprises of 254,437 households, with an average household size of 2.6 individuals with female-headed households accounting for 36.5% of the total. Most dwellings (97.2%) are classified as formal, which indicates a well-structured residential environment (Macrotrends, n.d.). However, home ownership is relatively low, with only 45.8% of households either owning or paying off their homes. Access to basic services is notably high, with a significant percentage of households having flush toilets connected to sewerage systems, weekly refuse removal, and piped water inside their dwellings. Furthermore, 97.8% of households have access to electricity for lighting (Mashigo, 2015).

Soshanguve's educational statistics depict a varied education landscape with only 1.4% of individuals aged 20 and above having received no schooling (Mashigo, 2015). Moreover, 42.4% of this age group have attained higher education, while 36.5% have matriculated. Soshanguve, as part of the city of Tshwane, is characterized by high unemployment rates, which stood at 44%. However, despite this challenge, the area boasts vibrant entrepreneurial activity that is predominantly driven by necessity (Mamokete Modiba et al., 2024). This includes businesses such as shoe repairs, salons, car-wash services, tuckshops, cell phone repair services, and motor mechanics – many of which are concentrated in the inner city (Mashigo, 2015).

The current health status in the City of Tshwane, particularly in Soshanguve, reflects unequal access to healthcare and challenges within the public health system, especially at the PHC level (City of Tshwane, 2020). Challenges such as overcrowding, long queues, transport unreliability, and financial constraints impact residents' ability to access healthcare services promptly. Limited healthcare infrastructure, the lack of resources, and understaffing pose as barriers on the system's efficiency. However, efforts were afoot to enhance access to public health clinics, with an intended target that was supposed to reaching over 63% of households

by 2022 - up from 59% in 2009 (Mamokete Modiba et al., 2024). This included the establishment of multiple clinics within the communities, aiming to bring services closer to residents (City of Tshwane, 2020).

Given its diverse population and prevalent healthcare access challenges, Soshanguve provided a unique opportunity to investigate perspectives and behaviours related to SRH. The study aimed to gather data that reflected the diversity within various segments of the population, specifically focusing on Sections BB, G, and JJ of Soshanguve.

Conducting the study in Soshanguve was a strategic decision because it provided valuable insights into factors influencing SRH behaviours. Findings from this diverse setting contributed to a better understanding of the multifaceted factors influencing SRH behaviours, which will inform the design and implementation of strategic interventions to address the specific needs of the population in Soshanguve.

3.5 POPULATION AND SAMPLING TECHNIQUE

The population included young adults and SRH service providers regardless of gender and marital status.

3.5.1 Population and Sampling Technique for Young Adults

For the young adult group, the study included individuals within the age range of 18 to 35. This age bracket deviates from the WHO age bracket because the youth-friendly services offered in the clinics range from individuals aged 12 to 40 years. So, this broader age range reflects the real-world service provision, where the boundaries of "young adulthood" can extend beyond the typical age range. The study eventually recruited and interviewed fifteen (15) young adults, comprising of seven (7) females and eight (8) males. From Clinic A, the researcher interviewed five (5) young adults, from Clinic B six (6) young adults, and from Clinic C four (4) young adults.

The researcher employed a convenience sampling technique, a non-probability sampling method where participants were selected from the large pool of young adults based on their availability and interest in the topic of the research (Bless, Higson-Smith & Sithole, 2013). This approach involved choosing young adults who were readily available during the study period, thus making it convenient and practical for participant-recruitment (Bless, Higson Smith & Sithole, 2013). The study selected young adults who had utilised or were currently using the clinic's SRH services and were present at the clinic on the day of data collection. The

convenience approach was beneficial for this study because it was quick, time-saving, and cost-effective. This really helped since the researcher had to recruit participants within a limited time with a limited budget (Bless, Higson-Smith, & Sithole, 2013). Also, it was convenient because it did not require a sampling frame, hence making it easier to access potential participants (Crowe et al., 2011). However, one of the primary drawbacks was that it cannot be considered as a statistical representation of the target population (Crowe et al., 2011). This limitation is relevant to the study's aim of understanding the perspectives of young adults and SRH providers in terms of the SEM framework, as the sample may not accurately reflect the broader population. This can lead to possible bias because the selected individuals might not represent the whole group accurately. This raises concerns about how well the findings can be applied to the larger population (Crowe et al., 2011).

3.5.2 Population and Sampling Technique for SRH Providers

For SRH providers, the study selected individuals with experience of working with young people aged between 18-35 years, specifically focusing on SRH services such as education on RSB, STIs and HIV, family planning, pregnancy services, and legal abortion services. Only five (5) SRH providers instead of eight (8) were available because two providers later refused to participate, and one was on maternity leave. From Clinic A, the researcher interviewed one (1) SRH service provider, from Clinic B two (2) SRH providers, and from Clinic C two (2) SRH providers. This clinic was selected due to its proximity, convenience, and reputation for offering at least 75% of the services that other clinics in the area do not provide. One of the clinics is a community health centre that offers 24-hour services, including specific Sexual and Reproductive Health (SRH) services such as treatment for STIs and abortions. These services are available in the Soshanguve Region 4 clinic.

Purposive sampling (also known as selective or subjective sampling) was employed, relying on the researcher's judgement to select participants who were most relevant and representative for the study (Cresswell et al., 2011). Unlike random sampling where every member of the population has an equal chance of being selected, purposive sampling targets a specific group of people who possess certain characteristics or experiences relevant to the research question (Cresswell, 2011), hence purposive sampling was ideal as this study required special expertise on the subject under investigation which aligns to the needs of the research. This study selected service providers with SRH expertise, specialised or professional knowledge, and extensive experience in working with young adults. This approach ensured that the data collected was rich, relevant, and informative.

While purposive sampling offers advantages in selecting participants who provide depth and relevancy to the research, it comes with several limitations that can affect the overall findings. For instance, the researcher may pick participants they think are the most suitable for the study, based on their knowledge of the topic (Etikan et al., 2016). This may introduce bias consciously or unconsciously and may potentially lead to skewed data that does not represent the broader population. In this study, only five providers were available for participation due to refusals and personal circumstances, such as maternity leave. This further limits the scope of the data collected and may lead to gaps in understanding (Etikan et al., 2016).

3.5.3 Participants Recruitment and Data Saturation

On the day of data collection, the researchers were given an opportunity to introduce the study in the waiting room and politely invited interested individuals to a separate room for screening and further explanation. After the recruitment of young adults, the study was introduced to all selected participants in a convenient space at the clinic. The researcher then invited young adults to participate in the research by explaining the study's goals and encouraging their involvement. Information sheets were disseminated to selected participants to read and decide on participation. Participants who were interested to participate in the study after learning about its purpose and procedures were requested to proceed to the interview station located in one of the consulting rooms.

Regarding the recruitment of SRH providers, the researcher served as the primary instrument to collect the data. The researcher visited the clinic prior to data collection to meet with the SRH providers in order to provide them with information sheets and interviews schedules. This was to minimise disruption to the healthcare facility's operations which saved time to allowing SRH providers to schedule interviews during their lunch breaks. On the day of the interviews, the researcher met with the providers at their workstations to reiterate the study's objectives by ensuring clarity, transparency, and inviting questions before the interviews.

With the recruitment of fifteen (15) young adults, saturation was reached in this study. Saturation occurs when no new information or themes emerge from additional interviews, indicating that the data collected is comprehensive and sufficient for analysis (Saunders et al., 2017). Studies suggest that saturation can often be achieved within 12 to 15 interviews, depending on the complexity of the topic and the homogeneity of the sample. For research

exploring personal and sensitive experiences like SRH, this range is often sufficient to ensure rich, detailed data without redundancy (Rahimi & Khatooni, 2024; Saunders et al., 2017).

3.5.4 Inclusion and Exclusion Criteria

For the young adults' group, inclusion criteria involved individuals falling within the age bracket of 18 to 35. The study further included young adults who had utilised or were currently using the clinic's SRH services and were present at the clinic on the day of data collection.

Additionally, participants were required to be literate in the English language which was used as the medium of communication for this study. The researcher was confident that participants would feel comfortable using this language, given its widespread usage in Soshanguve. The decision to use English was supported by previous researchers who also employed this language in their investigations within the geographical area (Steyn, Govender & Ndimande, 2018). Participants were required to sign the informed consent form, if in agreement with the details of the research. The study excluded participants with physical limitations, or medical/mental conditions that would prevent them from clearly expressing themselves. These criteria aimed to ensure that participants were suitable for the study.

For SRH providers, only those who worked in the youth-friendly clinics and provided services to 18 up to 35 years old young adults and were on duty on the day of data collection were selected. The criteria for including and excluding healthcare providers were to ensure the relevance of the selected participants to the research's aim, objectives, research questions, and context.

3.6 INSTRUMENTS

The researcher prepared information sheets (Appendix A and B) and informed consent forms (Appendix C) for participants to read and sign before participating voluntarily in the study. These ensured that the participants comprehended the aim, benefits, and any potential risks associated with the study. The information further offered participants an opportunity to assess the study's purpose to determine whether they wanted to participate or not. Moreover, with the participants' consent, all interviews were audio-recorded. The in-depth semi-structured interviews were guided by the interview questionnaire schedule (Appendix D and E) which was designed in the English language for data collection and analysis purposes.

Research Assistant: A male research assistant was employed to aid in interviewing male participants. Having a male research assistant was important for ensuring a comfortable and

open environment for male participants to feel uninhibited during interviews. This enhanced rapport and trust between the interviewer, the assistant, and the participants which potentially led to more elaborate, candid, and accurate responses. The research assistant was trained virtually such that every detail of the study was thoroughly explained and understood. Both the researcher and the assistant reviewed the guiding questions, examined the questions closely, and tested their effectiveness. We examined and discussed how respondents might interpret and respond to these questions, ensuring that they were clear, relevant, and unambiguous.

3.7 GAINING ENTRY

The process of gaining entry to the clinics to conduct this study was facilitated through a collaborative and ethical approach. The researcher worked closely with facility managers and the City of Tshwane Health District to ensure smooth access to all clinics. Firstly, the researcher approached facility managers to seek their permission to conduct research within the clinics via verbal and email communication, which involved the producing of relevant study documents. This step involved outlining the aim and objectives of the study to obtain formal approval, including a timeslot for data gathering sessions. This aligns with the ethical considerations of conducting research, thus emphasising the importance of obtaining informed consent and approval from gatekeepers and other relevant authorities (Appendix H) before conducting studies within healthcare settings (Sullivan et al., 2020).

3.8 DATA COLLECTION

The study conducted in-depth semi-structured interviews to obtain data from young adults and SRH providers. Semi-structured interviews were chosen for their balance between structure and flexibility (Creswell, 2011). This approach allowed the study to ask predefined questions while probing for deeper insights. Semi-structured interviews are particularly effective for sensitive topics such as SRH, as they enable participants to share personal experiences confidentially and comfortably in one-on-one sessions. Additionally, this method facilitates comparability across interviews, making it easier to identify trends and patterns while still capturing individual perspectives (Creswell, 2011).

For the young adults' group, the IDIs were audio-recorded with their permission. These interviews were conducted in vacant private consulting rooms at the clinics they attended, which ensured confidentiality and comfort for the participants. The interviews were of 45–60-minute duration which was sufficient for an in-depth exploration of their experiences and perspectives.

For participants who were SRH providers, the KIIs were also audio-recorded with their permission and took place in designated private spaces within the respective healthcare facilities. These interviews also lasted about 45 minutes each considering the complexity of their roles and the depth of insights they provided.

All study instruments were piloted prior to data collection to test the process, quality, practicality of the instruments, time-management, and audio-recording (Forero et al., 2018). Five (5) young adults were interviewed in Soshanguve Clinic C and one (1) SRH provider in Soshanguve Clinic A.

3.9 DATA ANALYSIS

The thematic analysis method was applied as it complements the interpretative paradigm's goal of uncovering subjective meanings and diverse perspectives (Braun et al., 2019). Thematic analysis is a qualitative research technique which focuses on identifying patterns and themes within a dataset (Mohammed, 2022). In this study, thematic analysis was chosen to identify SEM factors influencing SRH services at the *individual*, *interpersonal*, *institutional*, *community*, and *policy levels*. These underlying levels represented pre-identified themes for this study, with sub-themes subsequently being developed during coding processes, thus reflecting a rigorous approach to data analysis (Hemming et al., 2021). The study effectively captured multi-level factors, thus displaying its suitability for exploring complexities surrounding SRH services.

Abductive reasoning developed by Thompson (2022), is a form of logical inference, involving moving back-and-forth between deductive and inductive processes which were needed to refine the analysis processes which allowed for a balance between inductive and deductive reasoning (Thompson, 2022). Deductive reasoning involves applying existing theories or frameworks to analyse the data collected, which allows the researcher to test theories or hypotheses derived from existing literature against empirical data (Thompson, 2022). Inductive reasoning, on the other hand, allows the researcher to explore new phenomena or understand complex social issues without preconceived theories or hypotheses (Thompson, 2022). Hence, inductive reasoning emphasises the importance of letting the data speak for itself, which allows for the discovery of unexpected or novel findings (Braun et al., 2019).

This study adopted the following eight steps of abductive thematic analysis (Thompson, 2022).

Step 1: Transcription and Familiarisation

The researcher commenced by attentively listening to the audio-recordings, then transcribing verbatim responses into text, followed by repetitive readings to allow for the thorough familiarisation with the collected data. According to Thompson (2022), audio-recordings and field notes serve as primary sources of information which can be analysed concurrently with data collection or after the collection phase is completed. In this study, interview audio-recordings were analysed simultaneously with data collection. The transcribed were repetitively read out aloud to search and verify meanings and understandings behind the narratives and the contexts in which they occur (Braun et al., 2019).

Step 2: Coding

They were coded manually by using the SEM *a priori* themes on a word document, which resulted in the creation of codebooks for the young adults and SRH providers groups respectively (Appendix F). These themes and codes were then organised for reporting and discussing the findings. A code, as defined by Thompson (2022), is a brief word or phrase that represents a significant attribute or essence within language-based or visual data. For instance, codes may capture significant concepts or recurring ideas expressed by participants (Thompson, 2022). For the purposes of the abductive approach, deductive coding was first applied to predefine codes which fit under the pre-determined or *a priori* themes derived from the SEM framework which guided the initial organisation of the data (Braun et al., 2019). For example, when analysing participant responses, specific codes were assigned based on SEM levels (*individual*, *interpersonal*, *community*, *institutional* and *policy*) to categorise the data according to their contextual influences. Distinct codes were assigned to expressions of knowledge and awareness regarding SRH issues and services under the theme of individual-level factors.

Step 3: Codebooks

The codebooks (Appendix F) were then created to provide clarity and structure to the coding process. The process included labelling each code, which should be short, concise and remain close to the raw data to avoid too much of a conceptual leap (Thompson, 2022). For each code, there is a 'when-to-use' criterion which gives instructions relating to the conditions the code is in sync with a piece of text. For example, a quotation (text) from the transcribed data can be offered for further clarification. This comprehensive approach was crucial to enable the researcher to capture the richness and depth of the data regarding the phenomenon under investigation (Thompson, 2022).

Step 4: Development of Themes

"Developing themes begins by looking at relationships between different codes and sorting them based on their ability to collectively explain the story behind the data" (Thompson 2022: 1414). When one puts certain codes together that explain the context adequately, the grouping of such codes is called a sub-theme. In this study, this refers to those new sub-themes that emerge organically as they were analysed per pre-existing theme derived from the SEM framework (*individual*, *interpersonal*, *community*, *institutional*, and *policy levels*). Sub-themes are therefore known as subsets of broader themes and provide more detailed insights into unique perspectives and experiences of the participants (Thompson 2022). The focus was on developing codes within these themes and sub-themes to ensure their relevance and proper placement within the framework. Critical review and evaluation of the themes were conducted to ensure that the content and context of the data were accurately captured. This process guaranteed that each code remained relevant to its respective overarching theme and avoided duplication across the analysis.

Step 5: Theorising

At this point, the were disassembled, revisited, and organised into codes and themes (Thompson, 2022). This step is where the researcher explains the relationship and story between the themes in relation to the entire dataset (Thompson, 2022). The key aspect of this step is for researchers to simultaneously actively engage with both the theory and data to draw theoretical conclusions (Thompson, 2022). Therefore, the researcher effectively engaged with the dataset by reviewing existing knowledge categorised within the SEM framework and comparing it with the dataset to explain their relationship.

The starting point for integrating the SEM framework was by first understanding the multi-level influences (pre-identified themes) within the SRH context, and how they relate to the dataset. Then, where the data did not cohere accurately, the researcher attempted to be creative in theorising different explanations (Thompson, 2022).

Step 6: Comparison of Datasets

Thompson (2022) proposed comparing qualitative data quantitatively to assess the frequency of codes across different groups including the overlap. This step involves reviewing the coded data analysis to identify the frequency of specific codes among different participant cohorts (Thompson, 2022). It perceives whether certain themes or codes are more prevalent in one cohort compared to others, then use quantitative measures, such as counts or percentages, to

illustrate the distribution of codes across cohorts if applicable (Thompson, 2022). However, according to Thompson (2022), quantification is not necessary for qualitative thematic analysis, thus in this study quantification was not necessary.

This step also assessed the differences in themes or codes where the researcher examines how participant cohorts (Thompson, 2022) express each theme or code. It investigates variations in the interpretation, and the emphasis or context of codes between different groups (Thompson, 2022). In this study, the researcher observed differences in the prevalence of certain sub-themes and codes. For instance, codes relating to individual factors such as knowledge and attitudes were more commonly observed among young adults to understand the difference between those who experienced STIs, unplanned pregnancies, abortion services, or have been involved in health education campaigns. The codes related to interpersonal factors such as family dynamics and peer influence which were closely examined to identify differences between individuals from religious and traditional families.

Step 7: Findings

This step provides a means to visually present and interpret findings with headings denoting each theme – according to the SEM model's levels (Thompson, 2022). Various methods were employed to effectively display the data collected from participants. Tables were utilised to organise and summarise demographic information of the young adults and SRH providers. For example, demographic characteristics such as age, gender, and occupation of participants were tabulated to provide a clear overview. Direct quotes from participants were included throughout the report to provide authentic insights into their experiences or perspectives. These verbatim quotes were strategically inserted within the text to support key findings to enhance the narrative.

Step 8: Discussion

The writing up of the results in research is a critical stage that involves the interpretation, explanation, and contextualisation of the findings (Thompson, 2022). It aims to provide a comprehensive understanding of the implications of the results, their alignment with existing literature, and their contribution to the broader knowledge in the field. The discussion of results often bridges the gap between empirical evidence and theoretical frameworks, as it sheds light on the significance and practical implications of the research findings (Braun & Clarke, 2021). In this study the write-up section is referred to as the discussion (Chapter 5) where the researcher discusses the main findings that emerged from the collected data. Chapter 5 explains

the connection between the SEM and real-life data by interpreting and discussing the findings. It also links these findings to previous research by highlighting the study's significance and its contribution to future research.

3.10 TRUSTWORTHINESS

Trustworthiness in research refers to the degree to which the reader or user of the research can confirm the honesty of the way in which the research was conducted, and the reliability of the conclusions drawn (Singh et al., 2021). According to these authors, the concept of trustworthiness is crucial in ensuring the reliability and validity of research, particularly in qualitative research studies. Trustworthiness encompasses aspects of *credibility*, *transferability*, *dependability*, and *confirmability* of the research findings.

Credibility refers to the believability and accuracy of the research. In this study, credibility was strengthened through collecting data from multiple sources and triangulating the data between the IDIs with young adults, and the KIIs with SRH providers. Thereby, the study tried to ensure that participants' audio-recorded responses were truthful and believable.

Transferability relates to the extent to which the findings can be applied or transferred to other contexts (Stahl & King, 2020). Transferability can be ensured by richly documenting the context and background of the research to transfer the findings to different settings (Younas et al., 2023). According to Phillippi and Lauderdale (2018), this rich documentation is often referred to as providing a "thick description", allowing researchers to assess the applicability of the findings to other settings. This study provided rich and detailed information about the research setting, the participants, and the data collection methods and their associated limitations to allow other authors, scholars, and researchers to repeat a similar study. Transferability thus works better in qualitative studies such as this one because it ensures reliability and validity of the data through documentation and narrative analysis (Phillippi & Lauderdale, 2018), whereas generalisability involves rigorous quantitative methodological approaches by ensuring the reliability and validity of the data through statistical analysis and robust study designs (Guzik & Więckowska, 2023).

Dependability involves the consistency and stability of the research over time (Singh et al., 2021). To ensure the study's reliability and dependability, the researcher followed several steps. First, the research instrument and questions were piloted by engaging a small group of two (2) young adults resembling the target participants, and one (1) SRH provider. This early piloting

allowed for the identification and addressing of any issues or hiccups with the methods or questions. Prior to the collection of data, the research assistant was thoroughly briefed and encouraged to provide feedback on any challenges encountered pertaining to the effectiveness of the methods. Regular checks were maintained with research assistant throughout the data collection process. This involved regular debriefing and reviewing processes.

Confirmability pertains to the neutrality and impartiality of the research process and the findings (Forero et al., 2018) which relate to the degree to which the collected data and data analysis can be verified by others. To enhance confirmability, the researcher maintained a transparent and systematic process for data collection, coding, and analysis (Forero et al., 2018). Were transcribed verbatim, and the transcription process was performed by the researcher who thoroughly reviewed the transcripts and performed member-checks under the supervision of two study leaders.

3.11 REFLEXIVITY

The researcher's positionality can influence the research process. Positionality is about how someone sees the world and how they approach a research project by considering its social and political contexts (Holmes, 2020). It is shaped by the researcher's personal and professional background, beliefs, values, experiences, and social identities, which can influence one's perspectives, interpretations, and interactions throughout the research process (Holmes, 2020). This may affect the study design, participant selection, data collection and data interpretation of the study. Also, power imbalances may arise due to the researcher's role which may impact on data collection dynamics (Clarke et al., 2011). Furthermore, the researcher's background can impact data interpretation, selection of themes, and framing of findings within broader contexts (Clarke et al., 2011). Being conscious of their own positionality helps researchers understand their biases and how these may affect their work (Holmes, 2020).

During data collection, if the researcher is perceived as an authority figure, participants may feel compelled to provide socially desirable responses (Mbuthia, 2018). To mitigate this. The researcher made efforts to be transparent about personal and professional positions that might influence the data collection processes (Mbuthia, 2018). In this regard, the researcher remained alert during data collection to prevent personal biases from influencing interactions with participants. This included adhering to the research protocol and maintaining objectivity in data interpretation, as well as seeking input from supervisors to ensure that different viewpoints were considered.

Positionality can also affect how the researcher interprets data, particularly in qualitative studies where the researcher is an active participant in identifying and categorising themes (Clarke et al, 2011). Also, the researcher's own values and assumptions can shape which themes are highlighted and how the data is framed. To address this, the researcher employed several reflexivity practices during data analysis. Regular peer debriefings with the research assistant were held, allowing him to provide alternative interpretations of the data, which helped counterbalance the researcher's own biases. Thematic analysis was conducted with input from multiple researchers, ensuring that the findings reflected a broader range of perspectives, not just the primary researcher's viewpoint (Clarke et al., 2011).

3.12 LIMITATIONS

The study had methodological limitations in that it only included young adults who had accessed existing SRH services on the day of the fieldwork in Soshanguve; thus, it may not have represented the views of those who had not used or not been able to access these services. Additionally, only young adults who had received (or were currently receiving) SRH services at the three selected Soshanguve clinics were included in the study, which may not have accurately represented the general population, and thus limited the generalisability of the results among young adults across neighbouring clinics located in other Soshanguve districts. Another limitation was the exclusion of participants who had limited English proficiency which implied that the generalisability of the results was hindered. However, to minimise bias, the researcher triangulated data sources to increase the data's trustworthiness.

Lastly, accessing information from one clinic proved difficult. Some health providers did not want to join the study because they thought the researcher would judge them. Only five (5) providers agreed to be interviewed, and this could have resulted in omitting other valuable information on what was transpiring at SRH clinics.

3.13 ETHICAL CONSIDERATIONS

Ethical considerations are of paramount importance in any research involving human beings as they ensure that scientists and researchers conduct their work in a manner that upholds the rights and wellbeing of all individuals involved in research projects (Resnik, 2020). The American Psychological Association [APA] (2020) and University of the Free State Ethics Committee set forth standards that researchers must follow by emphasising the importance of respecting autonomy and minimising potential harm to research participants. Thus, in adherence to the University of the Free State Ethics Committee and APA Rules and

Regulations regarding research involving human subjects, the following ethical considerations applied.

Permission

The researcher obtained written ethical approval from the General/Human Research Ethics Committee (G/HREC) of the University of Free State (Appendix G). Further, written permission was obtained from the Department of Health at the provincial and district levels, to conduct the research by engaging young adults and SRH providers at three selected Soshanguve clinics (Appendix H).

Information Sheet and Informed Consent

The information sheet (Appendix A & B) and informed consent letter (Appendix C) were disseminated to participants. The contents were also verbally explained to the interviewees. The information sheets explained the research process, its purpose, and the risks involved. Upon agreement, participants were required to sign the informed consent form prior to voluntarily participating in the study.

Voluntary Participation

The principle of voluntary participation was explained to the respondents. They were also informed that they had the right to withdraw from the study at any time without being penalised in any way (Braun et al., 2019). Participants were made aware that there were no direct benefits for them but that the information they provide will contribute towards identifying strengths and weaknesses of the SRH services which may lead to improved interventions, policies, and pro-activeness towards better healthcare provision in Soshanguve.

Confidentiality and Privacy

Confidentiality in research entails protecting participants' information with utmost secrecy (Crowe, 2011). Participants were guaranteed that their identities, affiliations, and information would remain confidential. This principle is rooted in trust, assuring participants that their trust would not be broken for personal gain or betrayed in all research processes including the published findings. To maintain the privacy of the participants during data collection in clinics, the researcher requested a private space within the clinic to conduct the interviews to promote the welfare and dignity of participants.

Understanding the Study Risks and Protecting Participants

Study risks refer to potential negative consequences or harm that participants may experience because of participating in a research study (APA, 2020). These risks include physical discomfort, emotional distress, breach of confidentiality, or any other adverse effects. The researcher appreciated that the nature of the study could potentially elicit emotional responses from participants which could cause inordinate distress. A psychologist was informed (and on-call) about the study in case the wellbeing of any participant was compromised. Permission was granted by the GDoH after submitting a letter requesting to utilise the services of their affiliated psychologist for the study. The study also established trustworthiness through meticulous attention to data collection, analysis, and reporting.

Measures were implemented during the analysis phase to prioritise confidentiality to protect of participants. Pseudonyms were assigned to each participant to protect identities in all documentation and datasets (Creswell, 2014). Hard copies of the signed informed consent form were safely stored and locked in a drawer. The interview audio-recordings and transcriptions have been and will continue to be stored in a password-protected e-file encrypted via Google drive by the researcher for a period of five years. This aligns with the Protection of Personal Information Act (POPIA) to ensure that all information and identities will not be disclosed to anyone outside of this study.

CHAPTER FOUR: FINDINGS

4.1 DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

The final sample consisted of fifteen (15) young adults aged 22 to 35 years, with eight (8) males and seven (7) females who had visited the selected clinic sites for services during the data-collection period (Table 2), The young adults had finished high school and were employed, unemployed, or studying (see Table 2 below). They were recruited in specific clinics (Soshanguve Clinic A, Soshanguve Clinic B, and Soshanguve Clinic C) in various parts of Soshanguve, City of Tshwane.

Table 2: Young Adults' Demographic Data

Code	Pseudonyms	Age	Gender	Marital Status	Race	Educational Status	Occupation
Clinic A							
IDI M 01	Thabo	33	Male	Single	Black	Honours Degree	Social worker
IDI F 02	Mapula	30	Female	Single	Black	NQF level 3	Unemployed
IDI M 03	Tumelo	31	Male	Single	Black	Diploma	Programme manager
IDI F 04	Ntombi	29	Female	Married	Black	Honours Degree	Social worker
IDI M 05	Musa	23	Male	Single	Black	Matric (Grade 12)	Student
Clinic B							
IDI M 06	Given	28	Male	Single	Black	Diploma	Public health manager
IDI M 07	Moses	25	Male	Single	Black	Matric (Grade 12)	Welder
IDI F 08	Lebogang	30	Female	Married	Black	Grade 10	Unemployed
IDI M 09	Hlompho	22	Male	Single	Black	Matric (Grade 12)	Student
IDI F 10	Thando	24	Female	Single	Black	Higher Certificate	Unemployed
Clinic C							
IDI F 11	Gloria	25	Female	Single	Black	Degree	Teacher
IDI M 12	Thato	32	Male	Single	Black	Matric (Grade 12)	Facilitator
IDI M 13	Anda	35	Male	Divorced	Black	Matric (Grade 12)	IT technician
IDI F 14	Selaelo	24	Female	Single	Black	NQF level 4	Student
IDI F 15	Mokgadi	26	Female	Single	Black	Matric (Grade 12)	Student

The sample also consisted of five (5) SRH providers who were available during this period (Table 3) across the three sampled PHC facilities. They were recruited in specific clinics

(Soshanguve Clinic A, Soshanguve Clinic B, and Soshanguve Clinic C) in various parts of Soshanguve, City of Tshwane. The SRH providers were either professional nurses with SRH training or SRH trained health peer educators. They supervised the SRH unit of the clinic or helped with SRH services for adolescents and young adults by appointment.

Table 3: SRH Providers' Demographic Data

ID	Gender	Age	Level of Education	Occupation	Period of Providing SRH Services
	Clinic A				
HW 01	F	25	Diploma	Professional Nurse	2 years 8 months
	Clinic B				
HW 02	F	38	Diploma	Professional Nurse	Not sure
HW 03	F	57	Degree	Professional Nurse	10+ years
	Clinic C				
HW 04	M	23	Matric	SRH Professional	3 years
HW 05	F	23	Diploma	Family Planning Professional	10 months

4.2 YOUNG ADULTS' EXPERIENCES AND VIEWS OF SRH SERVICES

4.2.1 Individual-Level Factors

Three sub-themes were identified under individual-level factors. The first sub-theme focused on the knowledge and awareness of RSB as viewed by young adults, with two developed codes named, *RSB definition* and *awareness of RSB's risks*. The second sub-theme, knowledge and awareness of SRH aspects, included three developed codes: *knowledge of SRH, common SRH services utilised* and *attitude towards SRH services.*

Knowledge and awareness of RSB

RSB Definition: Almost all young adults understood the term RSB. They recognised that it involves unprotected sex, and having sex while intoxicated, among others. They stated that these reckless actions could lead to negative outcomes such as unplanned pregnancy and STIs. The following articulations confirm their understandings of RSB:

"So, we're talking about unsafe sex, basically... Unsafe sex means having sex with somebody not using protection... having sex under the influence of alcohol is also part of unsafe sex." (Thando, 24, M)

*"Engaging in sexual activities under the influence of drugs and alcohol, whereby you find yourself not using protection and end up having unprotected sex with a person you don't know their status." (*Anda, 35, M)

Awareness of RSB Risks: Awareness of the risks associated with RSB was another prominent sub-theme. Young adults highlighted the potential consequences of RSB such as HIV, STIs, and unplanned pregnancies:

"It's the risk of being infected with HIV, getting pregnant and ending up doing abortions." (Ntombi, 29, F)

"Consequences related to RSB include contracting STIs like gonorrhoea, syphilis, HIV, hepatitis B, and the risk of unplanned pregnancies. Also, the risk of being accused of rape or sexual assault." (Anda, 35, M)

Knowledge and awareness of SRH

Knowledge of SRH Services: Young adults were asked if they had ever heard about the term SRH, and if so, would they share their knowledge about it. It became apparent that most of them were not familiar with the term SRH and did not know that services such as family planning, pregnancy, STI and HIV/AIDS formed part of SRH.

Those who were familiar with the term SRH said that they had been exposed to some SRH aspects like HIV preventions, including condom use, through programmes organised either in the school setting or elsewhere by NGOs.

"I've heard about it at the public clinics whereby they're telling us how to use condoms, that we must test in order for us to get PrEP [Pre-exposure Prophylaxis] *so that we can prevent the disease like HIV and AIDS and also STIs from going further."* (Moses, 25, F)

*"During awareness campaigns, usually you hear such, but I wouldn't say I have in-depth knowledge of the sexual reproductive health services." (*Musa, 23, M)

*"Yes, I've heard about it... I started hearing about them from 2019 when the pill PrEP was being introduced…" (*Anda, 35, M):

Commonly utilised SRH Services: Young adults were asked about the types of SRH services they have utilised or are about to utilise at the SRH clinic. However, this was after the

researcher provided explanation and examples of SRH services, so those who were not aware of the term were now able to identify SRH aspects. Frequently used SRH services included STIs, HIV testing, PrEP, family planning, ToP, and antenatal services from clinics.

*"I once had STI and also went to do TOP. Now I am preventing…" (*Gloria, 25, F)

*"I was exposed to gonorrhoea... They introduced me to condoms and abstinence. So far, I've started to use condoms..." (*Thato, 32, M)

*"When I was pregnant, first thing, they test HIV for your protection and the protection of the baby. And they also test for the STIs, both for the protection of you and the baby to see whether you've contracted any other diseases." (*Mapula, 30, F)

The service that I had which has got to do with sexual health services was contraceptives, specifically condoms." (Thabo, 33, M)

*"I went to test in order for me to get PrEP and condoms." (*Moses, 25, F)

"After giving birth to my daughter, I decided to go for family planning." (Mokgadi, 26, F)

Attitudes towards SRH

One young adult mentioned a concerning trend among young adults regarding their attitudes towards SRH. He emphasised the lack of seriousness among his peers regarding SRH issues, which led to risky behaviours such as inconsistent condom use and avoidance of clinics offering SRH services. He reported:

"They don't take this thing very seriously… taking it very lightly. Some of them don't use condoms. They usually don't go to the clinics because they see themselves as old people. Old men who can't take care of themselves …" (Moses, 25, F)

Misconception about condom use

Young adults mentioned that their peers held the perception that condoms limit sexual pleasure and has sex less enjoyable. The evidence below bear testimony to such misconceptions:

"... so, there's a perception that using condoms limits pleasure. Some believe it's not enjoyable." (Ntombi, 29, F)

"The way we perceive it is that you cannot eat sweets being protected. So, our belief is that in order for the taste of the sweets... to feel it, then it means you need to unwrap the cover. Therefore, for us as young men, we always believe that a condom prevents us from enjoying the moment the way we're supposed to enjoy." (Thabo, 33, M)

"My peers don't believe in using condoms because they feel … when you're using condoms, you don't feel sex as much as when you are not using condoms." (Thato, 32, M)

4.2.2 Interpersonal-Level Factors

At this level, two sub-themes emerged: family dynamics and influences, and peer pressure and perceptions of SRH. Under the sub-theme of family dynamics and influences, four codes were developed: parental communication, utilisation of external educational resources, lack of family support and stigma, and family influence on help-seeking.

Family dynamics and influences on SRH access

Parental Communication: Young adults reported that communication with their parents could have played a crucial role in influencing their decisions about accessing SRH services. They preferred some communication with parents for them to make informed decisions regarding their sexual health. Only two of these young adults felt that their parents were open and comfortable to speak about SRH related issues, they said that this open discussion led to a better understanding of risks related to RSB, which thus encouraged them to access SRH services. The following verbatim responses confirm young adults' views on family dynamics:

"My family was open about discussing these matters and that communication helped me understand the risks and to access [SRH] *services when needed."* (Ntombi, 29, F):

"It was like a father and son thing when we were talking about them…to influence me to use SRH services so that I can be safe... "(Given, 28, M)

However, not all parents were open and comfortable to talk about SRH topics with children. This was indicated by three young adults as quoted below:

"Our parents are not open to us because … My parents are shy when it comes to their daughters. They don't discuss much." (Mokgadi, 26, F):

"It was difficult for my parents to talk with me about sexual reproductive health and sexual risk behaviour, because they feel like maybe if they went on and talked to me, maybe they

*encouraged me to have sex while they didn't know that if they talk to me, they were maybe saving me from a lot of things." (*Thato, 32, M)

Utilisation of External Educational Resources: One young adult mentioned that her parents resorted to external resources, such as television to discuss sexual health topics as a means to educate their children about SRH topics:

"Family ... for example, they choose television shows such as 'Daily Theta', all of those shows, they talk about health sometimes, okay, so what they would do ... They would make sure that we ... we watch those TV shows ... and so that you can get more knowledge and understand this activity better." (Lebogang, 30, F)

Lack of Support and Stigma: Some young adults felt that opening-up about sexual health might be perceived by their parents as an admission of wrongdoing or having unprotected sex. This was articulated below:

*"The attitude is going to be like, did you do something wrong? Why do you feel like you want to go and test for STI? You probably had unprotected sex. That's why you'd want to. You know the stigma behind the fact that why you want to go and test now, did you not play safe? Yeah, that's probably one of the things I think that's going to happen." (*Mapula, 30, F)

"Growing up, you're given advice that if you are sexually active, you should 'contain' information from home." (Musa, 23, M)

Family influence on help-seeking: Two young adults expressed that their families are supportive and do encourage seeking SRH services as they foster a health-conscious atmosphere at home. They mentioned the following:

*"My mom encourages us to go to the clinic." (*Anda, 35, M)

*"My family was supportive and positively influenced my access to services. They encouraged seeking help when needed, thus fostering a health-conscious home environment." (*Ntombi, 29, F)

On the other hand, Thabo indicated that his family did not have any influence because they do not know much about SRH topics.

"From the family point of view, they too, they don't have any influence at all because they lack knowledge." (Thabo, 33, M):

Peer pressure, and perceptions of SRH

Some young adults experienced peer pressure against using condoms, and this discouraged them from accessing RSB facilities.

"A conversation I remember…you only have unprotected sex when you trust your partner, but if you don't, you use protection." (Mapula, 30, F)

"In terms of peers, we always believe in engaging in risky sexual behaviours, so we discourage each other from accessing condoms in different facilities." (Thabo, 33, M)

"There's peer pressure there… That sometimes can make someone think that to use a condom is something that is not acceptable. Like it's you are doing something that is not right." (Lebogang, 30, F)

One young adult commented on the use of condoms as being a sign of fear to take risks or being less smart as a man, thus contributing to the misconception that condom-use was not masculine behaviour:

"As a man, when it comes to peers, it's like, um, when you're using condoms… you're afraid you don't want to take risks … They [peers] *think if you're using them* [condoms] *then as a man, you are not smart enough."* (Given, 28, M)

4.2.3 Community-Level Factors

Regarding this level, five significant themes emerged, including belief in traditional remedies, religious beliefs about premarital sex, community judgement and stigmatisation – all challenges facing men.

Belief in traditional remedies

Young adults mentioned that the use of herbs was encouraged as alternatives to SRH services, thus reflecting traditional approaches to health. The following excerpts express the above

"When we grow up, we were always taught that some of the things can be dealt with by remedies or herbs, among other ways of dealing with the SRH." (Thabo, 33, M)

"Culturally, the use of the SRH services is not encouraged. Culturally we just drink traditional herbs for libido." (Tumelo, 31, M)

Religious beliefs about premarital sex

Religious beliefs that inhibit sexual activity or provision of SRH information before marriage were mentioned as preventing young adults, especially adolescents from accessing SRH services. For instance, participants reported that religious beliefs such as premarital sex is a sin. This had effects on their perceptions of SRH issues and prevented them from seeking SRH related services.

"They affect us because of like they think that like…they're taking it that way that sex before marriage is a sin." (Given, 28, M):

"You know, sex before marriage is a sin. Yeah, I think they're trying to prevent us from having those kinds of issues." (Gloria, 25, F):

Community judgement and stigmatisation

Participants mentioned that there is still stigmatisation in the community concerning seeking SRH services. This led to people fearing judgement and open discussions on sexual matters. These were identified as significant barriers that discouraged individuals from accessing necessary health services as expressed below:

"Unfortunately, there's still a stigma in our community associated with accessing SRH services. People fear judgement and this hinders open discussions." (Ntombi, 29, F):

"I think they prefer private facilities or not in-and-around the surrounding areas that they live in ... because probably they are scared of maybe the neighbour bumping into them while going there to public clinics." (Mapula, 30, F)

"When you go to clinics, they already assume that maybe you're HIV…they conclude you're going through something which is not, you understand..." (Thato, 32, M)

Other young adults pointed out that in some cultures if teenagers visit a clinic to collect condoms, they are often viewed as being disrespectful or inappropriate. This precipitated stigmatisation and judgement towards those portrayed as being too young to be engaging in sexual activity and using contraceptives. The excerpt below portrays such fears and inhibitions:

"So, teenagers are scared ...We have fear to access to ... those SRH services due to other cultural beliefs that sees it as the disrespectful or inappropriate way of doing things like it's not your time already. They talk…. Why he's doing this? He should be going to school. Sometimes you may go to … I would say maybe at clinic and you ask for a condom and…. You are still a teenager maybe 16 or 15... to other cultural beliefs, it's inappropriate for a teenager to make use of condoms. That means the teenager is already engaging himself or herself in sexual activities, which is unacceptable to other cultural beliefs." (Lebogang, 30, F)

Institutional-Level Factors

Seven sub-themes emerged from this level. The first sub-theme focused on *places to access SRH services* for young adults. The second sub-theme centred on *user-friendly services*. The third one referred to the *attitude and judgement of SR providers,* and the fourth one concerned *privacy and confidentiality.* The fifth one related to *financial constraints*, the sixth one pertained to *inconvenient hours and long waiting times,* and the seventh one related to *gender biases.*

Places to access SRH services

Young adults expressed preferences for specific SRH services, with some favouring private above public or traditional facilities due to personal reasons.

Private Healthcare Services: Some young adults favoured private facilities due to there being respect for confidentiality and efficiency. The extracts below explain their preference:

*"I prefer to get these condoms from a private facility because they provide a feeling that everything is confidential." (*Thabo, 33, M):

*"They prefer private or not around … the surrounding that they live in." (*Selaelo, 24, F)

"I think the private services are the best because you don't have to wait in line for a very long time." (Given, 28, M):

Public Healthcare Services: Some participants preferred public services situated within their communities, and they expressed satisfaction regarding their services:

"Many young people prefer public clinic services." (Tumelo, 31, M):

"Trust the nearest health services, your clinics, and community health workers because obviously they are qualified to do the job and that makes them credible." (Musa, 23, M):

Economic considerations also played a role, as some young people (below) noted the affordability factor associated with accessing public health services:

"Choosing public facilities is preferable because the services are accessible to anyone, and you don't have to pay anything to receive services." (Thabo, 33, M):

Young adults also identified convenience and assurance of comprehensive support as key factors influencing their choice in seeking SRH services in public clinics:

"The convenience of a nearby clinic and the assurance of confidentiality are the main factors influencing my choice of where to seek SRH services." (Ntombi, 29, F):

Traditional Healthcare Services: Males mentioned that they mostly depended on traditional services within their communities, especially for sexual related issues:

"When it comes to STIs men depend mostly on traditional remedies because they believe in traditional methods that create a safe space where they don't see ... no one is going to stigmatise them... And then again... men specifically go to private clinics." (Thato, 32, M)

*"So, it's unlikely for me to say I'm going to visit a clinic. I prefer the traditional services around the community. I use them always." (*Tumelo, 31, M)

User-friendly services

Young adults shared both negative and positive experiences concerning service providers when accessing SRH amenities. Some of the young adults reported that they had mixed feelings regarding their satisfaction with the clinic services that they had sought. The most common reason for satisfaction/dissatisfaction was related to the way they were treated, and the quality of the service provided to them. The following articulations give credence to their views:

"It differs from facility to facility. Myself, I made use of services at [Clinic A]. *The service was good. You don't wait long. But at* [Clinic B] *it differs with days... there are days where when you go there, and you don't even have to wait. Then there are days where you even have to carry your own lunchbox."* (Tumelo, 31, M)

"There are no barriers and no issue of long queues. Once you get to the help desk, you just explain to them what you are looking for, and they will provide you with directions." (Anda, 35, M)

"I heard about a young person in an emergency situation. The clinic attended to them quickly, providing necessary assistance. It was a positive experience." (Ntombi, 29, F)

Attitudes and judgement: SRH providers

According to young adults, they were not treated appropriately in the healthcare facility. When utilising SRH services, they were dissatisfied with the care they received due to judgemental and negative attitudes of healthcare providers. These types of behaviours result in young people becoming anti-SRH providers and thus avoid seeking their services. The following responses indicate their views:

"Sometimes the nurses are not so friendly. The nurses, they will just lecture you... A person would just look at you, size you up and say, oh, you're even this age and now you are feeling that you want to be sexually active, so this and this. They don't really give good service." (Selaelo, 24, F)

"The barriers ... whereby you meet nurses who are being rude towards you, who are judging you... eh discriminating against you ... Who make you see yourself as a disappointment..." (Moses (25, F)

However, some young adults expressed satisfaction that they had benefited from the clinic they chose to access, suggesting a positive experience with the healthcare service providers:

"I've benefited from the services because at the end of the ... I got what I needed; they give us information about why we should take condoms ... how we should use them. And they make it ... make you feel free when you need more." (Lebogang (30, F)

"I had positive experiences with healthcare providers, especially with the accessibility of condoms." (Thabo, 33, M)

Privacy and confidentiality

According to young adults, privacy and confidentiality are still key challenges in public clinics. Tumelo indicated how healthcare providers separate them into groups based on the required services they need publicly:

"When you get to a clinic and then you are all in a hall, that health practitioner will just come and say, those who are here for health related, I mean for sexual health services, just go to the side. So, you wouldn't know if you ... want your neighbour to see you go to access those

services, that's why most young people are reluctant to use the service even though yes, they make use of the service." (Tumelo, 31, M)

Financial constraints

Financial constraints emerged as a prominent barrier as young adults emphasised that affordability posed a severe challenge when accessing SRH services:

"Financial constraints have been a barrier to accessing SRH services. Some individuals in our community struggle to afford even basic health care." (Ntombi, 29, F)

"I think it is very important for young people to have access to SRH services, but they can be hard to access if you don't have a lot of money or if you don't have transport." (Tumelo, 31, M):

Inconvenient hours and long waiting times

Inconvenient hours and long waiting times present substantial barriers to accessing SRH services. For instance, young adults said that they have to wait for long hours at public health facilities, which can be discouraging:

"My experience when I was... I was going through the gonorrhoea. The challenges that I had was I waited for a long time to get help because I was in pains... So, it was a little bit of a challenge because I was... saying should I leave or maybe stay... because of I was in pain I had to stay." (Thato, 32, M):

"Challenges young people face include long queues and delays in service. Sometimes it's due to a lack of efficiency in the clinic." (Ntombi, 29, F)

One of the young adults suggested that SRH service access could be improved and made quicker so that people won't be inconvenienced when visiting clinics.

"I think they must improve their services so that it can be faster so that we don't get identified when we go to the clinics." (Given, 28, M):

Perceived gender bias

The 33-year-old Thabo thought that SRH services were meant only for females; therefore, he felt that SRH services and information are ineffective and limited to female services such as such as pregnancy services, abortions, and family planning. This was perceived as a factor

leading them to avoid clinics thus depriving them of other essential healthcare interventions. They also felt that they were not taken seriously.

"...sometimes when you talk of sexual reproductive services, you think that it's one-sided, just like ... it is meant for ladies, not entirely for men... When you get to the clinic, sometimes when you are a male, you are not even taken seriously compared to the female counterpart... The information that is out there is one-sided when it comes to gender because the promotion makes it feel like SRH services are meant only for ladies. With ladies, there are different services within the SRH services that they can get, but with us… it's not enough!" (Thabo, 33, M)

4.2.4 Policy-Level Factors

At this level of analysis, two sub-themes emerged regarding SRH access: *access to SRH services as a right,* and *strategies to improve SRH access*. Within the sub-theme of *strategies to improve SRH access*, six codes were identified:

SRH services: access as a right

Out 15 young adults, only two participants expressed that they were not familiar with SRH rights. The rest had a good perception of the importance of young adults accessing SRH benefits, and the disadvantages of not accessing the services. For example, they mentioned that access to quality SRH services is and should be a fundamental right for the wellbeing of young adults.

"Access to quality SRH services should be considered a fundamental right. It's essential for the overall wellbeing and empowerment of individuals." (Ntombi, 29, F):

"All young people, everyone should have access to health services. Yes, it is correct. It is their fundamental right." (Thabo, 33, M):

Strategies to improve SRH access

Monitoring and Evaluation: Tumelo suggested that healthcare facilities should be regularly checked and evaluated to ensure that the services provided are up to standard. Tumelo further suggested that after visiting a facility, people should be given a form to share their feedback on the services they received. The facility manager should then review these comments to see how they can improve on their services.

"... and also, that they should be audits done regularly like this study. They should be done regularly at the facilities so that the workers at the facility would know that if they are actually given proper service or what, and then even the evaluation forms after one has visited the facility ... it's like they should be given the evaluation form to evaluate the services that they received on that day. And the facility manager should visit those reviews that the clients are making in the remarks section of the form." (Tumelo, 31, M)

Conducting Workshops for Healthcare Providers: Young adults advised that SRH service providers should be workshopped such that people's complaints should be addressed there too.

"I think maybe a workshop for nurses or doctors should be implemented by the Government and tell them all the complaints from the public. People who have been coming lately…So let's try, by all means to be a family. Let's try to love what you're doing as a nurse or as a doctor." (Gloria, 25, F)

Spreading Awareness and Information: Young adults acknowledged that they have limited information on existing SRH laws, and thus suggested more educational campaigns so that they can be well informed.

"Awareness of laws is limited, but there's knowledge about the legal age for certain services. More education is needed on existing laws regarding SRH." (Ntombi, 29, F)

"Campaign awareness is needed ...so that people out there can have more information regarding SRH." (Thabo (33, M):

"Providing more information and awareness campaigns would be much helpful for a lot of people. More equipment for clinics to provide such services would also be beneficial." (Anda, 35, M)

Educate Men about SRH: Some young adults recommended that more efforts should be made for educating men about SRH.

"I think if we can put more effort in educating men out there regarding the importance of SRH because there are so many services that men can get." (Thabo, 33, M)

Halting community stigmatisation: Young adults emphasised the need for community anti-stigma campaigns to raise awareness of SRH issues.

"To improve SRH access, there should be more community awareness programmes and efforts to reduce the stigma associated with seeking these services. Education is key." (Ntombi, 29, F)

School Based Programmes and Mobile Clinic: Some young adults recommended educating people more about SRH in schools and proposed regular placement of mobile clinics in public places such as schools. They believe that this could make it convenient for young adults to access SRH services.

"They should ask for space in schools, then they get to teach them; more especially in secondary schools because that's where it all starts." (Gloria, 25, F)

"There should be mobile clinics at schools and public places ... there should always be there so that it becomes easier for people to get access to them. And those mobile clinics they should put maybe once in a week or twice in a month. They should go among the communities and provide them with the services." (Lebogang, 30, F)

Figure 2 below outlines young adults' views and experiences regarding SRH clinic services for young adults in Soshanguve. The diagram provides the main themes adapted from the SEM with branches that expand into several related sub-themes.

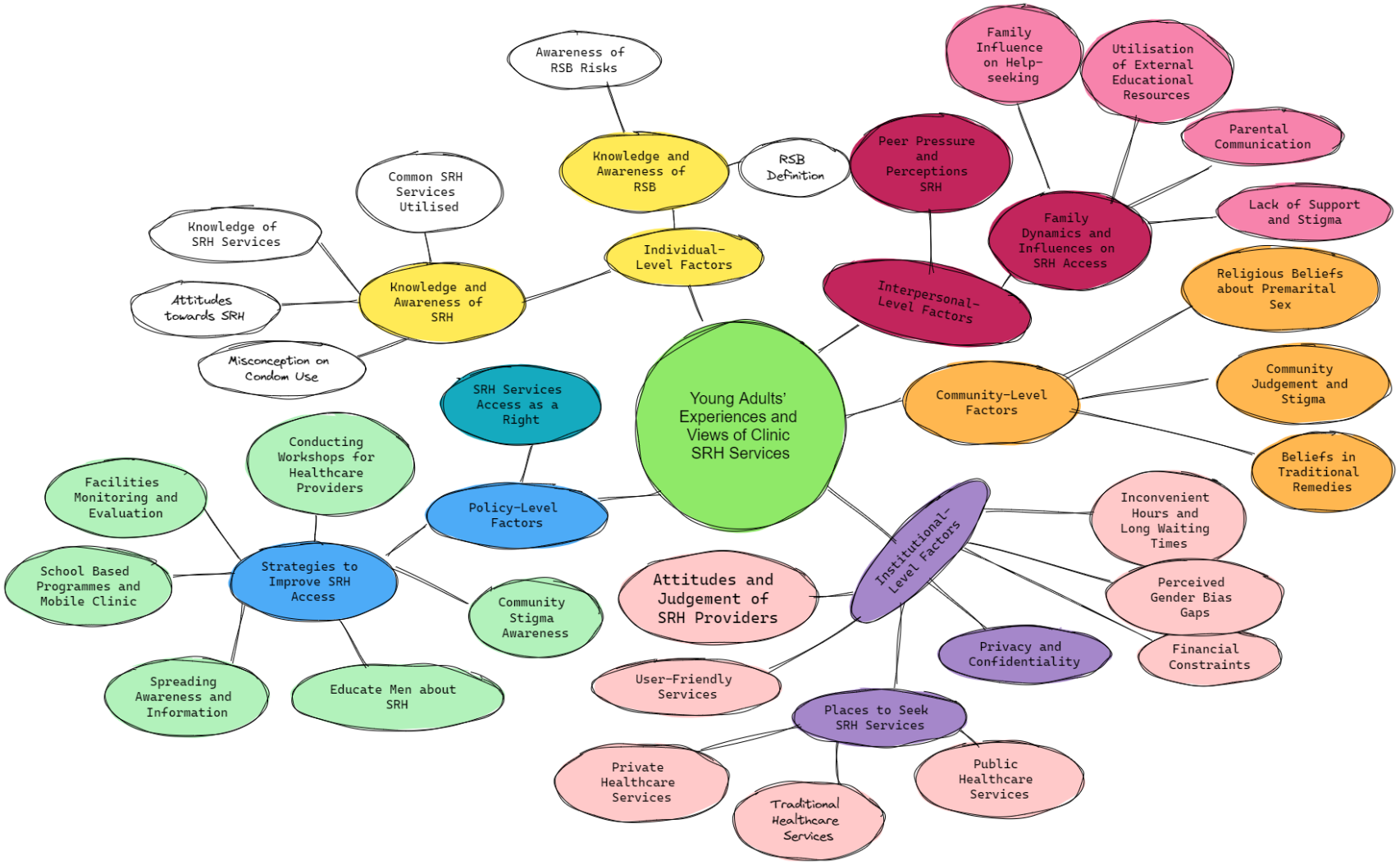

Figure 2: Young adults' views and experiences

4.3 SRH PROVIDERS' VIEWS AND EXPERIENCES OF SRH SERVICES FOR YOUNG ADULTS

This section presents SRH providers' views and experiences regarding barriers influencing young adults' access to and utilisation of clinic SRH services in Soshanguve, which are categorised into SEM levels. Each level is further divided into sub-themes that provide specific insights based on the responses from SRH providers.

4.3.1 Individual-Level Factors

There are four sub-themes categorised as individual-level factors, each addressing a different aspect of providers' views of young adults' knowledge, awareness, attitudes and behaviours, and misconceptions related to SRH.

Knowledge of RSB and SRH

According to SRH providers' responses, young adults in Soshanguve are sexually active but lack sufficient knowledge on protecting themselves against RSB.

"They are sexually active, but they don't have knowledge." (HW 03)

SRH providers also noted a disparity between the claimed and actual knowledge among young adults, who often resist learning about SRH.

"*They have this tendency of saying they know, whereas they don't know. And they don't want to learn… Because information is there."* (HW 04)

Awareness of SRH issues

The SRH providers observed that young adults frequently access SRH services for family planning yet have limited awareness and understanding of preventive measures against STIs. The SRH providers reported that these young adults typically visit clinics when they are already experiencing SRH-related issues such as STIs or pregnancy.

"What I've noticed is that most of my clients, they come with STIs, even if they came for family planning..." (HW 01)

"The clients who were coming here for CTOP, we were providing the Pap-smear for them. And then we found that two in ten were having the CILs [Cervical Intraepithelial Lesions]." (HW 03)

Another SRH service provider reported that it may be that young adults might not be getting enough information about when to use protection like condoms, even if they are engaging in family planning methods.

"I think they don't get enough information for them to know when this happens, and that they need to do this. Or I need to always use condom, no matter what. Even if I'm doing family planning, I still need to use protection." (HW 01)

Attitudes and behaviours towards SRH education and services

One of the SRH peer-educators observed negative attitudes among young adults towards SRH education, including noting apathy towards learning about SRH issues.

"...what I've learned is that they are stubborn ... they don't want to be fed with information." (HW 04)

The above evidence indicates that young adults in Soshanguve have knowledge about SRH issues and the services that are provided to assist patients. However, they exhibit concerning behaviours such as frequently seeking family planning services only after engaging in unprotected sex, thus reflecting a reckless attitude towards their sexual health.

"...they come for family planning after having unprotected sex without family planning. And when they come, they just say, I'm starting, knowing that when they start, you should take a pregnancy test first. And the pregnancy test sometimes comes out positive. And when it's positive, they want [a] *letter to do ToP. And that is the problem that we are facing."* (HW 02)

"*The implementations are working, but there is a lot of ignorance among people who must access these services."* (HW 03)

Myths and misconceptions about contraceptives

According to the SRH providers, misconceptions about contraceptives such as fear of weight gain and future infertility are prevalent among young adults. These myths are perceived as having a significant impact on young adults' willingness to use family planning methods.

"...they always think about the myths... They are going to be fat; they are going to gain weight and all those things. So that's why they don't want to use family planning." (HW 03)

"...most when they come with myths of what's family planning... they will come and say, they told me that implant does this and that." (HW 01)

4.3.2 Interpersonal-Level Factors

There are two sub-themes regarding this level: parental communication, and peer pressure and influences.

Parental communication

According to SRH providers, many young adults are afraid to talk to their parents about SRH. This was mentioned by one of the SRH providers who is also a mother:

"Most youths are afraid to talk to their parents." (HW 01)

Also, some parents are afraid to talk to their children about SRH. This was mentioned by one of the SRH providers who is also a mother:

"You might find that even if I'm a healthcare provider, I'm a mother, but I don't share that information with my child. You feel like you initiate early sexual activities." (HW 01)

On the other hand, according to one SRH provider, today's parents share SRH information to prevent their children from experiencing challenges like pregnancy:

"It's kind of rare to find a child that is maybe 15 years or 13 and does not share things with their parents... parents, they feed them some of the information as they don't want them to get pregnant at any stage. So that's why I say parents advise their children." (HW 04)

Peer pressure and its influences

The SRH providers indicated that peer pressure significantly affects young adults' decisions regarding sex and family planning. Many make choices based on their friends' actions rather than informed understanding.

"They're doing this because of peer pressure." (HW 01)

"Somebody is using family plans, so I also should use it even if they don't have boyfriends, but they still come because somebody is coming." (HW 02)

Other SRH providers pointed out that young adults usually do risky things to fit in with their friends to avoid being 'left out'.

"*I think its peer group pressure. Because most of them tell you that they were with friends who told them what I do ... Or I was breaking her virginity. My friends broke their partners' virginity and so… it's just peer group pressure*." (HW 03)

"It affects them because they will be like, okay, because my friend has done this, I want to do this, whereas you are not learning about it first; okay, is this safe for me to do it or is it not." (HW 04)

4.3.3 Community-Level Factors

There are two sub-themes regarding community-level factors: the impact of stigma and judgement, and limited community education about SRH services.

Judgement and fear

The SRH providers mentioned that community judgement and stigma in Soshanguve concerning family planning services discourage young adults from seeking necessary SRH care as they fear negative perceptions and gossip.

*"... you come for family planning, already they're thinking you're busy with boys... there is too much judgement from the community. (*HW 01)

"...the community prevents young people from coming to the clinic because as I am Lethabo and I see my neighbour and I'm afraid my neighbour will speak about me. Why is Lethabo at the clinic facility? Gossip. Major impact." (HW 04)

"If they see a young child or adult fetching condoms, they will gossip about that girl or that boy who has started to sleep around at her age…. They will say that's an embarrassment in our community." (HW 04)

Belief in traditional remedies

A SRH provider mentioned that some young adults belong to cultures that believe in traditional remedies for addressing SRH issues rather than visiting clinics for SRH medication and care:

"Some cultures believe in traditional remedies..." (HW 04)

Limited community education

A SRH provider mentioned the lack of education within the Soshanguve community about SRH services. This contributes to young adults avoiding these services, as both young individuals and their parents are not adequately informed.

"Community is not yet educated enough to accept that even young people can come and access these [SRH] *services*." (HW 01)

4.3.4 Institutional-Level Factors

There are five sub-themes regarding institutional-level factors: common SRH services accessed, missing appointments, booking systems, resource shortages, and matters of confidentiality.

Common SRH services accessed by young adults

According to SRH providers, young adults primarily seek family planning, STI management, and HIV testing services at clinics.

"Family planning and management of STIs. They come also for HIV tests." (HW 02)

"STIs is the most common one." (HW 03)

Missing appointments

One SRH provider reported that they face challenges with young adults missing family planning appointments, often due to the lack of adherence to scheduled dates.

"They miss their date most of the time... They don't adhere to their date…that's the problem." (HW 02)

Booking system and operational hours

About four SRH providers stated that clinic operating hours and inefficient booking systems pose challenges for young adults in accessing SRH services, particularly when these times interfere with school hours.

"We open from 07:00 to 16:00 every day." (HW 03)

"We are using the booking system and then she'll find that no…. the queue is too long. We will tell her to come the following week but then she wants to do it now, now." (HW 04)

Shortage of resources

One SRH provider mentioned occasional shortages of certain family planning methods like implants. This was perceived as a hindrance to the provision of comprehensive SRH care at clinics.

"...shortage of implants and delay in the delivery of pills in clinics affect us to help them prevent teenage pregnancies and other illnesses…" (HW 02)

Matters of confidentiality

Although confidentiality is assured during one-on-one sessions, there is an initial disclosure at the clinic entrance. Two SRH providers responded:

"...what we speak about in this room remains here." (HW 04)

"It's a one-on-one session... we assure them that whatever is being said remains in here, it doesn't go outside." (HW 05)

However, one SRH provider reported that the arrangement of separate service queues can compromise privacy.

"...when they enter through the gate, they must tell the person at the gate where they are going so that they can be directed properly. And so right there at the gate, they will just say, no, I'm not feeling well..." (HW 03)

"And then when she comes here, there's a queue for family planning, there's a queue for ToP, and then there are people who are there, and then she ends up saying, no, there's no confidentiality…" (HW 03)

4.3.5 Policy-Level Factors

There are three sub-themes under policy-level factors: access to sexual health, health promotion and awareness strategies, and strategies to improve SRH service access.

Access to sexual health services and patients' rights

The SRH providers believed in universal access to quality SRH care regardless of age. They emphasised non-judgemental support, especially for family planning and ToP services.

"Everybody has the right to come and get sexual reproductive services." (HW 01)

"… the right is open … young children… age of 12… can perform an abortion without the consent of their parents." (HW 05)

"The strategy that we are using is that… If she doesn't want to carry the baby, it's her right to do ask for an abortion. And then the abortion is free." (HW 03)

"With our law, I cannot say to anyone no… we must help them when they come for family planning… we can't send them back. No matter the age, even if they come at the age of 13." (HW 02)

Health promotion and awareness strategies

According to SRH providers, clinics use various channels including health promotions, peer education, and outreach programmes to educate young adults about SRH, thus leveraging partnerships with organisations like Love Life and WITS RHI.

"I have a partnership with the Love Life organisation. I have someone who I work with. Mostly when they are sitting there, she comes and gives them health education. So, when they come in here, they will really be having the information." (HW 01)

"We go to schools… I work with my ground breaker from Love Life. He's the one giving them the education when I'm busy working..." (HW 02)

"We have posters... and we also have pamphlets to give out." (HW 04)

Strategies to improve access to SRH services

The SRH providers suggested extending education to parents and utilising the school health nurses to make SRH services more accessible to young adults, including adolescents.

Community Education and Awareness: SRH providers emphasised the need for extending SRH education and awareness beyond young adults to include their parents:

"It [education] *must be extended to their parents. The parents must be aware of the service and encourage their children*." (HW 03)

School Health Nurses: One SRH service provider specifically recommended deploying nurses to offer SRH services in schools.

"I think if we can get school health nurses that start from school and spread them down, down to us, it will be easier." (HW 05)

Figure 3 below outlines SRH providers' views and experiences regarding SRH clinic services for young adults in Soshanguve. The diagram outlines the main themes adapted from the SEM, with branches that expand into several related sub-themes and codes.

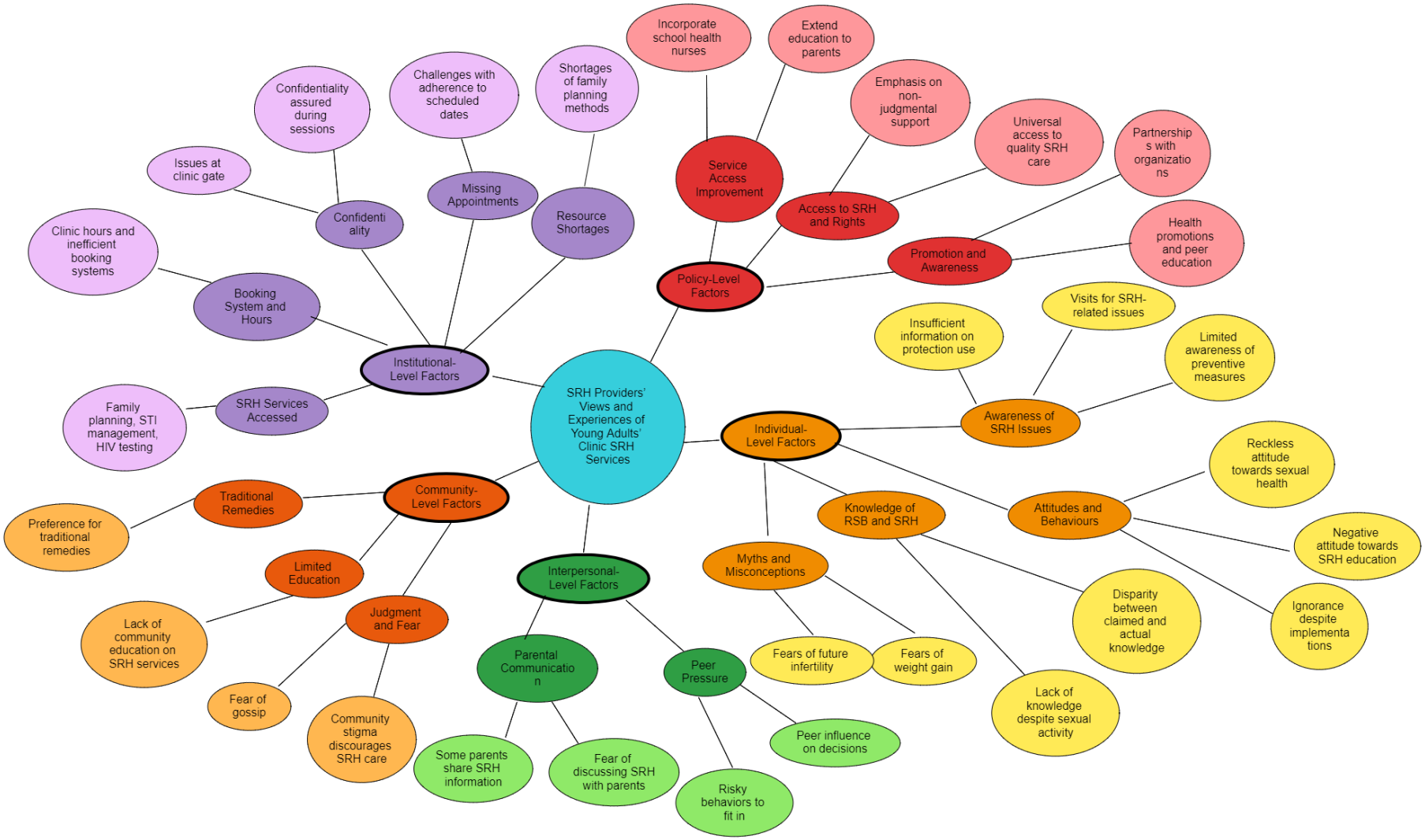

Figure 3: SRH providers' views and experiences

4.4 CONCLUSION

This chapter explored the views and experiences of young adults and SRH providers regarding SRH clinic services. The findings emerged by using semi-structured questionnaire guides (Appendix D and E) in three Soshanguve clinics (see Table 2). The study employed an abductive analysis, adapted from Thompson's (2022) approach, to combine deductive and inductive reasoning to analyse the findings. Deductively, findings were categorised into different levels such as *individual*, *interpersonal*, *community*, and *policy factors* (used as *a priori* themes). Inductively, more detailed sub-themes and codes were developed. Thus, the study presented comprehensive and detailed data on how these factors influenced the views and experiences of young adults and SRH providers regarding SRH services at PHC clinics. It identified barriers that hindered young adults' access to these services and proposed strategies to improve programmes and policies. Overall, these findings addressed the study's aim, objectives, and research questions. Key issues included individual factors like limited preventive awareness which often led to reactive rather than proactive access to SRH services. Negative attitudes towards SRH education and persistent myths about contraceptives and condom use were hindering legal protective measures. Interpersonal factors such as limited parental communication and strong peer influence clouded young adults' perspectives and decision-making. At the community level, factors such as stigmatisation and traditional beliefs were perceived as the most serious barriers to access SRH services. This was exacerbated by institutional challenges such as inefficient booking systems and confidentiality concerns at clinics. Recommendations included universal SRH service access, improved SRH education, involvement of parents, and implementation of effective school programmes to enhance young adults' SRH outcomes.

CHAPTER FIVE: DISCUSSION OF RESULTS

5.1 INTRODUCTION

This chapter discusses the results of the study by focusing on the views and experiences of young adults and SRH providers regarding young adults' utilisation of PHC-clinic SRH services. The implications of these findings are examined through applying the SEM's five levels of influence which delineate the factors influencing young adults' access to and use of clinic services. It interrogates the role of individuals' knowledge and awareness of RSB and SRH and other individual-related factors, interpersonal relationships, community-level influences, institutional barriers and facilitators, and policy-level factors that impact young adults' access to and utilisation of these services. Lastly, the chapter compares these findings with existing literature to confirm commonalities, disparities, and areas necessitating further exploration.

5.2 INDIVIDUAL KNOWLEDGE AND AWARENESS OF RSB AND SRH

The results revealed that while many Soshanguve young adults understand the concept of RSB and its associated risks, there is a significant gap in awareness and knowledge about SRH services. Most young adults recognise RSB as participating in unprotected sex, sex under the influence of substances and having multiple partners, with many understanding the consequences of HIV, STIs and unplanned pregnancies. From the perusal of current literature, other researchers also defined RSB as having sex with multiple partners and not using protection (Wado et al., 2020; Odimegwu & Ugwu, 2022). According to WHO (2019), not using condoms can increase STIs while not adhering to family planning practices can contribute significantly to unplanned pregnancies among young adults.

Regrettably, young adults' familiarity with SRH services is limited, often restricted to HIV testing and prevention programmes introduced through schools or NGOs. Moreover, there is limited information available to young adults about STI preventions, with many only learning about STIs while seeking other services such as contraceptives and abortions. This lack of comprehensive knowledge indicates the need for widespread education campaigns on SRH services to improve awareness and utilisation.

Additionally, the perceptions of SRH providers revealed RSB knowledge gaps among young adults in Soshanguve. According to them, young adults often lack understanding and

knowledge of SRH. This observation resonates with the experiences of many young adults who admitted to only visiting clinics when they were in dire need. It was evident that young adults typically begin accessing SRH services at clinics only after falling pregnancy or contracting STIs and HIV, thus indicating the low community-level awareness.

However, the above findings are not isolated, but form part of a broader trend. For instance, in a USA, Masonbrink (2020) found that the rates of STIs among adolescents were high, with almost one in four girls testing positive after visiting a clinic. Masonbrink (2020) ascribes this to the fact that fewer than half the number of sexually active teenagers received education on contraception and preventing STIs beforehand. In the West Coast Region of the Gambia, Isara and Baldeh (2021) focused on the prevalence of STIs among pregnant women, as well as their knowledge about STIs. Most women were reported to have low education and a lack of knowledge about STIs and HIV/AIDS which led them to ignore symptoms posing risks to their health (Siegfried et al., 2019; Alomair et al., 2020).

5.3 INDIVIDUAL FACTORS INFLUENCING YOUNG ADULTS' ACCESS TO SRH SERVICES

5.3.1 Negative Attitude and Behaviour

The perceptions of both young adults and SRH providers uncovered the negative attitudes and behaviours among Soshanguve young adults towards SRH services. Despite possessing some knowledge of SRH services like family planning, young adults exhibited negative attitudes or ignorance in utilising such clinic services. Young adults often sought help and initiated family planning services only after engaging in unprotected sex and already suspecting that they are pregnant, rather than using them preventatively. This indicates a reluctance to take responsibility for their actions and desire to avoid facing the consequences of unprotected sex. Additionally, it indicates that young adults are likely to disregard the importance SRH services in the future.

In congruence, Öz et al. (2021) revealed that young people exhibited archaic beliefs and attitudes towards sexual health care. However, the reluctance to engage with SRH services proactively may stem from societal factors such as discrimination and negative attitudes towards sexual minorities, as highlighted in a study by Morandini et al. (2022). Additionally, in north-western Nigeria, the healthcare providers' judgemental attitudes towards SRH-seeking

adolescents may have perpetuated the mistrust and failure among young adults to access SRH services timeously (Nmadu, Mohamed & Usman., 2021).

5.3.2 Myths and Misconceptions

The findings also indicate that young adults living in Soshanguve are still subjected to myths and misperceptions about certain SRH services like contraceptives, thus reflecting the lack of comprehensive knowledge about contraceptives among young females. According to the SRH providers, some of the young females held misconceptions that contraceptives lead to weight gain and could negatively impact future fertility. Such misconceptions could prevent them from seeking SRH services, which leads to risky decisions about their sexual health. Moreover, previous research has shown that young adults in low- and middle-income countries such as South Africa and Nigeria, believe that contraceptives could be dangerous to their health, affects their fertility, or even lead to cancer (Jonas et al., 2020; Hutchinson et al., 2021). Such beliefs, myths, and negative perceptions about family planning could affect access to SRH services and thus jeopardise SRH services' effectiveness (Hutchinson et al., 2021).

Among male young adults, there is a belief that condoms limit sexual pleasure. This misconception is erroneously reinforced by cultural metaphors and peer influences. The deeply rooted misconceptions of condom use represent a negative attitude towards sexual health because they perpetuate unsafe sexual practices. Thus, education programmes, targeted at correcting misconceptions and perceptions of masculinity, should be implemented to enhance sexual health outcomes.

5.4 INTERPERSONAL-RELATED INFLUENCING YOUNG ADULTS' UTILISATION OF SRH SERVICES

5.4.1 Parent-Child Communication

Findings indicated that open communication between parents and their children about SRH topics positively influenced young adults' decisions to access SRH services. Conversely, the lack of such communication, often due to parents' discomfort or reluctance in providing information, leads to significant barriers. Both Soshanguve young adults and SRH providers acknowledged that it was difficult to talk about SRH issues with parents or elders and vice-versa. Consequently, young adults avoided utilising SRH services at clinics, potentially limiting access to crucial healthcare resources. This perspective was also observed in a study by Sidamo et al. (2021) that identified a norm-driven protective role of SRH providers in

Southern Ethiopia. These authors noticed that the difficult role of SRH providers was exacerbated by prevailing norms concerning sex and contraception which parents believed should be reserved for married women.

Additionally, findings in this study demonstrated that attitudes towards SRH issues varied from family-to-family. Some families were willing to encourage clinic visits for SRH education while others avoided these topics altogether, believing that it is either culturally unacceptable or would perpetuate early sexual debut. Some families relied on television medical programmes to educate their children on sexual matters. This highlights the diverse approaches of families to access SRH information, and the varying levels of openness to discuss SRH issues. On the positive side, a Western Cape study by Narker (2022) found that some mothers tried to speak to their adolescent children about sex and SRH, while other mothers simply told their adolescents to attend the clinic for contraception without much explanation. Likewise, as observed in Ugu, KwaZulu-Natal, some parents in South Africa hold beliefs that SRH conversations are better managed by professionals like teachers or healthcare workers rather than family members (Govender et al., 2020).

Also, some parents were opposed towards premarital sex and thus avoided discussing issues related to SRH. Hence, young adults held perceptions that it was advisable to avoid discussing sex matters with parents or elders. Similarly, results from a study conducted in Nigeria on parent-child communication on sex-related matters revealed that even though some would initiate conversations about sex matters, many young adults mentioned that they were seldom understanding as they focused on advising against premarital sex (Olusanya & Jegede, 2022).

A South African study conducted by Mbatha (2021) found that open discussions reduce the likelihood of adolescents engaging in RSB; however, authoritarian parent-child relationships hinder these conversations, thus making it challenging for adolescents to discuss RSB matters. In another South African study by Modise (2019), it was discovered that creating an open and safe environment for SRH discussions could enable parents to offer accurate information, address concerns, and guide their children towards making responsible and informed choices. However, effective communication between parents and adolescents about SRH transcends merely imparting accurate information. When parents find it difficult and uncomfortable to discuss sex matters with their children, children tend to seek information from peers, sometimes resulting in misleading information (Duby, 2022). Hence, educating parents on how to initiate

discussions with their children on SRH issues is imperative to prevent them from making unwise decisions.

5.4.2 Peer Pressure on SRH Access

Perspectives from both SRH providers and young adults prove that peer pressure is a significant challenge on decision-making regarding SRH services. This study revealed that peer pressure played a dual role as it can either encourage young adults to seek SRH services which results in positive health outcomes or contribute to stigma and fear which discourages them from accessing SRH services. For instance, one of the SRH providers mentioned instances when young adults accessed family planning methods simply because their friends were using them. Conversely, some young adults avoided using condoms because they feared being perceived negatively by their peers, thus exposing negative peer influence on SRH decision-making.

Similarly, findings on peer influence in other countries like Malaysia by Zakaria et al. (2022) reported that peer pressure led to either positive or negative conduct regarding young adults' decision-making and behaviour patterns regarding SRH. They noted that positive peer support promoted healthier behaviours, while negative peer influence led to risky behaviours. In Ethiopia, Brazil and Indonesia, Olson et al. (2022) revealed similar findings in their cross-sectional studies - most young people still felt embarrassed when accessing condoms in public clinics, and also when buying them in stores because they were afraid of being judged their peers. Amiri et al. (2021) assessed SRH needs among Syrian refugees in Jordan and noted that peer influence played a significant role in family planning decisions; while some peers preached the avoidance of family planning methods, others advised their friends to use them (Amiri et al., 2021).

5.4.3 Social Context Roles

In some communities, social context roles and the demonstration of bravery and risk-taking are lauded (Goodrum et al., 2017). In this study, Soshanguve young adults mentioned that within their peer groups, condom use was seen as a sign of fear of taking risks and not being smart or manly. This social context can create an environment where condom use and SRH services are stigmatised and seen as a lack of confidence or a fear to engage in risk-taking behaviours. This perception could be aligned to findings from literature conducted in various African contexts (Duby et al., 2021; Bukuluki et al., 2021). For instance, in a South African study, the beliefs about gender and what it means to be masculine were reported to have affected young males'

use of condoms – young males often avoided condom use in order to appear sexually experienced and masculine (Duby et al., 2021). Some sub-Saharan African young males even boasted about impregnating a girl to gain 'respect' (Maharaj, 2022). In Uganda most young adult males reported that they would rather use the 'withdrawal method' than using condoms (Bukuluki et al., 2021).

The perception of condom use as a sign of weakness can lead young adults to choose methods like withdrawal instead. Within social peer groups, using methods like withdrawal can be seen as a way to conform to group norms that emphasise masculinity measures.

5.5 COMMUNITY-RELATED CHALLENGES THAT HINDER ACCESS TO SRH SERVICES

5.5.1 Social Norms and Stigma

The responses from both young adults and SRH providers indicated that in Soshanguve stigma regarding SRH issues still persists among young adults. They mentioned that young adults, especially adolescents, who access clinic SRH services or obtain condoms, are often perceived as engaging in age-inappropriate behaviour or pre-marital sexual activities. In other words, pre-marital sex is often labelled as being immoral and promiscuous, which leads to gossip, labelling, and discrimination. Thus, this made young adults to often feel a sense of guilt and avoid accessing SRH services for fear of being considered immoral. A similar qualitative study conducted by Hall et al. (2018) who focused on the stigma surrounding adolescent SRH in Ghana and its impact on family planning outcomes, found that stigma related to non-marital sex came from several sources such as parents, communities, and elders. Community leaders label non-marital sex as being immoral because it is believed that only married couples should engage in sexual activity. Nyblade et al. (2017) in north-western Tanzania state that stigma often manifested in verbal harassment, social isolation, and physical punishment from families, community members, and healthcare providers.

In Soshanguve, stigma is enacted through gossip and false assumptions when young adults try to utilise SRH services at clinics. For instance, young adults were uncomfortable visiting public clinics for necessary SRH services because they dreaded encountering familiar faces, such as neighbours who might judge them and falsely associate their visits with HIV or other STIs. From the literature review, similar results in KwaZulu-Natal, South Africa, were reported by

Ngwenya et al. in 2020 and Duby et al. in 2021. Their findings revealed that stigmatisation was particularly intense regarding the utilisation of SRH services. Those who could afford private clinics would opt to go there, while those who could not afford such services avoided clinics and engaged in unsafe sex, regardless of the outcomes (Duby et al., 2021).

5.5.2 Religious or Cultural Beliefs

In this study, parents, community members, and the society at large were perceived to be influenced by cultural and religious beliefs such that they did not support nor discuss sexual matters including the use of contraceptive services with young adults, especially adolescents or unmarried young adults. Findings highlighted that communities still believe in traditional remedies as alternatives to accessing SRH services at clinics. This confirms that traditional beliefs and practices may still be hindering access to modern SRH services and information. Similar findings were reported in a study by Klu et al. (2022) which uncovered the influence of cultural remedies toward SRH in Ghanaian rural communities where traditional beliefs and practices were deeply ingrained in young adults; for instance, young adults expressed a preference for using herbs and traditional remedies for managing reproductive health issues, citing cultural beliefs about the efficacy and safety of these practices. Another study by Smith et al. (2019) found that women in South African villages who held strong traditional beliefs were less likely to seek modern SRH services which led to unmet contraceptive needs and limited access to prenatal care. This preference for traditional approaches to health issues suggest that cultural norms still play a significant role in shaping individuals' choices regarding SRH services and information.

The issue of religious restrictions in Soshanguve could be inferred from interpersonal-related factors as some young adults mentioned that teachings surrounding pre-marital sex as a sin, restricted them from discussing SRH topics or accessing clinic services if they were unmarried. Other studies in African cultures revealed similar beliefs, where the utilisation of SRH services among young adults is often influenced by religious teachings and societal norms (Ezenwaka et al., 2020; Igboin, 2021; Harrington et al., 2021). For instance, certain Christian perspectives, consider pre-marital sex as being sinful (Igboin, 2021). Additionally, studies in Nigeria (Ezenwaka et al., 2020) and Kenya (Harrington et al., 2021) described various religions' view on pre-marital sexual intercourse and the utilisation of contraceptives among unmarried adolescents as being taboo, immoral, and sinful, thus leading to limited discussions and access of SRH services and contraceptives. These findings underscore the impact of religious and

cultural beliefs on shaping attitudes towards SRH and contraceptive use among unmarried adolescents.

5.6 INSTITUTIONAL-RELATED BARRIERS TO YOUNG ADULTS' ACCESS TO SRH SERVICES

5.6.1 Clinic Preferences

This study found that Soshanguve young adults had preferences regarding access to SRH services. A few young adults preferred private facilities by citing factors such as staff adherence to confidentiality and efficiency, while the majority preferred public services because of affordability, convenience, and assurance of support. Traditional services were also mentioned as a preference by some young adults, particularly young males. Adhiambo, Ngayo and Kwena (2022) confirm that young adults in Africa have a range of preferences regarding SRH services – a few preferred private facilities, while the majority preferred a mix of public and traditional services which were influenced by cost, proximity, confidentiality, and perceived quality of care. Lastly, a South African study by Nyasulu et al. (2018) found that while a considerable number of students in Northern Cape communities utilise both clinic and traditional services, there is a low overall utilisation of PHC services.

5.6.2 Financial Constraints and Travel Costs

In this study, most young adults utilise public clinics; hence, financial constraints were not a major issue in Soshanguve. Although both young adults and SRH providers mentioned that some individuals might face difficulties with transportation costs, the majority appreciated that public clinics provide free services and are conveniently located within walking distance to where most young people live. This is advantageous, especially for those who may not have the funds for private clinic fees and transportation costs. This convenient and free access to care services made a huge difference in their lives.

Studies in the townships located in KwaZulu-Natal and in the Eastern Cape also highlight that public SRH services at clinics are free and in close proximity to the homes of young adults (Adeniyi et al., 2020; Sidamo et al., 2023). Similarly in Limpopo and Mpumalanga, Mulaudzi (2023) found that both youths reported public and private facilities as available and often utilised; yet many young people preferred free public facilities. However, some remote public clinics in these provinces were used less often because of transportation costs and other logistical challenges (Winchester & King, 2018; Sidamo et al., 2023; Mulaudzi, 2023).

In a similar study conducted in Kenya, transportation costs were a major barrier hindering young people from seeking SRH services in rural areas (Wamalwa et al., 2018). These authors reported that young people often had to choose between paying for transport to a clinic and paying for necessities such as food and school fees. Similarly, Kruse et al. (2019) in the USA found that financial constraints are more experienced in remote areas where young people had to travel long distances to access SRH clinics. Hence, the high cost of transport which made it unaffordable for many young people living in poverty, further hindered accessibility to clinics' services.

5.6.3 Consent and Confidentiality

The responses of participants revealed that while confidentiality within Soshanguve clinics was emphasised and assured of, during one-on-one sessions SRH service providers revealed that these aspects were not watertight because at the clinic gate patients may need to declare their reason for their visit. Separate queues for different services may also impinge on confidentiality. Hence, if the nature of the visit becomes apparent to others, then patients will be inhibited from accessing health facilities. In support, Corley et al. (2020) extracted findings from 102 studies conducted in Africa, Asia, Australia, Europe, and North America which identified poor privacy and confidentiality practices, along with healthcare provider bias, as significant barriers hindering young people's access to SRH services. Ngwenya et al. (2020) confirm that the lack of privacy and confidentiality in South African healthcare settings can erode self-confidence and trust, potentially affecting the rate of healthcare utilisation by young individuals.

5.6.4 Operational Hours, Booking System, and Long Waits

Another significant barrier to young adults accessing and utilising SRH services was the issue of inconvenient clinic opening hours. The SRH providers expressed that most Soshanguve clinics' operating hours did not align with young adults' school schedules. The operating hours clashed with the set times of the schools. Some SRH providers also mentioned that the hours of operation are often not convenient for young adults and thus cause a significant barrier to SRH service utilisation. Long queues were also reported as another barrier causing long waiting periods which frustrates young adults and make them negative towards public SRH clinics. This study also found that the current booking system is a big issue leading to waiting for weeks to access SRH services, particularly for ToP. Similarly, a Kenyan study noted that young adults who waited for lengthy periods at clinics were more likely to report feeling frustrated and

discouraged by the system (Wamalwa et al., 2018). These feelings could lead young people to delay or even totally avoid seeking SRH services in the future.

5.6.5 SRH Providers' Attitudes towards Young Adults

One of the major reasons why young adults in this study were reluctant to access the health facilities was the fear of how they would be treated by SRH providers. While some SRH providers displayed a positive attitude toward young adults, there was an underlying element of judgement towards Soshanguve young adults. Many young adults reported negative experiences with SRH providers, including judgement, discrimination, and disrespect. Similar findings were revealed in sub-Saharan African studies where young adults reported unfavourable attitudes and behaviours of SRH providers that discouraged them from attending or returning to clinics for follow-up treatment (Jonas et al., 2018).

In Kenya, young people who reported negative experiences with SRH providers, indicated that they were less likely to seek SRH services in the future (Wamalwa et al., 2018). Similarly, other studies in South Africa by Smith et al. (2018) and Khuzwayo and Taylor (2018) found comparable results emanating from young adults who reported that whenever they try to access public health care for services like SRH or HIV/STI testing, the SRH providers often act in a judgemental and unfriendly manner towards them (Smith et al., 2018).

Sidamo et al. (2021) elaborates that in some sub-Saharan African countries, SRH service providers' attitudes were marked by an unsupportive stance towards the utilisation of SRH services by young adults, especially adolescents; their attitude was primarily attributed to prevailing social norms linked to premarital sex which prejudices them against offering SRH services to unmarried adolescents. They would instead counsel young adults to abstain from sexual activity until marriage because providing SRH services for unmarried adolescents means encouraging premarital sexual activity (Sidamo et al., 2021). Another study conducted in Denmark corroborated these results by articulating that the attitudes of health professionals in dealing with young adults' sexual health were indeed influenced by societal, cultural, and educational factors (Gerbild et al., 2021).

On the other hand, some young adults shared positive experiences in this study by praising the SRH services as being efficient and user-friendly as providers were approachable and helpful. Such positive encounters contributed to a sense of satisfaction and confidence in the health system. In a similar study by Narker (2022), most adolescents in the Western Cape, South

Africa, felt comfortable and even enjoyed their SRH experiences during consultations. This positivity contributed to regular attendance, thus signifying the crucial role SRH providers play in influencing adolescents' decisions to utilise local public clinics.

5.6.6 Gender Disparities at Clinics

Young male adults in this study mentioned that they feel SRH providers 'do not take them seriously' when it comes to assisting them with essential SRH services. They mentioned that SRH clinics tend to have comprehensive SRH information for females, and that the services are more female-oriented. This was confirmed during interviews with SRH providers who recommended that more information should be given to females, implying a potential bias towards services for females to be prioritised, which could leave males feeling marginalised. Similar findings emerged in Soweto, South Africa, where SRH clinics provided services for young people, but frequently overlooked gender equality principles, especially side-lining the prevalence of a high number of males using drugs, initiating early sexual activity, and seeking assistance for condom use (Otwombe et al., 2015). This underscored the importance of prioritising the need for counselling services to address sexual health and drug use specifically tailored for young males.

Similarly, the above findings resonate with those of Ogidan et al. (2022) who found that men preferred male-oriented or male-friendly SRH services in Nigeria as they felt that they were not taken seriously by SRH providers who concentrated more on female-oriented services such as family planning and abortions. Likewise, Adhiambo, Ngayo and Kwena (2022) examined gender issues regarding the quality of SRH provision in Western Kenya and found that young males preferred older male service providers, while young females preferred younger female providers close to own their age. This highlights the gender and age-specific preferences which, if not met, may contribute to young adults, particularly males, feeling voiceless concerning SRH provision.

5.7 POLICY-RELATED STRATEGIES FOR ENHANCING YOUNG ADULTS' SRH SERVICES

5.7.1 Access to SRH Services as a Universal Right

This study emphasised that young adults and SRH providers believed that everyone should have easy access to quality SRH services. The main findings pointed to accessing quality SRH services as a basic right for everyone, especially for young adults as it plays a critical role in

their overall development, wellbeing and sense of empowerment. The SRH providers referred to legal frameworks that support universal access to SRH services, specifically open, inclusive, equal, non-judgmental, and friendly services for all young adults seeking SRH services at clinics. Similar views were expressed in a study in Nepal by Adhikari and Adhikari (2021) that SRH legal frameworks promote overall wellbeing, empowerment, and fundamental health rights for all young adults. In Asia, Yuvaraj and Kundu (2020) also noted that access to quality SRH services is crucial for all young adults to make informed decisions about their SRH, which aligns with the broader global discourse on sexual and reproductive rights. Adhikari and Adhikari (2021) reiterated that youth-friendly SRH services are essential to ensure that young adults exercise their right to access quality SRH information and services.

5.7.2 Strategies to Improve SRH Service Awareness and Utilisation

Both young adults and SRH providers in this study provided valuable recommendations to improve SRH access, particularly within communities.

Health Promotion and Awareness Strategies

Both young adults and providers suggested the need for awareness campaigns to disseminate information about SRH, including details about existing laws related to reproductive health. Their responses also emphasised that educational campaigns focusing on SRH issues among young adults would be valuable for empowerment and knowledge acquisition to make informed decisions regarding SRH needs. This will deter young people from spreading myths, misconceptions, and inaccurate information amongst each other, thus leading them to make uninformed SRH decisions. Education on topics such as contraception, STIs, and healthy sexual relationships imparted at awareness campaigns could empower individuals and young adults to take control of their health and destigmatise discussions around SRH.

Additionally, addressing the aspect of stigma in communities through awareness campaigns could reduce barriers to SRH access and thus encourage SRH service utilisation. By challenging misconceptions and promoting acceptance, these campaigns may create a more supportive environment for individuals seeking SRH services. Similar suggestions were reported by Adhikari and Adhikari (2021) who highlighted the crucial role of awareness campaigns in motivating and empowering young adults regarding SRH matters in Nepal. These young adults believed that such awareness campaigns would discourage the spread of myths and provide accurate information on SRH and relevant laws to encourage young adults to freely

access SRH services. Furthermore, as evidenced in this study, young adults recognised the importance of including all men in SRH discussions as being vital to promote comprehensive health care. Lastly, Ogidan et al. (2022) found that efforts to educate men about SRH services can lead to increased awareness and utilisation of these services.

Community and school-based programmes

Other concerns by both young adults and SRH providers included the incorporation of SRH education into school curricula and community awareness programmes to address the root causes of RSB and issues related to SRH service access and utilisation. Introducing SRH education in schools and communities, as recommended by young adults, sets the foundation for informed decision-making from an early age. Young people will gain essential SRH knowledge to effectively navigate their SRH needs earlier than later. In previous South African studies, young adults thought that having contraceptives and family planning services available within the school premises would be beneficial, making it easier for students to access them without parental involvement (Adekola et al., 2023; Jonas et al., 2020; Munyai et al., 2023). Similar findings were reported in studies from countries such as India and the Netherlands, which emphasised the positive impact of school-based contraceptive services (Papineau et al., 2021; Yau et al., 2021). However, other literature points out that it is essential to be sensitive to cultural taboos surrounding sexuality, particularly in some schools in Limpopo, South Africa, where discussions about sexuality are usually reserved for adults, which poses potential challenges to implementing such initiatives (Adekola et al., 2023; Jonas et al., 2020; Munyai et al., 2023). The findings of a study conducted in Nigeria by Nmadu, Mohamed and Usman (2020) highlighted the importance of the creation of a conducive social environment that is supportive of SRH services with interventions focusing not exclusively on young adults, but also family and community values.

Mobile clinics

Both young adults and SRH providers in Soshanguve suggested the use of mobile clinics to avail services directly to public places, including schools. Establishing mobile clinics in public spaces, particularly within schools, will facilitate easier access to SRH services for young adults. This approach will also address the challenge of avoiding SRH clinics because of the fear of being seen by parents and neighbours. Importantly, it will also reach young adults located in remote rural communities or those who may face barriers such as unfavourable clinic

operating hours which often clash with work or school hours which will improve young adults' overall SRH service availability and accessibility. Referring to a study conducted in Georgia on barriers to and facilitators of mobile HIV care access, Henkhaus et al. (2021) reported similar views of SRH providers regarding mobile clinics. They agreed that mobile clinics are crucial for engaging difficult-to-reach populations by providing healthcare services directly to communities via vans or buses. In this study, SRH providers suggested that these mobile clinics should not only provide HIV and family planning but should also cater for other STIs and SRH health services.

Nicholas and Deji (2023) perceived that while mobile clinics offer significant benefits to underserved remote populations, their effectiveness can also be undermined by barriers such as the lack of health insurance coverage and unreliable transport services in Africa. In many developing nations, a substantial portion of the population remains uninsured or underinsured, thus limiting access to vital healthcare services (Nicholas & Deji, 2023). Kruse et al. (2019) observed in rural USA communities that without adequate insurance, individuals may be unable to afford the services provided by mobile clinics, thus rendering these clinics less effective in reaching the populations that need them the most. This situation is exacerbated by the limited availability of government-funded health insurance programmes, which often have restrictive eligibility criteria in addition to being plagued by bureaucratic inefficiencies (Nicholas & Deji, 2023, 3-4).

An unreliable transportation system can stem from a variety of factors including poor infrastructure, lack of maintenance, and inadequate funding (Kruse et al., 2019). In many developing countries, the road networks are often underdeveloped, with dirt roads that become impassable during rainy seasons (Mlangeni et al., 2022). This makes it challenging for mobile clinics to reach remote rural areas where SRH healthcare services are most needed. For instance, in South Africa, HIV prevention promoters mentioned that rural areas can be difficult to access due to vast distances and poor road conditions, thus leading to infrequent visits by mobile clinics (Mlangeni et al., 2022). Additionally, the vehicles used by mobile clinics may be subject to frequent breakdowns due to poor maintenance and the harsh conditions they must navigate through (Kruse et al., 2019). This not only disrupts the schedule of mobile clinics but also increases operational costs as more funds are diverted to vehicle repairs and maintenance. Unreliable transportation can also affect the logistics of staffing and supplying mobile clinics as delays or cancellations can lead to understaffed clinics and reduced quality of care, as well

as shortages of essential medicines and equipment due to delayed deliveries (Kruse et al., 2019; Mlangeni et al., 2022).

Lastly, in South Africa, Nkosi (2023) who explored patients' (aged 15-55) experiences regarding the use of mobile health clinics in the KwaMachi rural area of KwaZulu-Natal, found that while young people where happy with services from mobile clinics, they raised concerns about privacy concerns during consultations, lack of essential medication, limited services, lack of doctors, and inadequate management of clinical records.

5.8 STUDY LIMITATIONS AND STRENGTHS

In addressing the limitations of the study, it is essential to acknowledge and navigate potential biases and constraints that may impact the robustness and generalisability of the findings.

Secondly, the study omitted young people who are averse to SRH services or public clinics, and therefore were unlikely to be present at the clinics. This could have introduced sampling bias, potentially limiting the generalisability of the results not only to a broader population, but also to other aspects of SRH services. Data triangulation, which involves gathering perceptions from multiple sources such as both young adults and service providers, was employed as a strategy to mitigate this limitation.

Thirdly, the reliance on self-reported data and the geographical delimitation of the research may have introduced biases which limited the cross-cultural applicability of the findings. Relying on what people say about themselves in the study could introduce inaccuracies. For instance, individuals may not precisely report some SRH practices due to fear of being judged or misunderstood, which can skew results or make people say what they think is popular (Cobo et al., 2021).

Fourthly, looking only at young adults might not depict the holistic picture of different age groups' views of and experiences with SRH. Even though the study attempted to consider cultural differences, it might not have fully succeeded, thus affecting the interpretation of results.

It was difficult to recruit young adults aged between 18-20 years as they were mostly at school. To ensure their inclusion in future studies, researchers should partner with schools, colleges, and universities to reach more members of this age-group. Paid advertisements on platforms such as Facebook and TikTok could be utilised to reach specific age groups and populations,

thereby enhancing recruitment efforts across diverse settings (Fevriasanty, 2022). Offering incentives such as gift cards, airtime, or sanitary products may serve as motivators for participation.

By conducting the study in multiple settings, a broader understanding of SRH challenges across distinct cultures can be gained. Using both numbers and people's stories (a mixed-methods approach) could give a complete picture regarding the topic. Furthermore, in the future, it is important to delve deeper into cultural beliefs and practices that affect SRH services. Also, future studies need to monitor and evaluate the effectiveness of community-level SRH campaigns. Exploring new ways like mobile clinics and online platforms to disseminate SRH information to young adults is worth researching.

Despite its limitations, the study had practical strengths that could inform policy priorities and interventions. The SEM method successfully facilitated the study in gathering rich and insightful information. By examining *individual*, *interpersonal*, *community*, *institutional* and *policy* influences, the study successfully explored SRH issues from multiple perspectives. The SEM technique enabled the study to capture participants' attitudes and behaviours towards SRH services. Exploring interpersonal dynamics informed how relationships with peers, family members, and healthcare providers shaped SRH practices and preferences. Community-level factors provided insights into local norms, and how to access barriers such as ineffective support systems affecting SRH service utilisation. Thus, the study gathered rich and in-depth data that not only identified knowledge gaps and challenges, but also elicited targeted interventions and policy recommendations. This holistic approach not only enhanced the depth of understanding, but also aimed to ensure that future interventions are more responsive and effective in addressing the diverse SRH needs of young adults.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

This study was conducted as a result of persistent adverse health indicators such as unplanned pregnancies, unsafe abortions, and STIs including HIV, which indicated that young adults continue to engage in RSB regardless of its negative outcomes. This situation warranted an investigation into the utilisation gap of SRH services and other sexual health interventions. The literature reviewed in this study presented that RSB, including unprotected sexual activity, is highly prevalent among young adults, thus accentuating the importance of understanding the factors influencing RSB. Factors such as peer pressure, social activities, and influences from social media and the internet all influenced young adults to engage in RSB.

The aim of this study was to explore the experiences and views young adults and SRH providers regarding SRH services in Soshanguve, City of Tshwane, South Africa. By adopting the SEM framework, the researcher was assisted in identifying a variety of factors influencing the behaviour and attitude of young adults towards SRH services and their utilisation. Furthermore, the SEM framework informed the identification of targeted interventions aimed at addressing gaps in SRH services while promoting positive SRH-seeking behaviours.

The findings of this study also indicated that in Soshanguve young adults' knowledge and awareness of SRH issues were limited which negatively affected their access to and utilisation of SRH clinic services. It was clear that all five of the five multi-faceted levels of influence adopted from the SEM method significantly contributed to the extent of SRH knowledge and sexual health-seeking behaviour among Soshanguve young adults.

At the *individual level*, young adults' experiences in accessing SRH services were shaped by their knowledge, attitudes, and beliefs regarding SRH. At the *interpersonal level*, communication patterns within families played a pivotal role in influencing young adults' views towards accessing and utilising SRH services. Cultural norms surrounding discussions about SRH also posed as barriers, which delayed open SRH discussions and access to services. Additionally, peer group conversations significantly affected young adults' decisions to seek SRH services. At the *community level*, societal attitudes, including religious constraints and negative attitudes towards SRH that also played a great part in influencing young individuals' access to services. At the *institutional level*, a number of factors shaped service accessibility,

delivery, and acceptability in terms of young people. These include challenges such as inconvenient clinic operating hours and negativity from providers. Lastly, at the *policy level* interventions were viewed as crucial to support the provision of comprehensive and youth-friendly SRH services. This includes policies aimed at addressing systemic barriers to SRH service access such as stigma and discrimination to foster a supportive and user-friendly environment for young adults to efficiently access the services they require.

The overall findings underscored the inter-relatedness of the five levels of influence within the SEM model. For instance, young adults' views and utilisation of SRH services depended on the individual level factors such knowledge and awareness. Additionally, it included the attitude and behaviours of young adults regarding SRH education and services. However, these *individual-level factors* were also influenced by young adults' perceptions related to cultural or religious beliefs (*community-level barriers*). This included the knowledge they have regarding societal norms, relationships with parents, and family dynamics (*interpersonal-level barriers*), which in turn restricted parent-child open discussions on SRH issues. Moreover, *institutional-level barriers* including providers' attitudes towards adolescents seeking SRH services, further exacerbated access to clinics. Importantly, the *policy-level barriers* require comprehensive and astute interventions to mitigate systemic challenges to foster an enabling accessible environment for young adults regarding SRH services.

6.2 RECOMMENDATIONS

Addressing SRH issues among young adults residing in Soshanguve requires a comprehensive understanding of the multifaceted factors shaping attitudes, behaviour, and access to services. Considering the SEM framework, it was evident that SRH-related behaviours and outcomes are influenced by wide range of *individual*, *interpersonal*, *community*, *institutional* and *policy-level* factors.

In recognising the significance of the SEM framework, interventions aimed at promoting positive SRH outcomes must consider the complex interplay among levels within the unique context of Soshanguve. By acknowledging the diverse influences affecting SRH services, intervention strategies suggested by young adults and SRH providers in this study, can be utilised to effectively address the specific needs and challenges faced by young adults in this township. In this regard, this study sets the phase for exploring and implementing

recommendations that prioritise the integrated approach outlined in the SEM framework to enhance SRH outcomes among Soshanguve young adults.

At the *individual level*, the study recommends conducting in-depth cultural analyses to provide valuable insights into the specific beliefs and practices shaping young adults' perceptions of SRH. This understanding can inform tailored interventions that address individual-level factors to promote positive SRH behaviours. Additionally, exploring alternative healthcare channels such as online platforms, can offer personalised SRH information and services that align with individual preferences and needs.

At the *interpersonal level*, the study recommends promoting open communication within families and between young adults by developing supportive centres for conversations centred on SRH topics, including communication barriers between parents and young adults within Soshanguve. In other words, the goal should be to involve parents in SRH education programmes to enhance communication and create supportive environments for young adults to seek professional guidance and support.

At the *community level*, the study suggests assessing the effectiveness of current community-level awareness campaigns in Soshanguve regarding SRH services in order to better understand what influences young adults to use (or avoid) these services. This could be achieved by involving peer networks to share SRH information to encourage responsible sexual behaviour.

At the *institutional level*, it is crucial to consider the specific needs of Soshanguve young adults by dissecting cultural, gender, and socioeconomic components. Thus, this study recommends inclusivity to fruitfully address the unique challenges faced by different groups of young adults when accessing SRH services. Allocating sufficient resources and funding towards the implementation of effective SRH programmes and services within Soshanguve clinics is also imperative to provide comprehensive and youth-friendly care to promote the overall health and wellbeing of young adults.

At the *policy level*, the study suggests circumventing financial barriers and overcoming the stigma linked to seeking SRH services. This might involve creating new strategies within the health system and enhancing existing ones to ensure that all young adults have efficient and equal access to SRH services. Additionally, the health system should develop a system for regular evaluation to monitor the effectiveness of the interventions, and to adjust them based

on the changing needs and problems of young adults in Soshanguve. Regular evaluation will help to ensure that SRH services meet the various needs of young adults, and deal with SRH issues in a community context.

Finally, Figure 4 below provides a summary of recommendations aimed at addressing the limitations identified in the study by incorporating SEM levels for advancing SRH services for young adults.

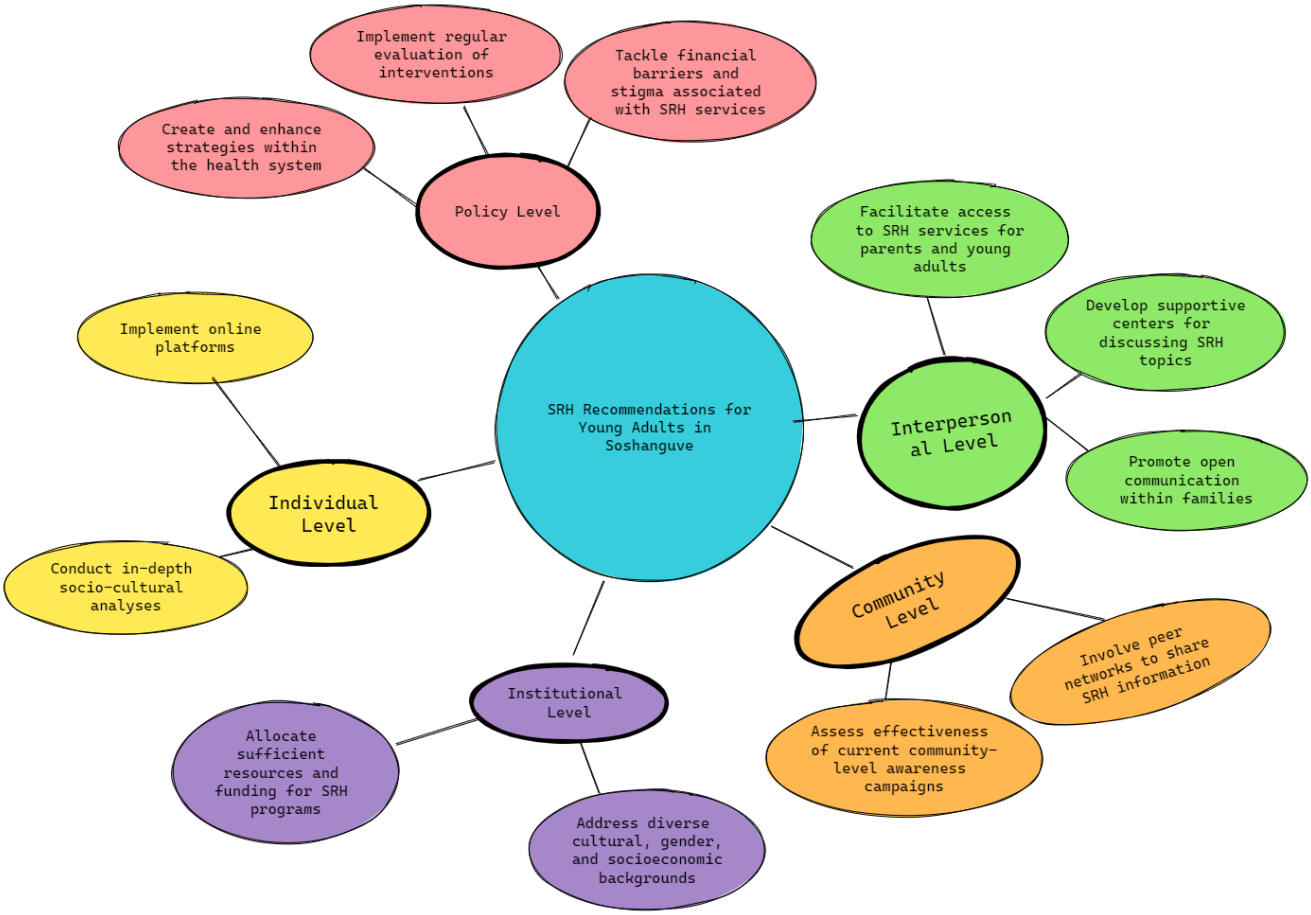

Figure 4: Summary of SRH service strategies for young adults (Adapted from SEM: Bronfenbrenner, 1979)

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APPENDICES

Appendix A: Information Sheet for SRH providers

Title of the research project

Sexual and Reproductive Health Interventions: Experiences and views of young adults and providers in Soshanguve

Principle investigator / researcher(s) name(s) and contact number(s):

Maeko Naum Gloria 2019827324 0763164516

Name of Faculty: Humanities

Name of Department: Centre for Health Systems Research and Development Department (UFS Main Campus)

Study leaders' names and contact numbers:

Prof. Christo Heunis 051 401 3407

Prof. Gladys Kigozi-Male 051 401 3333.

What is the aim/purpose of the study?

The aim is to explore your experiences and perspectives regarding Risky Sexual Behaviours (RSB) and Sexual and Reproductive Health (SRH) services in Soshanguve. The research seeks to obtain a better understanding of the provision of SRH services and what is currently working and not working for young adults in these clinics. Therefore, I would like to invite you to participate in this study by sharing any relevant information that might be beneficial to this research.

Who is doing the research?

I am Gloria Maeko, currently conducting a research study in fulfilment of the requirements of the Master of Health Systems Studies at the University of the Free State.

Has the study received ethical approval?

This study has received approval from the General Human Research Ethics Committee of UFS (G/HREC). A copy of the approval letter can be obtained from the researcher.

Approval number: UFS_HSD2023/0680

Why are you invited to take part in this research project?

As an SRH service provider, you were purposefully selected for this study. I would like to hear about your experiences as someone who participated in the service provision. I kindly ask you to participate in this study freely and voluntarily—the choice whether to participate is yours alone. Participation in this study is voluntary, so you will not be paid for it. If you choose not to take part, you will not be affected in any way whatsoever. You may stop the interview at any time. If you do this, I will respect your decision. The study involves a one-on-one interview and is expected to take no longer than 45 minutes. To minimise service disruption, I will make appointments with the respective SRH providers.

What is the nature of participation in this study?

You will be required to sign a consent form indicating your voluntary participation and acceptance of the audio-recording of the interview. To ensure your privacy during this interview, I have requested a private space where you can feel comfortable and free to speak openly. You will be participating in an interview with open-ended questions where you will share your honest and transparent experiences and perspectives on SRH services. The questions will focus on the obstacles you encounter while delivering SRH services and your opinions on the factors that affect the provision of SRH services for young adults.

Can the participant withdraw from the study?

Being in this study is voluntary, and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time without giving a reason.

What are the potential benefits of taking part in this study?

There is no direct benefit to you but the information you provide will contribute towards identifying strengths and weaknesses of the SRH services and describes what needs to be improved and/or scaled up so that the interventions and policies can be reviewed and implemented better in Soshanguve.

What is the anticipated inconvenience of taking part in this study?

At present, I do not anticipate any major risk of harm that may arise from your participation in this study. However, if you experience any distress because of participating in this study, you will be referred to a psychologist affiliated with this health facility.

Will what I say be kept confidential?

A strict confidentiality protocol will also be maintained throughout the study, where only my supervisors and I will have access to this information. You will be required to sign a consent form, but this will be kept separate from the data collected. All collected data will be kept securely to prevent any unauthorised access. All information provided will be kept confidential and not shared with anyone under the Protection of Personal Information Act (POPIA). Your information will only be reviewed by the study supervisors and by the ethics committee (if requested) to safeguard your information. Your responses will only be used for research purposes and your name will not be connected to your answers. Instead, the researcher will create a pseudonym to hide your identity in any produced documents after the study. The consent form with your name will be kept separate from and will not be linked with the interview schedule or audio recording.

How will the information be stored?

Hard copies of the informed consent form you signed, and your transcribed interview will be stored by the researcher for a period of five years in a locked cabinet; electronic information will be stored on a password protected computer and encrypted google drive. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After five years all hardcopies will be destroyed, and electronic information will be deleted permanently.

Will I receive payment or any incentives for participating in this study?

Participation in this study is voluntary, so you will not be paid for it. If you choose not to take part, you will not be affected in any way whatsoever.

How will the participant be informed of the findings/results of the study?

If you would like to receive a copy of results you can contact me or my supervisors. We will be happy to share the document with you.

My contacts are as follows: 076 316 4516 or email: 2019827324@gmail.com.

Researcher's supervisors: Prof. Christo Heunis, 051 401 3407 and/or Prof. Gladys Kigozi-Male, 051 401 3333.

For any ethical queries, please contact Amanda Smith on 051 401 2075 or email on SmithAM@ufs.ac.za.

Thank you for taking the time to read this information sheet, and for possibly participating in this study.

Appendix B: Information Sheet for Young Adults

Title of the research project

Sexual and Reproductive Health Interventions: Experiences and views of young adults and providers in Soshanguve.

Principle investigator / researcher(s) name(s) and contact number(s):

Maeko Naum Gloria	2019872324	0763164516
Name of student/researcher	Student number	Contact number

Faculty and Department:

Humanities: Centre for Health Systems Research and Development

Study leader(s) name and contact number:

Profs Christo Heunis, 051 401 3407

Gladys Kigozi-Male, 051 401 3333

What is the aim / purpose of the study?

The aim is to explore your experiences and perspectives regarding **RSB** and SRH services in Soshanguve. It seeks to identify areas that require improvement and expansion, while also learning from the areas that work well and those that do not. Therefore, I would like to invite you to participate in this study by sharing any relevant information that might be beneficial to this research. Please be assured that any information you provide will be kept confidential and used solely for research purposes.

Who is doing the research?

My name is Gloria Maeko, and I am conducting a study on Sexual and Reproductive Health Interventions: Experiences and Views of Young Adults and Providers in Soshanguve.

Has the study received ethical approval?

This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher.

Approval number: UFS_HSD2023/0680

Why are you invited to take part in this research project?

You were selected to participate in this study because you are a young adult located in Soshanguve and currently use or have utilised the clinic's SRH services. Hence, I would like to hear about your experiences as someone who has visited the clinics to access SRH services. I kindly ask you to participate in this study freely and voluntarily—the choice whether to participate is yours alone. Participation in this study is voluntary, so you will not be paid for it. If you choose not to take part, you will not be affected in any way whatsoever. You may stop the interview at any time. If you do this, I will respect your decision.

What is the nature of participation in this study?

You will be required to sign a consent form indicating your voluntary participation and acceptance of the audio-recording of the interview. To ensure your privacy during this interview, I have requested a private space where you can feel comfortable and free to speak openly. You will be answering open-ended questions about your experiences and views of SRH services in the clinics targeted. You are expected to express yourself openly and honestly during the interview.

Can the participant withdraw from the study?

Being in this study is voluntary, and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

What are the potential benefits of participating in this study?

There is no direct benefit to you but the information you provide will contribute towards identifying strengths and weaknesses of the SRH services and describes what needs to be improved and/or scaled up so that the interventions and policies can be reviewed and implemented better in Soshanguve. Thus, develop recommendations. Thus, develop recommendations.

What are the anticipated risks of taking part in this study?

At present, I do not anticipate any major risk of harm that may arise from your participation in this study. However, if you experience any distress because of participating in this study, you will be referred to a psychologist affiliated with this health facility.

Will what I say be kept confidential?

Your information is confidential and note that only I and my supervisors will have access to this information. You will be required to sign a consent form, but this will be kept separate from the data collected. All collected data will be kept securely to prevent any unauthorised access. All information provided will be kept confidential and not shared with anyone under the Protection of Personal Information Act (POPIA). Your information will only be reviewed by the study supervisors and by the ethics committee (if requested) to safeguard your information. Your responses will only be used for research purposes and your name will not be connected to your answers. Instead, the researcher will create a pseudonym to hide your identity in any produced documents after the study. The consent form with your name will be kept separate from and will not be linked with the interview schedule or audio recording.

How will the information be stored and destroyed?

Hard copies of the informed consent form you signed, and your transcribed interview will be stored by the researcher for a period of five years in a locked cabinet; electronic information will be stored on a password protected computer and encrypted google drive. Future use of the stored data will be subject to further research ethics review and approval if applicable. After five years, all the hardcopies will be destroyed, and electronics will be deleted permanently.

Will I receive payment or any incentives for participating in this study?

Participation in this study is voluntary, so you will not be paid for it. If you choose not to take part, you will not be affected in any way whatsoever.

How will the participant be informed of the findings/results of the study?

If you would like to receive a copy of results you can contact me anytime, I am happy to share the document with you.

My contacts are as follows: 076 316 4516 or email: 2019827324@gmail.com
Researcher's supervisors: Prof. Christo Heunis, 051 401 3407 and/or Prof. Gladys Kigozi-Male, 051 401 3333.

For any ethical queries, please contact Amanda Smith on 051 401 2075 or email on SmithAM@ufs.ac.za.

Thank you for taking the time to read this information sheet and for possibly participating in this study.

Appendix C: Consent Form

FREE STATE
UNIVERSITEIT VAN DIE
VRYSTAAT
YUNIVESITHI YA
FREISTATA
UFS

Consent to participate in this study

I, the undersigned,

_____

(participant's full names to be included), (the "Participant")
Confirm that I voluntarily agree to participate in the research study referred to as the
Sexual and Reproductive Health Services: Experiences and views of young adults and providers in Soshanguve (the "Study") in relation to

_____

And which Study is being conducted by

_____

(Insert the name of the researcher), (the "**Researcher**").

I, the undersigned Participant, further confirm that–

1. the Researcher has explained the nature, procedure, potential benefits and anticipated inconvenience of my participation in the Study;
2. I have read (or had explained to me) and understood the Study as explained in the attached information sheet;
3. I have had sufficient opportunity to ask questions and am prepared to participate in the Study;
4. I understand that my participation in the Study is entirely voluntary and that I am free to withdraw at any time without penalty (if applicable);
5. I voluntarily provide the UFS and the Researcher with my personal information and consent to the UFS and the Researcher collecting, disclosing and processing my personal information in order to conduct the Study and any related activities in relation thereto;
6. I hereby acknowledge and confirm that I understand the purpose for which the UFS and the Researcher may collect, store, use, delete, destroy, outsource, transfer or otherwise process, as the context and circumstances may require and as contemplated in terms of POPIA, my personal information as set out herein;
7. I am aware that the findings of the Study will be anonymously processed into a research report, journal publications and/or conference proceedings and that my personal information will be aggregated and de-identified at such stage;
8. I also give the UFS permission to share, without notification, the collected data with other researchers at the UFS or other Higher Education Institutions. This permission is dependent on the same principles of ethical research practices, anonymity/confidentiality, safekeeping of information, and other issues listed above applying.

I, the Participant, agree to the recording of the <insert specific data collection method>.

Full Name of Participant: _____

Signature of Participant: _____ Date: _____

Appendix D: KII: Guiding Questions for SRH Providers

This discussion seeks SRH providers' insights into how the SRH services are currently being implemented and provided to young adults, and how they can be strengthened better to meet the health needs of the targeted young adults. Participants will also reflect, looking back, whether, in its current format, the services have achieved their objectives and if not, where and why. This more profound understanding of the SRH services processes will allow the researcher to make appropriate recommendations for the SRH services' implementers and policymakers.

Section A: Demographics

1. Please tell me your age.
2. What is your educational qualification?
3. Please tell me how many years of experience do you have in providing SRH services?
4. Please explain your SRH role. (More than one role can be mentioned. Etc. Implementer, monitor, manager or facilitator)
5. Who, if any group, is targeted by the SRH services? (Adolescent females or males and young adults?)
6. What training, if any, did you receive to implement SRH services? (Probe the type of training and if the training is helpful for the current role).

Knowledge of RSB

7. Tell me about common **RSB**-related issues in your community area. ***Probe reasons behind these patterns.***
8. Tell me about the key drivers of these **RSB** in your community.
9. How, if in any way, do gender norms and expectations shape **RSB** in this area? ***Probe how gender roles and expectations may influence an individual's RSB and access to health services.***

Knowledge and Provision of SRH services

10. What is your opinion about South African Sexual and Reproductive Health Rights (SRHR)? ***Probe for opinions what works well and what does not work. Probe for challenges and what could be improved.***

11. What has been your experience in providing SRH services to young adults? ***What methods has been working for you? What could be improved?***
12. What messages, if any, are used to communicate about SRH services to inform and encourage young adults to access services? ***What services are readily accepted by young adults? Which ones are not?***

Factors influencing the use of SRH among young adults, framed within SEM.

13. How, if in any way, do individual-level factors influence young adults' uptake of SRH services? ***Can you describe any specific individual factors (personal beliefs, attitudes and experiences,) that you have observed in your practice that have influenced young adults' decision to use or not use SRH services?***
14. How do you think community or social factors can impact young adults' decision to use or not use SRH services, based on your experience as a healthcare provider? ***Could you share any specific examples or instances where you have observed community or social factors affecting young adults' use of SRH services (cultural belief or religion or peer influence etc.)?***
15. What are the community's perceptions of SRH services? ***Probe for how do they influence utilisation? Probe for community attitudes towards SRH services and how they shape service utilisation.***
16. How, if in any way, have the services assisted in addressing issues related to young adults' health outcomes, such as STIs and unplanned pregnancies?

Appendix E: IDI Young Adults' Case Study Guiding Questions

The interview aims to obtain young adults experiences of SRH services in their communities, their knowledge and views on SRH services and their feelings on the current services offered to them. The objective is to identify areas for improvement and strengthening of SRH services to better meet the needs of young adults.

Section A: Demographic

1. How old are you?
2. What is your occupation?
3. What is your gender?
4. What is your highest education level?
5. How long have you been staying in Soshanguve?
6. What is your marital status?
7. How many children do you have?

Individual level: Knowledge of <u>RSB</u> and SRH services among young adults in Soshanguve

8. What do you understand by the term *Risky Sexual Behaviour*?
9. What are the consequences or potential risks related to **<u>RSB</u>**? ***Probe how familiar they are with the impacts of unprotected sex, e.g., unplanned pregnancies or STIs.***
10. Have you ever heard about SRH services? ***a) If yes, probe; can you provide examples of the types of services you have heard or know of? (For instance, could you list them?)***
11. Which types of these services have you used? Probe if visiting the clinic was their first option or if they have seen other facilities prior***. Probe the type of the facility e.g., public facility/ private facility or traditional facility or community health worker/mobile/other.***
12. What did you know about SRH services before you used them, and where did you learn this information?

Interpersonal level: Perspectives of family and peers' views towards SRH

13. How do your family members view sexual activity among young adults?
14. How do your peers perceive the use of condoms?

15. How, if in any way, do families or peers influence access to SRH information and services?

Community level: Beliefs surrounding SRH services among young adults.

16. How do cultural norms affect young adults' access to SRH services at clinics? ***Probe for the role of social and cultural beliefs, including taboos, stigma, and discrimination.***

Institutional level: Provision and accessibility of SRH services in Soshanguve

17. Where do young adults usually seek SRH ***services in Soshanguve- public or private facilities, traditional health services, community health workers or mobile clinics? Probe for reasons for their preference.***
18. What barriers do young adults face when accessing SRH services in clinics? ***Probe for challenges such as affordability, inconvenient hours, or long waiting times?***
19. Share your personal experience with the SRH providers and this clinic you chose for SRH services. ***Probe: Are there any obstacles or benefits you encountered during the process?***
20. What can be done to improve access and provision of SRH services?

Policy Level: Knowledge of the rights of SRH services in South Africa

21. Do you believe that all young adults should have access to quality SRH services as a fundamental right? ***Could you please explain your answer?***

Appendix F: Codebooks

Codebook Young Adults Experiences and Views of SRH Services

Individual Level Factors					
Sub-Theme	**Code**	**Definition**	**When to use**	**When not to use**	**Example quote**
Knowledge and Awareness of RSB	RSB Definition	Refers to RSB, characteristics such as engaging in unprotected sex, multiple partners etc.	When discussing RSB and its risks.	When discussing topics not related to RSB.	*"So, we're talking about unsafe sex, basically... Unsafe sex means having sex with somebody not using protection... having sex under the influence of alcohol is also part of unsafe sex." (Thando, Age, 24, F)*
Attitudes towards SRH		Young Adults' attitudes towards SRH services	When discussing young adults' attitudes of SRH services	When discussing issues not related to young adults' attitudes SRH service	*"They don't take this thing very seriously…taking it very lightly. Some of them don't use condoms. They usually don't go to the clinics because they see themselves as old people. Old men who can take care of themselves" (Moses, Age, 25, M)*
Misconception on Condom Use		Young Adults' misconceptions on condom use and other SRH services	When discussing young adults' misconceptions on condom use and other SRH services	When discussing issues not related to young adults' misconceptions on condom use and other SRH services	*"...so, there's a perception that using condoms limits pleasure……. Some believe it's not enjoyable" (Ntombi, Age, 29, F).*
Interpersonal Level Factors					
Sub-Theme	**Code**	**Definition**	**When to use**	**When not to use**	**Example quote**

Family Dynamics and Influences	Parental Communication	Refers to open discussions within families regarding sexual health, which influences individuals' decisions to access SRH services	When discussing the influence of family communication on SRH service-seeking behaviours	When the influence of family communication is not relevant	*"My family was open about discussing these matters and that communication helped me understand the risks and access to [SRH] services when needed." (Ntombi, Age, 29, F)*
	Utilisation of External Resources	Influence of external resources (e.g., media) on accessing SRH services	When discussing the influence of external resources	When discussing other external influences not related to SRH services	*"…. they choose television shows such as daily Theta, all of those shows, they talk about health sometimes... They would make sure that we… we watch those TV shows, okay and then so that you can get more knowledge and understand this activity better." (Lebogang, Age, 22, M)*
	Lack of Support and Stigma	Fear of judgment or stigma associated with discussing sexual health issues, leading to reluctance in seeking SRH services	When discussing barriers related to stigma and judgment	When discussing unrelated topics	*"Yeah, the attitude is going to be like, did you do something wrong? Why do you feel like you want to go and test for STI? You probably had unprotected sex." (Mapula, Age, 30, F)*
	Family Influence on Help-seeking:	Positive influence of family support on accessing SRH services	When discussing family influence	When discussing other family influence related topics.	*"My family was supportive and positively influenced my access to services. They encouraged seeking help when needed, fostering a health-conscious environment." (Ntombi, Age, 29, F).*
Peer Pressure and Perceptions SRH		Peer Pressure and Perceptions of SRH Services	When discussing peer influence on condom use and RSB	When discussing other peer-related topics	*" So, our belief is that in order for the taste of the sweets...to feel it, then it means you need to unwrap the cover." (Thabo, Age, 33, M) "When it comes to peers, it's like, um, when*

					you're using condoms, you, you're afraid, you know, you're afraid you don't want to take risks..." (Given, Age, 28, M)
Community Level Factors					
Sub-Theme		**Definition**	**When to use**	**When not to use**	**Example quote**
Beliefs in Traditional Remedies		Beliefs in traditional remedies or herbal practices for addressing SRH issues, influenced by cultural norms and upbringing	When discussing cultural beliefs and norms	When discussing unrelated cultural beliefs and norms	*"...When we grow up, we were always taught that some of the things can be dealt with by remedies or herbs, among other ways of dealing with the SRH." (Thabo, Age, 33, M).*
Religious Beliefs about Premarital Sex		Perceived religious beliefs about sex before marriage or between to unmarried couple	When discussing religious beliefs about sex before marriage	When discussing unrelated beliefs about sex before marriage	*"You know, sex before marriage is a sin. Yeah, I think they're trying to prevent us from having those kinds of issues" (Gloria, Age, 25, F)*
Community Judgement and Stigma		Perceived issues related to community judgement and stigma on young people accessing SRH services	When discussing community judgement and stigma on young people accessing SRH services	When discussing issues not related to community judgement and stigma on young people accessing SRH services	*"Unfortunately, there's still a stigma in our community associated with accessing SRH services. People fear judgment and this hinders open discussions" (Ntombi, Age, 29, F).*
Institutional Level Factors					
Sub-Theme		**Definition**	**When to use**	**When not to use**	**Example quote**
Places to Seek SRH Services	Private Healthcare Services	Preference for private healthcare facilities due to perceived confidentiality and quality of service	When discussing preferences for private healthcare	When discussing unrelated preferences for private services	*"I prefer to get these condoms from a private facility because private facilities provide a feeling that everything is confidential." (Thabo, Age, 33, M).*
	Public Healthcare Services	Utilisation of public healthcare facilities for SRH services	When discussing utilisation of public healthcare	When discussing unrelated utilisation of public services	*"Many young people, they prefer public services." (Tumelo, Age, 33, M)*

	Traditional Healthcare Services	Utilisation of traditional healthcare practices for SRH issues, influenced by cultural beliefs and norms	When discussing utilisation of traditional healthcare.	When discussing unrelated utilisation of traditional services	*"When it comes to STI as and everything men depend mostly on traditional because they believe that in traditional... that's the safe space where they don't see... no one is going to stigmatise them... And then again... men specifically go to private clinics..." (Thato, Age, 32, M)*
User-Friendly Service		Young Adults' views and experiences regarding the ease of use and accessibility of healthcare services	When discussing positive experiences with SRH services	When discussing negative experiences with SRH services	*"When I visited the facility... the service was user-friendly because the waiting period was not that long." (Tumelo, Age, 33, M) "It differs from facility to facility. at A clinic. The service was good. You don't wait long. But at B clinic it differs with days... there are days where when you go there, I don't even take time." (Tumelo, Age, 33, M)*
Attitudes and Judgement by SRH Providers		Experiences with SRH providers, including judgment, discrimination, and rude attitudes	When discussing SRH provider attitudes	When discussing unrelated provider attitudes	*"Sometimes the nurses are not so friendly...A person would just look at you, size you up and say, oh, you're even this age and now you are feeling that you want to be sexually active..." (Selaelo, Age, 24, F)*

Privacy and Confidentiality		Concerns about privacy and confidentiality when accessing SRH services	When discussing privacy and confidentiality concerns	When discussing unrelated privacy and confidentiality issues	*"When you get to a clinic and then you are all in a hall, that health practitioner will just come and say, those who are here for health related, I mean for sexual health services, just go the side. So, you wouldn't know if you ... want your neighbour to see you go to access those services, that's why most young people are reluctant to use the service even though ..." (Tumelo, Age, 33, M)*
Financial Constraints		Financial barriers hindering access to SRH services	When discussing financial barriers to accessing SRH services	When discussing unrelated financial constraints	*"Financial constraints have been a barrier to accessing SRH services...Some individuals...struggle to afford even basic health care." (Ntombi, Age, 29, F)*
Inconvenient and Long Waiting Times		Long waiting times at healthcare facilities, discouraging service utilisation	When discussing waiting time barriers	When discussing unrelated waiting time issues	*"Challenges young people face include long queues and delays in service...due to a lack of efficiency in the clinic." (Ntombi, Age, 29, F)*
Perceived Gender Biases Services		Gender-based disparities in service provision, leading to longer wait times and less prioritisation for male service seekers	When discussing gender biases in service provision	When discussing unrelated gender biases	*"...sometimes when you talk of sexual reproductive services, you think that it's one-sided, just like... it is meant for ladies, not entirely for men..." (Thabo, Age, 33, M).*
Policy-Level Factors					
Sub-Theme		**Definition**	**When to use**	**When not to use**	**Example quote**

SRH Services Access as a Right		Views on SRH related rights and quality of SRH services including accessibility and availability for young adults	When discussing views related SRH related rights and quality of SRH services including accessibility and availability for young adults	When discussing views not related SRH related rights and quality of SRH services including accessibility and availability for young adults	*"... it [access] should be given to young people free and very accessible. Young people should actually normalise accessing these services so that we can also deal with the stigma that is attached to young people accessing these services is." (Tumelo, Age, 33, M)*
Strategies to Improve SRH Access	Facilities Monitoring and Evaluation	Young adults' suggestion regarding monitoring and evaluating healthcare facilities to ensure quality service provision	When discussing monitoring and evaluation of facilities	When discussing unrelated monitoring and evaluation topics	*"... and also, that they should be audits done regularly like this study They should be done regularly at the facilities... the facility manager should visit those reviews that the clients are making in the remarks." (Tumelo, Age, 33, M)*
	Conducting Workshops for Healthcare Providers	Suggestions for conducting workshops for healthcare providers to improve service quality	When discussing workshops for healthcare providers	When discussing unrelated workshop topics	*"I think maybe a workshop for nurses or doctors should be implemented by the government" (Gloria, Age, 25, F).*
	Spreading Awareness and Information	Proposals for awareness campaigns to provide more information about SRH services	When discussing spreading awareness about SRH services	When discussing unrelated awareness campaigns	*"Awareness of laws is limited, but there's knowledge about the legal age for certain services. More education is needed..." (Ntombi, Age, 29, F)*
	Educating Men about SRH Education	Suggestions for educating men about the importance of SRH services	When discussing educating men about SRH services	When discussing unrelated education topics	*"Campaign awareness is needed ...so that people out there can have more information regarding SRH... " (Thabo, Age, 33, M)*

	Community Stigma Awareness	Recommendations for community awareness programmes to reduce stigma associated with SRH services	When discussing community stigma awareness programmes	When discussing unrelated community awareness programmes	*"To improve SRH access, there should be more community awareness Programmes and efforts to reduce the stigma associated with seeking these services. Education is key." (Ntombi, Age, 29, F)*
	School Based Programmes and Clinic Mobiles	Suggestions for implementing school-based programmes and mobile clinics to improve SRH service access.	When discussing school-based programmes and mobile clinics.	When discussing unrelated school or clinic topics.	*"They should ask for space in schools, then they get to teach them more especially in secondary schools, because that's where it all starts." (Gloria, Age, 25, F)*

Codebook SRH Providers' Experiences of Providing SRH Services to Young Adults

Individual-Level Factors				
Subtheme	**Definition**	**When to use**	**When not to use**	**Example quote**
Knowledge of RSB and SRH	Attitude toward SRH services among young adults	When participants discuss views on young adults' attitudes towards SRH services	When participants discuss views unrelated young adults' attitudes to SRH services	*"Even if they come for family planning and what not, but most of them what I've noticed is that they come with STI… already…" (HW01)*
Awareness of SRH Issues	Gaps in knowledge about SRH practices and methods among young adults	When participants discuss views on the knowledge young adults have or do not have related to SRH services	When participants discuss views unrelated to knowledge gap young adults have or do not have to SRH services	*"What I've noticed is that most of my clients, they come with STIs, even if they came for family planning... STI is the number one problem in the youth that I work with." (HW01)* *"They have this tendency of saying they know whereas they don't know. And some of these things are caused by... are caused by them don't want to learn. They don't want to learn. Because information is there, but they don't want to learn" (HW04)*
Attitudes and Behaviours towards SRH Education and Services	Views on young adults' attitudes towards SRH education	When participants discuss views on young adults' attitudes towards SRH services education	When participants discuss views unrelated young adults' attitudes to SRH services education	*"...what I've learned is that we are stubborn... we don't want to be fed with information." (HW04)*
Myths and Misconceptions on contraceptives	Misconceptions and myths surrounding family planning methods and their impact on service utilisation	When participants discuss views on myths and misconception among young adults about SRH services such as family planning	When participants discuss views other myths and misconception among young adults unrelated to SRH services	*"...they always think about the myths. The myths are the ones that overcome all this...They are going to be fat; they are going to gain weight and all those things. So that's why they don't want to use family planning." (HW03)*
Interpersonal-Level Factors				
Code	**Definition**	**When to use**	**When not to use**	**Example quote**

Parental Communication	Communication barriers between young adults and parents regarding SRH issues	Use when participants make comments about how family dynamics and their influence	Do not use this the interaction is not focusing on family dynamics and their influences	*"Most youth are afraid to talk to their parents. You might find that even if I'm a healthcare provider, I'm a mother, but I don't share information with my child." (HW01)*
Peer Pressure and Influences	Influence of peer pressure on SRH decision-making	Apply when participants make comments about social influences on their behaviour	Do not use this when the participants discuss issues unrelated to peer pressure	*"They're doing this because of peer pressure." (HW01)*
Community-Level Factors				
Code	**Definition**	**When to use**	**When not to use**	**Example quote**
Judgment and Fear	Community judgment and stigma affecting young adults seeking SRH services	When participants discuss the impact of community judgment and stigma on young adults accessing SRH services	When participants discuss views unrelated to stigma and judgment affecting SRH services	*"Community judgments are there because when you are a young person and you come for family planning, already they're thinking you're busy with boys." (HW01)*
Beliefs in Traditional Remedies	Beliefs in traditional remedies or herbal practices for addressing SRH issues, influenced by cultural norms and upbringing	When participants discuss views on traditional remedies and herbal practices related to SRH	When participants discuss views unrelated to traditional remedies and herbal practices	*"Some cultures believe in remedies or remedies... okay let me not say it will... This generation, we have tried to change our cultural believes, I don't think cultural have influence." (HW04)*
Limited Education	Lack of education in the community about SRH services and practices	Apply when participants discuss gaps in community education related to SRH.	Do not use when the participants discuss issues unrelated to limited education in communities	*"Community is not yet educated enough to accept that even young people can come and get services" (HW01)*
Institutional-Level Factors				
Code	**Definition**	**When to use**	**When not to use**	**Example quote**

Common SRH Services Accessed	SRH providers' observations on the primary SRH services sought by young adults, including family planning, STI management, and HIV testing	When participants understand the common SRH services accessed by young adults	When participants' primary focus is not on the specific SRH services accessed by young adults	*"Family planning and management of STIs They come also for HIV test." (HW02).* *"STIs is the most common one." (HW03)*
Missing of Appointments	SRH providers' challenges with patients missing appointments and the need for engaging education methods	When participants are exploring challenges in appointment adherence and education methods	When participants' focus is not on missed appointments and challenges in education methods	*"They miss their date most of the time... They think I don't know them." (HW02)*
Booking System and Working Hours	SRH providers' concerns about clinic operating hours and the efficiency of the booking system in serving young adults	When participants explore challenges related to clinic hours and the booking system	When participants' primary focus is not on clinic hours and the efficiency of the booking system	*"The clinic's operating hours, from 7 AM to 4 PM, might not always match the schedules of young adults." (HW03)*
Shortage of Resources	SRH providers' observations on shortages of certain family planning methods and its impact on comprehensive care	When participants share challenges related to resource shortages in SRH service provision	When participants' primary focus is not on resource shortages affecting SRH services	*"Maybe they get things...shortage of implants and another thing that is most common is teenage pregnancy and HIV." (HW04)*
Matters of Confidentiality	SRH providers' emphasis on confidentiality and challenges related to declaring reasons for visiting the clinic, affecting privacy	When participants identify challenges in maintaining confidentiality and consent in SRH services	When participants' primary focus is not on issues related to confidentiality and consent in SRH services	*"...when they enter the gate, they must tell the person at the gate where they are going so that they can be directed properly." (HW03)*
Policy-Level Factors				

Code	Definition	When to use	When not to use	Example quote
Access to Sexual Health and Rights	SRH providers' emphasis on providing open, inclusive, and non-judgmental support to all individuals seeking help with sex and pregnancy	To highlight the importance of non-judgmental support and access to SRH services	When participants' focus is not on policy-level implications and non-judgmental support	*"With our law, I cannot say to anyone no, like patient rights we must give them when they come for family planning asking for family planning, we can't send them back." (HW02)*
Health Promotion and Awareness Strategies	SRH providers' strategies in educating patients about SRH methods, including health promoters, peer educators, and partner organisations	When participants share various strategies employed in promoting SRH awareness	When participants 'primary focus is not on health promotion strategies and awareness efforts	*"We've got healthcare providers, health promoters that stand in all the patients waiting in facilities about what methods we have, where to have them." (HW05)*
Research Partnerships	SRH providers' collaborations with research partners to stay updated on SRH issues and service utilisation	When participants are exploring partnerships aimed at improving SRH service provision	When participants' primary focus is not on research partnerships in SRH service improvement	*"At the moment, the one that we work very closely with is the Pfizer. Any changes, any results regarding any research that has been found, that has been done, they come, and we sit with them, and they talk to us about it" (HW05)*
Strategies to Improve SRH Service				
Code	**Definition**	**When to use**	**When not to use**	**Example quote**
Community Education and Awareness	SRH providers' suggestions for extending SRH education beyond young adults to include their parents	When participants explore strategies for improving community awareness and education	When participants' primary focus is not on community education and awareness	*"It [education] must be extended to their parents. The parents must be aware of the service and encourage their children." (HW03)*

School Health Nurses	SRH providers' recommendation of incorporating school health nurses into family planning education to facilitate access for young adults	When participants suggest ways to enhance accessibility to SRH services for young adults	When participants' focus is not on incorporating school health nurses into family planning education	*"I think if we can get school health nurses that start from school and spread them down, down to us. It will be easier." (HW05)*

Appendix G: Ethical Clearance

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS UV

GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)

31-Jul-2023

Dear Ms Naum Maeko

Application Approved

Research Project Title:
Sexual and Reproductive Health Interventions: Experiences and views of young adults and providers in Soshanguve Ethical Clearance number:
UFS-HSD2023/0680

We are pleased to inform you that your application for ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. Furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Outcome: Approved

Please note that the GHREC has amended the project's risk level to LOW RISK. If you do not agree with this amendment, please contact us within seven (7) days of the date of this letter.

Yours sincerely **Dr**
Adri Du Plessis
Chairperson: General/Human Research Ethics Committee

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Appendix H: Study Authorisation

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TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 12/10/2023
PROJECT NUMBER: 71/2023
NHRD REFERENCE NUMBER: GP 202309 010

TOPIC: Sexual and Reproductive Health Services: Experiences and views of young adults and providers in Soshanguve

Name of the Lead Researcher:	Ms Mahlatse Maeko
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Name of the Department:	The University of The Free State

"VB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THA T RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED WITH CONDITIONS "Firstly, I want to assure you that I will personally handle the recruitment process.
To further minimize disruptions to the participants, I will schedule staff interviews at their convenience. Appointments will be arranged during lunchtime or after working hours, ensuring flexibility and ease of participation. I am committed to employing every possible means to reduce disturbances and respect their daily routines. "

Date 12/10/2023

Dr. Manei Letebele-Hartell
Chairperson: Tshwane Research Committee

Date• 2023.10.1

Mr. Mothomone Pitsi
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Appendix I: Certificate of Editing Language

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PROFESSIONAL LANGUAGE EDITING SERVICES

STRIVING FOR

Brian Naidoo (BA Hons. in English; BA Hons in TESOL; BEd Hons.
BA- English major; UDE [English]; UCT Cert. in Legal &
Business Writing; UCT Cert. in Copy-Editing; MA Coursework in Research
UFS. Assessor Cert. UFS; Umalusi Evaluator of Schools.

SPECIALISING IN THE LANGUAGE EDITING OF THESES, DISSERTATIONS, JOURNAL ARTICLES, PROPOSALS, BOOKS, POLICIES AND PUBLICATIONS

CERTIFICATE FOR EDITING A DRAFT MASTER'S DISSERTATION

TOPIC: **Sexual and Reproductive Health Services: Experiences and views of young adults and providers in Soshanguve**

NAUM MAHLATSE MAEKO

Master's Degree

B. Naidoo **ID 5606255134081** **20/07/2024**

TO WHOM IT MAY CONCERN

This certificate confirms that the above-mentioned student submitted her draft master's dissertation to me for language-editing, which included correcting in-text citations and the list of references. This was duly edited and returned to the student. I make no claim as to the accuracy of the research content. The text, as edited by me, is grammatically correct. After completion of the language editing, the student has the option to accept or reject changes prior to re-submission to the supervisor. The editor is not accountable for any additional content and changes that may have been executed post-editing.

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THANK YOU FOR YOUR SUPPORT