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Young Women's Access to Sexual and Reproductive Healthcare Services in Cape Town

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A Minor Dissertation Submitted in Partial Fulfilment of the Requirements for the Award of the Degree of Master of Social Science in Social Development

Submitted: 10/02/2024

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Acknowledgements

I extend my heartfelt gratitude to all those who have supported me throughout this research journey. Your involvement, guidance and unwavering support have been instrumental in the completion of this dissertation.

First and foremost, I would like to express my sincere appreciation to Dr. Shanaaz Hoosain for your exceptional support and expertise throughout this research process. Your guidance has been invaluable, and I am very grateful for your mentorship.

I am also grateful to Partners in Sexual Health for its collaboration in this study. Special thanks to Ms. Patricia De Lora and Ms. Fahranaaz Daniels for providing me with the opportunity to conduct my research, as well as for your assistance in recruiting participants and facilitating the interview process.

To the participants of this study, I extend my heartfelt thanks for your openness and honesty during our conversations. Your willingness to share your thoughts, feelings and attitudes on this important topic has enriched this research.

Lastly, I wish to express my gratitude to my family and friends for their love and support throughout this journey. Your encouragement has been a constant source of strength.

To each and every one of you, your involvement in this study has been invaluable, and I am deeply appreciative of your contributions. Without your support, this research would not have been possible. Thank you.

Abstract

Many women in low-and-middle-income countries, including South Africa, struggle to access sexual and reproductive healthcare services. This study aimed to describe young women's experiences to access sexual and reproductive healthcare services in Cape Town, South Africa. This study employed a qualitative research design, specifically a phenomenological descriptive approach. Semi-structured face-to-face interviews were conducted with 16 young women aged between 18-25, who have accessed sexual and reproductive healthcare services in Cape Town. Interviews were facilitated by Partners in Sexual Health, an organisation that provides and advocates for sexual and reproductive health & rights in South Africa. Thematic analysis was then employed, and the analysis was framed using the socio-ecological model for health. The findings of this study revealed that young women in South Africa face challenges in accessing accurate information about sexual and reproductive healthcare services, leaving them unprepared to make informed decisions about their sexual health. Limited knowledge about sexual and reproductive healthcare services, coupled with a lack of support by family and friends, community stigmatisation, and disrespectful and unprofessional treatment by healthcare workers hinders young women in having positive experiences while accessing sexual and reproductive healthcare clinics. In addition, the findings of this study underscore the limited autonomy that young women have in making their own decisions about their sexual health. Furthermore, this study suggests that to fully understand the experiences of young women accessing sexual and reproductive healthcare services, it is necessary to consider not only individual factors but also contextual factors such as interpersonal relationships and societal norms and values. This study emphasises the importance of autonomy of young women in making decisions about sexual health. Therefore, there is a significant need for comprehensive sexuality education to enhance young women's understanding of their sexual health, improve communication within families and among peers, and shift community attitudes towards recognising the importance of sexual health among young women.

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List of Abbreviations

AGYW	Adolescent Girls and Young Women
CSE	Comprehensive Sexuality Education
FP	Family Planning
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
LCMIs	Low-and-middle-income countries
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
POA	Programme of Action
PSH	Partners in Sexual Health
SABSSM VI	Sixth South African National HIV Prevalence, Incidence and Behaviour Survey
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Healthcare
SRHR	Sexual and Reproductive Health & Rights
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UN	United Nations

Chapter 1: Problem Statement

1.1 Introduction

Sexual and reproductive health (SRH) encompasses the overall physical, mental and social well-being in all matters concerning the reproductive system throughout the life course (CDC, 2019). This study focuses on young women's access to SRH services in Cape Town, South Africa. This chapter introduces the topic chosen for this study. It contains the statement of the problem, and the rationale and significance of the study are described. The research questions and objectives for this study are presented, as well as the main concepts used in this study. This study aimed to describe the experiences of young women regarding their access to SRH services in Cape Town, South Africa. It sought to understand the meaning of making informed decisions regarding one's own access to SRH services, fertility, use of contraceptives, treatment, and prevention of sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), safe and healthy pregnancy, and safe and healthy termination of pregnancy. Moreover, this study explored the effects of young women's experiences in accessing SRH services on their daily lives.

1.2 Statement of the Problem

Since the United Nations (UN) coordinated the International Conference on Population and Development (ICPD) in Cairo, in 1994, access to SRH for adolescents and young people has been a serious public health concern globally (Obisie-Nmehielle et al., 2022). Although much progress has been made over the past decades regarding SRH, many women in low-and-middle-income countries (LMICs), including South Africa, struggle to access SRH services (Kriel et al., 2023, p.2). Access to SRH services is essential for ensuring young women's rights to make informed decisions regarding fertility, appropriate contraception, and termination. It also affirms the right to a healthy and satisfactory sex life and a safe and healthy pregnancy and birth (Bearinger et al., 2007; Bohren et al., 2022).

South Africa is a country with high levels of unintended pregnancy, HIV infections and stigmatisation of young women and girls (Davids et al., 2020; Department of Health, 2017). Pregnancy among young girls and women has increased since the beginning of 2022, with over 150.000 girls and women pregnant in the 2022/2023 financial year. Societal factors, deficiencies in the healthcare system and gender-based violence (GBV) are significant causes

of this large number of pregnancies (Sharma, 2023). In 2022, the sixth South African National HIV prevalence, incidence, and behaviour survey (SABSSM VI) found that the HIV prevalence in South Africa was 12.7%, translating to approximately 7.8 million people living with HIV. HIV prevalence amongst women is almost twice as high compared to men (Human Sciences Research Council, 2023). Especially adolescent girls and young women (AGYW) aged 15-24 contract a quarter of new HIV infections each year, three times as high as their male counterparts (Duby, McClinton Appollis, et al., 2021a). Moreover, in terms of GBV and intimate partner violence (IPV), South Africa recorded to 10.516 rapes, 1514 cases of attempted murder, and 14.401 assaults against female victims in July, August, and September of 2023. In the same period, 881 women were murdered. This shows that GBV is on top of the list of women-rights issues that need to be addressed (Mpako & Ndoma, 2023).

In light of these figures, access to appropriate sexual and reproductive health services for young women is critical in South Africa, to decrease the number of unintended pregnancies, HIV rates and cases of GBV and IPV. South Africa is actively striving to achieve universal access to healthcare, which entails individuals acknowledging and comprehending their healthcare needs, with affordable services readily available through a healthcare system capable of anticipating and meeting the needs of its population (Lince-Deroche et al., 2019). However, SRH services for young people are constrained by the lack of committed services, inadequate staff training, healthcare providers' attitudes and human resource deficits (Pillay et al., 2019). Young women may therefore have difficulties in accessing SRH services.

Access to healthcare is determined by the fit between the clients and the system through the following dimensions: availability, affordability, and acceptability (Thiede et al., 2007). Recent studies indicate that young women in South Africa face challenges in fully accessing SRH services that are also deemed acceptable and affordable (Stuthers et al., 2012). These challenges stem from factors such as young women's limited knowledge about SRH services, the patriarchal gendered dynamics in a community, and experiences of stigmatisation and judgement from family, community members and healthcare workers (Erasmus et al., 2020; Jonas et al., 2017, 2018, 2019; Pillay et al., 2019).

Nevertheless, most research on access to SRH services in South Africa tends to concentrate on the thoughts and experiences of healthcare workers and (pregnant) adolescents (Erasmus et al., 2020; Jonas et al., 2017, 2018, 2019; Pillay et al., 2019). As a result, there is a gap in

understanding the experiences of young women accessing SRH services, as their perspectives on sexual and reproductive healthcare have not been thoroughly explored in existing literature. Therefore, this study attempts to describe the experiences of young women aged 18-25 in accessing SRH services in Cape Town.

1.3 Rationale and Significance of the Study

The purpose of this study is to gain new knowledge about young women's access to SRH services in Cape Town. The findings of this study may be significant because they may contribute to the identification of barriers to accessing SRH services in a specific area in Cape Town. The identification of these barriers, along with the thoughts and ideas of the participants in this study, could support local organisations, clinics, and healthcare workers by developing new initiatives and programs. They could create interventions that are more effective in addressing the root causes of barriers that young women experience by going to a sexual and reproductive healthcare clinic or service, and spread and improve public awareness of the need for SRH services.

1.4 Research Goal

To describe the experiences of young women aged between 18-25 in accessing SRH services in Cape Town, South Africa.

1.5 Main Research Question/s

Main research question

What are the experiences of young women in accessing sexual and reproductive healthcare services in Cape Town?

Sub-questions

- What does accessing sexual and reproductive healthcare services mean for young women in Cape Town?
- What does fertility, using contraceptives, safe and healthy pregnancy and termination, and treatment and prevention of STIs, including HIV mean to young women in Cape Town?
- What are the effects of accessing sexual and reproductive healthcare services on the daily lives of young women?

1.6 Research Objectives

- To describe the experiences of young women who have accessed SRH services
- To understand the meaning of the ability to access SRH services and make informed decisions about one's own fertility, use of contraceptives, safe and healthy pregnancy and termination
- To understand the effects of the experiences of young women's access to SRH services on their daily lives

1.7 Main Assumptions

The researcher assumed that when young women access SRH services, they know their options and can make informed decisions about their use of contraceptives, safe and healthy pregnancy and childbirth, and safe and healthy termination. Furthermore, she assumed that the stigmatisation of the use of contraceptives by young women in the community could be a potential barrier to unintended pregnancies (Bohren et al., 2022; Erasmus et al., 2020; Pillay et al., 2019).

1.8 Clarification of Concepts

Experiences

Experiences refer to the personal encounters, interactions, events, and situations that individuals undergo throughout their lives. These encounters encompass a wide range of sensory, emotional, cognitive, and social aspects, shaping an individual's perception, understanding, and memories. Experiences are subjective and can be influenced by various factors, including personal perspectives, cultural backgrounds, and contextual circumstances. They contribute to the development of an individual's knowledge, attitudes, beliefs, and overall understanding of the world around them (Jensen & Thomassen, 2020). Understanding the concept of experiences is central to this study, as the encounters of these young women at SRH clinics span a range of sensory, emotional, cognitive, and social factors. These factors deeply shape their perceptions, attitudes, and behaviours concerning sexual and reproductive health.

Sexual and reproductive healthcare (SRH) services

SRH services include services such as family planning (FP) and counselling; prenatal and postnatal care and delivery; termination of pregnancy and post-abortion care; treatment and prevention of STIs, including HIV, and; information and counselling services with regards to human sexuality (Jonas et al., 2018, p.2). Young women in this study describe their experiences with these services.

Young women

There are multiple definitions for young women in South Africa, the following are of importance for this study. According to the National Youth Policy 2020-2030, 'youth' is defined as individuals between the ages of 14 and 35 years (Department of Women, n.d.). The National Strategic Plan for HIV, TB and STIs 2017-2022 (Department of Health, 2017b) and The National Adolescent and Youth Health Policy 2017-2022 (Department of Health, 2017a) both use the age range of 15-24 to define 'youth' concerning health interventions. For this study, young women between the age of 18-25 have been interviewed. Due to the sensitivity of the topic, only adults have been involved in the study.

Access

According to Penchansky & Thomas (1981), access considers the fit between the clients and the health system. The general concept of access draws on five dimensions: availability, accessibility, accommodation, affordability, and acceptability. Following the work of Thiede et al. (2007), these dimensions are often interlinked and, as such, they focus on three dimensions: availability, affordability, and acceptability. The concept of access and how it connects to this study will be further explained in Chapter 2.

1.9 Conclusion

This chapter provides the statement of the problem for this study. It emphasises the rationale and the significance of this research, as well as the primary research question, sub-questions, research objectives, main assumptions and the clarification of the concepts used by the researcher.

Chapter 2: Literature Review

2.1 Introduction

This chapter is a review of the literature regarding young women's access to SRH services. Therefore, this chapter aims to provide a comprehensive understanding of the current knowledge and gaps regarding access to SRH clinics and services. This chapter first focuses on sexual and reproductive health in different perspectives (global, Sub-Saharan Africa and South Africa). Thereafter, it discusses the concept of access to healthcare regarding sexual and reproductive healthcare in South Africa. Finally, the researcher discusses the theoretical framework and legislation involved in this study.

2.2 Sexual and Reproductive Health

SRH refers to a state of complete physical, mental, and social well-being in all matters relating to the reproductive system throughout the life course (CDC, 2019). It involves the capability to enjoy a satisfying and safe sex life and the freedom to decide if, when, and how often to reproduce (United Nations Population Fund, n.d.). Sexual and reproductive health also encompasses the right to access accurate information, education, and healthcare services related to sexuality and reproduction. This holistic approach recognises that sexual and reproductive health is not merely the absence of disease but a positive and enriching aspect of life (Marie Stopes International, 2022).

In South Africa, sexual and reproductive healthcare initiatives seek to mitigate the negative consequences of sexual activity and reproduction while promoting safe and fulfilling sexual relationships for individuals of all ages, including adolescents and those beyond the reproductive age. These efforts address various challenges, such as gender discrimination, disparities in healthcare access, legal restrictions, sexual coercion, and GBV (National Department of Health, 2019). This definition is of importance in this study because this study describes the experiences of young women's access to SRH services.

2.2.1 Sexual and Reproductive Health: A Global Perspective

Since the UN coordinated the ICPD in Cairo, in 1994, access to sexual and reproductive healthcare by youths and adolescents has been a serious public health concern globally (Obisie-Nmehielle et al., 2022). The ICPD recognised that a woman's sexual and

reproductive health and well-being include not only her access to, and the use of, contraception, but also additional other factors: the care that she receives during pregnancy and childbirth; her ability to access safe abortion care to the full extent of the law, and post-abortion care to manage complications of an unsafe abortion or miscarriage in all settings, as well as receiving adequate follow-up including post-abortion contraception, and; her capacity to receive or avoid treatment for STIs, including HIV infection (Sundewall & Kaiser, 2019, p.15). The ICPD Programme of Action (POA) called for 'meeting the educational and service needs of adolescents and young women to enable them to deal in a positively and responsibly with their sexuality' (United Nations, n.d.a). It should be emphasized that the conference's examination of the social conditions of women in Sub-Saharan Africa (SSA) presented the incentive for the many recommendations that emerged during the conference (Edouard & Okonofua, 2023). This indicates that SRH issues in SSA and South Africa are of paramount importance and require urgent attention and resolution.

Following the ICPD in 1994, the Colombo Declaration of Youth and the UN Millennium Development Goals (MDGs) and the UN Sustainable Development Goals (SDGs) 2030 advocated for universal access to sexual and reproductive healthcare information and services for young people (Obisie-Nmehielle et al., 2022). Following the MDGs, the SDGs prioritised sexual and reproductive health. Goal 3 (Good Health and Well-being), "ensures health by reducing the global maternal mortality rate (MMR) to less than 70 per 100.000 livebirths" (3.1); "end the epidemics of AIDS", etc. (3.3), and; "ensure universal access to SRH services, including for information and education, family planning, and integration of reproductive health into national programmes and strategies" (Jonas et al., 2017; WHO, n.d.a). Goal 5 (Gender Equality) ensures "health by ending all forms of discrimination against women and girls" (5.1); "eliminate all forms of violence against women and girls" (5.2); "eliminate all harmful practices, such as child, early, and forced marriage and genital mutilation" (5.3), and; "ensure universal access to sexual and reproductive health & rights (SRHR) as agreed under the POA of the ICPD" (5.6). Goal 10 (Reduced Inequalities) "ensures health by reducing inequality within and among countries, relates to achieving SRHR for priority populations most affected by HIV, discrimination and fulfilling the right to development" (National Department of Health, 2019, p. 15; WHO, n.d.b). These are essential prerequisites for ensuring that young people, particularly young women, can make educated decisions about the prevention of sexually transmitted diseases, and when to have children.

Over the 25 years that have passed since the first ICPD in Cairo, the global context has shifted considerably, with implications for SRHR, related to the following outcomes: Between 2000 and 2020, the global maternal mortality ratio (MMR) decreased by 34.8%, from 342 to 223 deaths per 100.000 live births (WHO, 2023c). However, in 2020 one woman died every 2 minutes from preventable causes related to pregnancy, which represents approximately 800 women dying daily. This data indicates a MMR of 223 maternal deaths per 100.000 live births, which is greatly above the UN SDG 3.1 of reducing the global MMR to less than 70 deaths per 100.000 live births by 2030 (Khalil et al., 2023). In 2023, global contraceptive use of any technique was predicted to be 65%, with modern methods accounting for 59%. No other modern method has been adopted voluntarily by so many people, with an estimated 748 million women using modern contraceptives (Ali et al., 2023). In 2023, abortion was allowed on request for 661 million women of reproductive age (35%) in 77 countries, and for 457 million women of reproductive age (25%) in 12 countries for broad socio-economic reasons. 226 million women of reproductive age (12%) in 47 countries were allowed abortion to preserve health, and 416 million women of reproductive age (22%) in 43 countries in order to save the mother's life. However, abortion is still prohibited for 111 million women (6%) in 22 countries, which results in an estimated 39.000 women and girls dying from consequences of unsafe abortions, according to the World Health Organisation (Center for Reproductive Rights, 2023; FOCUS2030, 2023). In 2022, approximately 39 million people were living with HIV worldwide. Of these, 37.5 million were adults and 1.5 million were children (<15 years old). 53% were women and girls (WHO, 2023b). Globally, an estimated 736 million women – nearly one-third of all women aged 15 and older – have experienced physical and/or sexual IPV, non-partner violence, or both at some point in their lives. The vast majority of violence against women and girls is committed by current or previous husbands or intimate partners. More than 640 million women, or 26% of those aged 15 and older, have experienced IPV (UNWomen, 2023). Furthermore, cervical cancer is the fourth leading cause of cancer in women worldwide, with approximately 604.000 recent cases and 342.000 deaths in 2020 (WHO, 2023d). Cervical cancer incidence and mortality rates are higher in LMICs. This reflects significant discrepancies caused by a lack of access to the national human papillomavirus vaccine, cervical screening and treatment services, as well as social and economic factors. Persistent infection with the human papillomavirus causes cervical cancer. Women living with HIV are six times more likely to get cervical cancer than women living without HIV (WHO, 2023d).

Even though SRHR has shifted considerably over the past 25 years, the delivery of appropriate, effective, accessible, equitable and acceptable services is key to supporting young people to realise their SRHR (Pillay et al., 2019). As demonstrated by the statistics provided, SSA, including South Africa, has significant room for improvement in its sexual and reproductive healthcare rates. Therefore, SRH rights and services need to significantly increase to come in line with international and national policies and the SDGs.

2.2.2 Sexual and Reproductive Health: Sub-Saharan Africa

Despite global agreements, SRH needs for many women, especially adolescents and young women are still not met in SSA, including South Africa. These services continue to be grossly inadequate, especially in LMICs (Kuruvilla et al., 2016). This deficiency is consistent with high rates of unwanted pregnancies, particularly among adolescents; maternal mortality and morbidity; infant and child mortality; STIs, including HIV; and unsafe and illegal termination of pregnancy (Hindin & Fatusi, 2009). As a result, the burden of SRH-related diseases and death is particularly high in LMICs, especially in SSA (Jonas et al., 2018).

In recent decades, SSA has seen an increase in access to numerous SRH services (Hagos et al., 2023). However, notable gaps remain, including extensive sexuality education; sexual health and well-being counselling; preventing and addressing gender-based and sexual violence; preventing and treating infertility and subfertility, and; access to safe abortion care (both where abortion care is restricted and where abortion is legal) (Hagos et al., 2023). Where SRH services are accessible, they may remain unreachable for the most marginalised people, related to the following poor SRH outcomes: SSAs MMR of 545 per 100.000 live births, remains significantly greater than the global objective of less than 70 maternal deaths per 100.000 live births set by the SDGs, with progress varying across and within countries (WHO, 2023a). It is estimated that only half of married or partnered women in SSA get their FP requirements fulfilled by modern contraceptive methods (WHO, 2020). SSA has five countries where abortion is lawful and unrestricted, up to a certain gestational age (CRR, 2023). Abortion is restricted or outlawed in others, resulting in unsafe and risky procedures. Abortion is responsible for an estimated 10% of maternal fatalities in the region each year (Say et al., 2014). In SSA, women and girls contract more than 60% of new HIV infections in the region. Besides, stigmatised and marginalised Sub-Saharan populations have an increased risk of HIV (accounting for half of all new infections) and have poorer access to services

(UNAIDS, 2023). Across Africa, one-third of women have experienced GBV (van Eerdewijk et al., 2018). A significant portion of such abuse is perpetrated by an intimate partner, and evidence links IPV to increased rates of HIV infection, unwanted pregnancy, preterm birth and poor mental health (WHO, 2021). Among other regions, cervical cancer incidence and mortality rates are highest in SSA. Inequalities in the availability of immunisation, screening and treatment facilities and services, risk factors such as HIV incidence and social and economic factors such as gender, sex, poverty and biases all contribute to regional disparities in cervical cancer burden (WHO, 2023d). It is the leading cause of cancer-related mortality in most Sub-Saharan African countries (Arbyn et al., 2020).

The gaps and statistics provided show that many girls and young women are still in need of greater access to sexual and reproductive healthcare services, especially in LMICs, particularly in SSA, including South Africa.

2.2.3 Sexual and Reproductive Health: South Africa

South African healthcare system

Understanding the South African healthcare system is crucial for this study as it provides insights into the context within which young women in South Africa navigate sexual and reproductive healthcare issues. The South African Department of Health is in charge of the healthcare in South Africa (International Citizens Insurance, n.d.). However, South Africa lacks a universal healthcare system. Instead, it is two-tiered: the wealthy, many of whom have private medical insurance, use the private sector, while the least advantaged rely primarily on the underfunded public sector (Mhlanga & Garidzirai, 2020). Nevertheless, the socio-economically disadvantaged are more likely to experience disability, poor health and the occurrence of more than one condition or disease, and are less likely to make use of inpatient care (Buisman & García-Gómez, 2015). Even though the government subsidises the public system, it is generally underfunded and badly managed. To access a private healthcare service or facility, one has to pay out-of-pocket or be covered by health insurance (Gordon et al., 2020).

Access to healthcare is challenging in South Africa, according to Müller, 2017, where the vast majority of the population depends on health services in the under-resourced and overburdened public sector. Less than 28% of the population is employed in the private

sector, which accounts for 46% of all health spending in the nation. Merely 16% of South Africans are covered by medical aid, with the remaining private sector users having to pay for their own and relying on public hospitalisation services.

State of sexual and reproductive health

In South Africa, sexual and reproductive healthcare services for young people are constrained by the lack of committed services, inadequate staff training, healthcare providers' attitudes and human resource deficits (Pillay et al., 2019). Young women are inordinately affected by unsafe and/or forced sex related to GBV, often resulting in unintended pregnancy, STIs and HIV (Department of Health, 2017c). Moreover, young women continue to be vulnerable, with STIs, HIV, female genital schistosomiasis, and a high prevalence of teenage pregnancy (Galappaththi-Arachchige et al., 2018).

Pregnancy among young girls and women has increased since the beginning of 2022, with over 150.000 girls and women were pregnant in the 2022/2023 financial year. Societal factors, deficiencies in the healthcare system and GBV are significant causes of this large amount of pregnancies (Sharma, 2023). In 2022, SABSSM VI found that the HIV prevalence in South Africa was 12.7%, translating to approximately 7.8 million people living with HIV. HIV prevalence amongst women is almost twice as high compared to men (Human Sciences Research Council, 2023). However, SABSSM VI showed that of people aged 15 years and older living with HIV in South Africa, 90% were aware of their status, 91% of those who were aware of their status were on antiretroviral therapy, and 94% of those on antiretroviral therapy were virally suppressed (Human Sciences Research Council, 2023). Especially AGYW aged 15-24 contract a quarter of new HIV infections each year, three times as high as their male counterparts (Duby, McClinton Appollis, et al., 2021a). Moreover, in terms of GBV and IPV, South Africa recorded to 10.516 rapes, 1514 cases of attempted murder, and 14.401 assaults against female victims in July, August and September of 2023. In the same period, 881 women were murdered. This shows that GBV is on top of the list of women's rights issues that need to be addressed (Mpako & Ndoma, 2023). In light of these figures, access to appropriate SRH services for young women is critical in South Africa, to decrease the number of unintended pregnancies, HIV rates and cases of GBV and IPV.

Cape Town

In Cape Town, there are 69 clinics and 14 Community Day Centres under the authority of the City of Cape Town, which provide SRH services (Western Cape Government, 2022). Most women of reproductive age access SRH clinics and services from the public healthcare sector (Fataar et al., 2022). According to the City of Cape Town (2022) and the Western Cape Government (2022), there were 106.607 visits by young women aged between 15 and 24 to SRH clinics and services in Cape Town in 2021/2022. Of these visits, 68% were for basic health education, 18% for FP services, 10% for STI testing and treatment, and 4% for pregnancy-related services. This shows that young women in Cape Town are actively trying to address concerns related to SRH.

2.3 Access to Sexual and Reproductive Health

For understanding the meaning of sexual and reproductive health, this study builds on the concept of access to healthcare, but will only refer to sexual and reproductive health. The conceptualisation of access to healthcare is important to examine the experiences of young women accessing SRH services because it provides a framework for understanding the various factors that influence young women's ability to obtain and utilise services. This comprehensive understanding is essential for developing targeted interventions and policies to improve access and ensure that young women can effectively utilise SRH services to meet their needs (Baker et al., 2023). Access to healthcare is identified as a basic human right and is a complex, universal concern (Saurman, 2016). Universal access to healthcare entails individuals acknowledging and comprehending their healthcare needs, with affordable services readily available through a healthcare system capable of anticipating and meeting the needs of its population. This is an aspect that South Africa is actively striving to achieve (Lince-Deroche et al., 2019). To provide a comprehensive overview of access, this research draws on the access framework, rooted in the taxonomy of Penchansky & Thomas (1981).

According to Penchansky & Thomas (1981), access reflects the fit between the clients and the system. It is viewed as the general concept which summarizes a set of more specific areas of fit between the patient and the healthcare system. These areas, the dimensions of access, are availability, accessibility, accommodation, affordability, and acceptability (Reoch & Thomson, 2018, p.2). These dimensions each refer to their own aspects: availability measures the needs of the client; accessibility refers to geographic accessibility, which is determined by

how easily the client can physically reach the provider's location; accommodation reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client; affordability is determined by how the provider's charges relate to the client's willingness and ability to pay for services; and lastly, acceptability, which captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and contrariwise (McLaughlin & Wyszewianski, 2002, p. 1441).

These dimensions are often interlinked, which is why in their work of exploring the dimensions of access, Thiede et al. (2007) merged the accessibility and accommodation dimensions into the availability dimension. Consistently, Thiede et al. (2007) outline three dimensions, namely: availability, affordability and acceptability.

2.4 Access to Healthcare in the South African Context

According to Thiede et al. (2009) availability refers to physical access, affordability refers to financial access and acceptability refers to cultural access. The following paragraphs each cover these dimensions in accordance with the South African context regarding young women's access to sexual and reproductive healthcare services.

2.4.1 Availability

Availability refers to physical access; it measures the needs of the client. Thereby, accessibility and accommodation are included in this dimension, according to Thiede et al. (2007). This dimension captures the supply-side features of access to healthcare and can be thought of as, '… health services … in the right place and at the right time that they are needed' (Thiede et al, 2007: 108).

When considering the availability of sexual and reproductive healthcare services for young women in South Africa, themes of knowledge and information, and the state of clinics and other facilities arose (Erasmus et al., 2020; Fataar et al., 2022; George et al., 2020; Jonas et al., 2019; Pillay et al., 2019; Stuthers et al., 2012; Zuma et al., 2020).

In terms of knowledge and information, Erasmus et al. (2020) explored the barriers to pregnant adolescents seeking antenatal care (ANC) services in Mitchells Plain, South Africa. They highlighted that many girls did not know how and when to access ANC services, and,

they had little knowledge about general sexual and reproductive healthcare. Moreover, in examining young women's health and healthcare providers' experiences of sexual and reproductive healthcare services, Pillay et al. (2019) found that there is a shift in knowledge and ignorance of young women regarding sexual and reproductive health; they know more about HIV, sex and pregnancies than older women. This research showed that when these young women found out they were pregnant or needed another service, they complied with the rules of the clinic regarding how to deal with the pregnancy or another health issue.

Furthermore, Jonas et al. (2019) found that nurses in their research believed that AGYW require more knowledge and education on family planning services, including different types of available contraceptive methods. Nurses perceived young women's inadequate understanding of sexual and reproductive healthcare services as a barrier, contributing to their limited access to and under-utilization of sexual and reproductive healthcare services. Additionally, nurses claim that young women's knowledge is clouded with the myths around contraceptive use, which discourages them from using contraceptives.

Besides limited knowledge and information, gender norms and dynamics also limits AGYWs' access to sexual and reproductive healthcare clinics and services. On that account, George et al. (2020) show the connection between gender inequality and sexual and reproductive rights for adolescent girls in SSA, in reviewing structural determinants of gender inequality. They found that tackling the gendered dynamics that shape young people's health and especially the sexual and reproductive healthcare of young girls is critical. Gender norms frequently stigmatise adolescent girls and young women who inquire about contraceptives, are sexually abused, or become pregnant. These norms also illustrate the dominance of men in sexual relationships in communities in South Africa, they believe men should take full control of relationships and sexual activity, while women should hold off any sexual relationships until they are 'old enough', finished their education, are working or married (Zuma et al., 2020). According to George et al. (2020), gender power relations affect both men and women, but the structural shape of gender inequality flagrant concentrate disadvantage against girls and women. Girls tend to get less information and education about sexuality and reproduction then boys and they have poorer access to sexual and reproductive healthcare services and clinics.

Regarding the state of clinics and services and available resources, Stuthers et al. (2012) assessed service availability and healthcare worker's opinions about young women's sexual and reproductive health in Soweto, South Africa. As a result of the facility assessments Stuthers et al. (2012) found that on several occasions, contraceptive methods like intrauterine devices were available in clinics, but nurses were not familiar with the procedures. Thereby, they also reported that many clinics provided limited services to young women by e.g. making them pay for treatments, when they should be free. In addition, most facilities did not have any adolescent-friendly policies in place. In terms of birth control, modern contraceptive methods are available at no cost in the public sector health services and include male and female condoms, injectable progestogen contraceptives, intrauterine devices, sub-dermal contraceptive implants, oral contraceptives and sterilisation. Notably, not all the listed contraceptive methods are offered at all public health facilities and methods may not always be available due to stockouts and lack of provider training in some methods (Fataar et al., 2022, p.2).

In conclusion, the availability of sexual and reproductive healthcare services for young women in South Africa is influenced by various factors, including knowledge and information, gender norms and dynamics, and the state of clinics and facilities. Studies have highlighted the importance of addressing barriers related to knowledge and information, as many young women lack adequate understanding of SRH services, leading to under-utilisation of available services. Gender norms and dynamics also play a significant role, with societal expectations often limiting young women's access to and utilisation of sexual and reproductive healthcare. Furthermore, the state of clinics and services, including the availability of resources and the presence of adolescent-friendly policies, affects young women's ability to access comprehensive care. Addressing these challenges requires targeted interventions aimed at improving knowledge, challenging harmful gender norms, and enhancing the quality and accessibility of healthcare facilities. By addressing these factors, South Africa can work towards ensuring that young women have equitable access to sexual and reproductive healthcare services, allowing them to make informed decisions about their health and well-being.

2.4.2 Affordability

Financial access is a term used to describe the relationship between the cost of medical care and client income. The client's perception of value for money, their comprehension of prices, total costs, and potential credit arrangements are all taken into account (Burger & Christian, 2020). A significant priority on the affordability agenda is the financial risk of poor health, especially for impoverished persons, and the role of the health system in protecting individuals and households from this risk. As a result, the affordability dimension's relational component establishes a link between healthcare expenditures and a household's or an individual's financial capacity. Thus, this aspect of access is connected to the larger subject of healthcare financing. Another important factor in affordability, particularly for the poor, is the opportunity cost of ill health in to earn potential (Thiede et al., 2007).

In South Africa, affordability-focused policies have eliminated user fees and increased priority programmes with the goals of enhancing access to healthcare for the most vulnerable populations, according to Van Der Berg et al. (2002). Nevertheless, more recent studies found that post-1994 user-fee abolition increased the likelihood of vulnerable groups accessing public healthcare facilities (Koch, 2017). According to Goudge et al. (2009), more comprehensive actions are required because fee elimination alone does not provide greater access to public healthcare. Even if public healthcare services are 'free' or reasonably priced, people may be discouraged from using them becauseof perceptions of poor quality. Honda et al. (2015) argue that increasing the accessibility and affordability of public healthcare in South Africa is unlikely to have a positive impact on health outcomes as long as the services' quality is inadequate. The experiences of consumers using public healthcare services are important for policymakers to understand.

By considering progress in access to healthcare in South Africa in the post-apartheid era, Burger & Christian (2020) stated that the lower levels of availability and affordability imply that only 53% of the South Africans in their study had full access to healthcare, i.e. acceptable healthcare that is also available and affordable. They expressed that difficulties with availability and affordability are due to remoteness, vulnerable groups have to travel further to health facilities and pay more to do so. In terms of sexual and reproductive health for young women, this means that it is often difficult for them to find an affordable clinic or service that can help them and has all the SRH services available.

2.4.3 Acceptability

Acceptability refers to cultural access, and according to Reoch & Thomson (n.d.) it is 'the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics'. As such, acceptability has become a key component in the design, evaluation and implementation of healthcare interventions (Sekhon et al., 2017).

Dillip et al. (2012) understand access as a concept representing the degree of 'fit' between the clients and the system, based on Penchansky & Thomas' (1981) seminal paper. According to this perspective, acceptability is defined as 'the relationship between provider attitudes about acceptable personal characteristics of clients and client attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers'. The term acceptability was used to characterise how clients reacted to personal traits of providers, such as sex or ethnicity, facility type, provider or facility's religious affiliation, and facility neighbourhood. In response, providers were characterised as having attitudes towards desired client characteristics or funding resources, such as a disinclination to treat welfare patients.

South African young women may face judgement due to their age, gender, or sexual orientation, either from their family, community, or healthcare providers once they seek support regarding sexual and reproductive healthcare services. Findings from several studies have pointed out the often-negative attitudes of healthcare workers, family and community members towards young women seeking information or treatment at a sexual and reproductive healthcare service (Erasmus et al., 2020; Jonas et al., 2017, 2018, 2019; Pillay et al., 2019; Stuthers et al., 2012).

First, by looking at healthcare workers' opinions about adolescents' sexual behaviour and utilisation of sexual and reproductive healthcare services, Stuthers et al. (2012) found that most healthcare workers have negative thoughts regarding young women having sex, which affects young women's ability to access sexual and reproductive healthcare services. Their beliefs were that women should not have sex before marriage, and if they do they need to protect themselves. Stuthers et al. (2012) believed that young women ignore information they receive about HIV and pregnancy prevention. Abstinence would be a preferred method of family planning, and termination of pregnancy is considered as a sin. These issues resulted in often harsh and negative attitudes towards young women in the clinic.

Comparatively, in a systematic review to determine healthcare workers' behaviours and related personal determinants associated with providing adequate and quality SRH services to adolescents and young women in Sub-Saharan Africa, Jonas et al. (2017) found several factors contributing to the behaviours and personal determinants of healthcare workers about sexual and reproductive health from Sub-Saharan Africa. Negative behaviours and attitudes of healthcare professionals, as well as personal determinants like poor knowledge and proficiency in SRH services, and related factors, like the lack of necessary medication and equipment are associated with the provision of inadequate SRH services. The research included in this review frequently indicated unfavourable behaviours, including negative attitudes of healthcare workers towards specific SRH services, especially SRH services for adolescents and young women. Negative behaviours and attitudes by healthcare professionals are unlike to encourage women in general to access and utilize SRH service, but more specifically young women.

Furthermore, Jonas et al. (2018) explored and gained an in-depth understanding of healthcare workers' beliefs, motivations and behaviours affecting adequate provision of sexual and reproductive healthcare services in Cape Town. Their results show that professional healthcare workers are faced with several challenges when providing SRH services to adolescents. These challenges include current sexual and reproductive healthcare guidelines and policies, conflicting personal norms and values regarding adolescents' SRH services, limited access to schools where they can provide sexual education and pregnancy prevention services, and healthcare-related factors such as time constraints. However, Jonas et al. (2019) explored 'nurses' views on and perceptions of adolescent girls' barriers and needs to accessing and utilising sexual and reproductive healthcare services.' The findings of this study demonstrate that 'nurses are generally supportive of adolescent girls using sexual and reproductive healthcare services such as contraceptives and continue to encourage them to use the services. However, nurses acknowledged the challenges faced by adolescent girls, which prevent them from optimally accessing and utilizing sexual and reproductive healthcare services.'

In terms of stigma and judgement, Erasmus et al. (2020) found that barriers to adolescents seeking antenatal care often focused on a discourse of adolescent pregnancy being negligent, shameful and deviant. Pregnant adolescents frequently internalised these beliefs and were frantic about other's reactions within antenatal care facilities, at school, in their community

and their families. These stigmas and judgements regarding adolescent pregnancy contributes to the continuation of a culture of shame and non-disclosure, which prevents young pregnant girls from receiving the treatment they need.

On top of that, in examining young women's health and healthcare providers' experiences of sexual and reproductive healthcare services in terms of antenatal care, postnatal care and termination of pregnancy, Pillay et al. (2019) show that 'nurses constantly felt the need to 'punish' young women for early motherhood, which undermines the agency of young women to make informed contraceptive choices. Thereby, although young women had the requisite knowledge about termination, they had little agency to assert their rights. This challenges the assumption that knowledge and rights are sufficient to access SRH services. In settings where young women have limited power, knowledge and rights become irrelevant.' They need support from healthcare workers to utilise appropriate services.

This literature on the acceptability dimension of access to healthcare highlights the pervasive challenges faced by South African young women when seeking sexual and reproductive healthcare services, emphasising the prevalence of negative attitudes, judgement and stigma from different stakeholders, including healthcare providers, communities and families (Erasmus et al., 2020; Jonas et al., 2017, 2018, 2019; Pillay et al., 2019; Stuthers et al., 2012).

2.5 Theoretical Framework

To understand the meaning that young women give to their experiences of accessing sexual and reproductive healthcare services and clinics, this study drew on the social-ecological model of health.

2.5.1 Socio-Ecological Model

The socio-ecological model is a theoretical framework that perceives human behaviour as both influenced by and exerting influence upon multiple levels. Originating from Urie Bronfenbrenner's foundational work, the socio-ecological theory offers a comprehensive lens for comprehending human development within the intricate web of interconnected social systems. It posits that individuals are influenced by multiple environmental layers, ranging from immediate settings to broader societal and cultural contexts (Bronfenbrenner, 1977). The socio-ecological model is underpinned by core principles elucidating the interrelations

between environmental conditions and human behaviour and well-being (Stokols, 1996). Building upon the work of McLeroy et al. (1988), this model provides a systematic framework for identifying and understanding the major influences and factors that contribute across five distinct levels: the individual, the interpersonal, community, organisational and health system, and public policy.

The socio-ecological model assumes particular significance in the conceptualisation of young women's experiences in accessing SRH clinics and services. It serves as a structured approach for understanding the intricate factors that shape and influence individual and community attitudes, societal norms, organisational dynamics and health system factors relevant to young women's access to SRH services. Each of these levels captures the multifaceted perceptions surrounding access to such services. Consequently, a comprehensive approach is imperative in the development of effective and multifaceted strategies and policies aimed at addressing the barriers to accessing SRH services in Cape Town, South Africa.

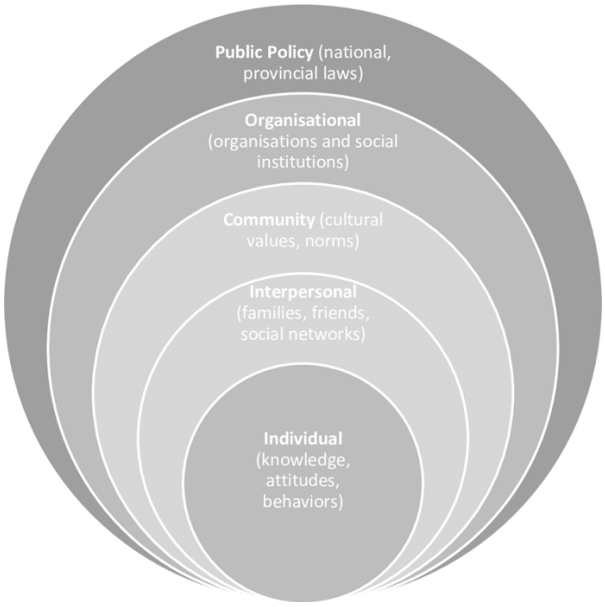

Figure 1: Socio-ecological Model

Individual (intrapersonal) level

The initial tier of the socio-ecological model, the intrapersonal level, explores individual characteristics such as age, gender, education, wealth and health, and knowledge, attitudes, behaviour and self-concept, alongside considering the developmental history of the individual

(Krug et al., 2002). It is imperative to acknowledge that this level is consistently subject to substantial influence from prevailing community and societal norms and expectations. These normative factors play a pivotal role in shaping health behaviours, access to support systems, and the establishment of a secure sense of identity and stability (McLeroy et al., 1988). This observation holds relevance to the positioning of young women concerning sexual health in South Africa.

Interpersonal level

Interpersonal relationships with family members, friends, neighbours, colleagues and acquaintances play a crucial role as influential factors in shaping individuals' health-related behaviours (Golden & Earp, 2012). Recognising the significance of the social groups to which an individual belongs is imperative. Notably, significant others hold substantial influence in decisions related to various aspects, for example the timing of medical consultations, the adoption of preventative health behaviours, and choices about residential locations, among others (McLeroy et al., 1988). In this study, this level of influence consequently shapes the ability to navigate challenges related to pregnancies or STIs. Social relationships constitute integral components of social identity, offering essential social resources including emotional support, information dissemination, access to new social connections and roles, and tangible assistance in meeting both social and personal obligations and responsibilities.

Community and societal factors

The community level constitutes the third tier within the socio-ecological framework. As posited by McLeroy et al. (1988), the term 'community' encompasses mediating structures to which individuals belong, exemplified by one's residential location, such as a neighbourhood. These mediating structures comprise entities like families, informal social networks, churches, voluntary associations, and neighbourhoods, serving as pivotal sources of social resources and social identity. Significantly, these structures function as repositories and influential determinants of larger community norms and values, individuals' beliefs and attitudes, and various health-related behaviours. They serve as the underpinnings of social support networks, fostering social connectedness, cohesion, resource sharing, and overall support within the community (Caperon et al., 2022; McLeroy et al., 1988). In communities characterised by a culture of empathy and support, the accessibility of SRH services for

young women may be facilitated. Conversely, in communities lacking active community engagement or support, accessing such services might prove to be more challenging for this group.

Organisational and health system level

The organisational level focuses on the influence exerted by institutions and entities such as schools, workplaces and healthcare systems. Organisational practices and policies hold influence over individual and community health outcomes (Scarneo et al., 2019). Organisations play a significant role in providing crucial economic and social resources. They serve as important conduits for the dissemination of social norms and values, particularly through their interactions with individuals. Consequently, organisations can exert both positive and negative effects on the health of their members (McLeroy et al., 1988). In this study, the conduct exhibited by nurses and healthcare workers in SRH clinics plays a pivotal role in influencing the experiences of young women seeking access to these services.

Public policy level

Public policy delves into the examination of cultural and social norms, alongside health, economic, educational and social policies, which contribute to the creation, perpetuation, or mitigation of socio-economic inequalities among different groups (Scarneo et al., 2019). This encompasses regulations, laws and policies at the local, state and national levels. Policies are instituted to safeguard the well-being and enhance the quality of life for all citizens, often taking the form of legislation enacted across various institutional levels. Theoretically, policies should facilitate the implementation of optimal guidelines to enhance access to SRH clinics and services for young women. To be efficacious, the adoption and implementation of such strategies should account for all levels within the socio-ecological framework (McLeroy et al., 1988).

2.6 Policy and Legislations related to Sexual and Reproductive Healthcare

Section 27 of the South African Constitution states that “everyone has the right to access healthcare services, including reproductive healthcare”. Hence, sexual and reproductive healthcare rights are enshrined in this section and every citizen of South Africa has a right to access sexual and reproductive services and the freedom to make their own choices about

their own body (Maimela, 2018). This section discusses the most relevant laws and policies to this research.

The 2005 Children's Act allows youth above 12 years to access sexual and reproductive healthcare services, including HIV testing, family planning (contraceptives) and termination of pregnancy, without parental consent (Stuthers et al., 2012). In addition, abortion in South Africa is legally regulated by the "Choice on Termination of Pregnancy Act". This act provides that a pregnancy is allowed to be terminated during the first 12 weeks, and under peculiar circumstances between 12 and 20 weeks. Besides, only the consent of the woman herself is necessary to terminate the pregnancy. Women should have access to information regarding their rights concerning this Act (Chapter 37 Reproductive Rights, n.d.).

Other than the laws mentioned above, South Africa has a 'National Integrated Sexual & Reproductive Health and Rights Policy' (SRHR Policy). The goal of this policy is to promote safe and high-quality reproductive healthcare services and practices by women, men and youth through informed choice and with a rights-based approach (National Department of Health, 2019).

The SRHR Policy has five objectives, which are: (1) "Equip all people to make informed decisions about their SRHR and ensure that their SRH rights are respected, protected and fulfilled"; (2) "Increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages"; (3) "Ensure access to respectful and non-judgemental SRHR services for priority groups"; (4) "Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the healthcare system", and; (5) "Promote multi-sectoral engagement and shared accountability for sustainable and rights-based service delivery" (National Department of Health, 2019).

Nationally, the SRHR Policy is aligned with the following strategies and approaches: "National Department of Health Strategic Plan 2015-16 to 2019-20"; "National Strategic Plan for HIV, TB and STIs 2017-2022"; "Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2022", and; "National Health Insurance". Furthermore, it is also aligned with the following guidelines: the "National Contraception Clinical Guidelines"; "National Clinical Guidelines for Safe Conception and Infertility"; "National Guidelines for Implementation of Choice on Termination of Pregnancy"; the "Sexually Transmitted

Infections Management Guidelines"; "National Clinical Guidelines for Cervical Cancer Control and Management"; "National Clinical Guidelines for Breast Cancer Control and Management"; and the "Guidelines on the Management of Post-Exposure Prophylaxis in Occupational and Non-Occupational Exposures" (National Department of Health, 2019).

Furthermore, the UNs' SDG 3.8. strives towards "achieving access to effective, affordable and quality medical care and guaranteed universal coverage for all" (United Nations, 2015). In addition, South Africa's National Development Plan mandates the provision of universal, efficient, equitable and quality healthcare (Republic of South Africa, n.d.). Because of these global and national policy requirements, socio-economic disparities in access to healthcare continue to be a top priority on the policy agenda (Gordon et al., 2020).

2.7 Conclusion

The purpose of this literature review was to examine the experiences of young women in accessing sexual and reproductive healthcare services. The review encompassed an analysis of the current landscape of sexual and reproductive healthcare on a global, continental and national scale. Moreover, the concept of access to healthcare was discussed, highlighting factors of availability, affordability and acceptability of access within the South African context. Furthermore, the socio-ecological model was explored, underscoring the significance of various levels within the ecological system that contribute to health behaviour. Finally, the review delved into the existing policies and guidelines governing sexual and reproductive healthcare for young women in South Africa.

Chapter 3: Methodology

3.1 Introduction

This chapter focuses on the methodology used for this study. It provides a presentation of the following: the research design; the population and sample procedure; the data collection; the data analysis and data verification; the limitations of the study; ethical considerations; reflexivity, and; the conclusion.

3.2 Research Design

This study employed a qualitative research design, chosen for its emphasis on gaining insight and understanding an individual's perception of experiences, events and circumstances (Denny & Weckesser, 2019; Remshardt & Flowers, 2007). It can be characterised as interpretative and naturalistic, aiming to comprehend and explain beliefs and behaviours within the context they occur (Draper, 2004). Given that the research question sought to describe the lived experiences of young women who accessed sexual and reproductive services in Cape Town, a qualitative phenomenological descriptive design was adopted. This design, aligned with phenomenological principles, investigates human experiences through the descriptive narratives provided by the participants, specifically exploring the lived experiences of young women accessing a SRH clinic (Remshardt & Flowers, 2007). It delves into the meaning attributed by individuals to their lived experiences of the phenomenon, focusing on the participants' perceptions of the event or situation (Tiwari, 2021).

3.3 Population and Sampling

The imperative identification of a suitable population and sample is fundamental for obtaining data that addresses the research question (Dibley et al., 2020). A population refers to the entire group of people, events or other phenomena that could be included in the research because they meet the inclusion criteria; the participant resource refers to a place, a service or an organisation which can provide participants for the study, and; a sample, the cluster of people, events or other phenomena from which the study retrieves its answers (Schmitz, 2012).

Study population and sample characteristics

The study population identified in this research consisted of any South African young woman, who has accessed a sexual and reproductive healthcare clinic located in Cape Town. The purpose of the visit could range from FP and counselling; to prenatal and postnatal care and delivery; to termination of pregnancy and post abortion care; to treatment and prevention of STIs, including HIV, to; information and counselling services regarding human sexuality.

Inclusion criteria

The sample of the study was selected according to the following inclusion criteria:

- Participant needs to be woman
- Participant needs to have South African nationality
- Participant needs to be aged between 18-25
- Participant needs to have accessed a SRH clinic or service within the preceding 18 months as of August 2023
- Participant needs to speak English
- Participant needs to be in the possession of a phone

Failure to any of these inclusion criteria resulted in the exclusion of the candidate from participation in this study.

The decision to interview participants aged 18-25 was made because these young women are old enough to make their own decision to participate in this research, particularly given the potentially sensitive nature of the topic. Because the sensitivity involved, it may be necessary to exclude as many people as possible regarding consent and the actual interview (Thummapol et al., 2019). Moreover, participants were required to speak English, as the researcher is from the Netherlands and can therefore only speak English. To facilitate communication and coordinate interviews arrangements, possession of a mobile phone was imperative.

The targeted sample size falls within the range of 15 to 20 participants. While Guest et al. (2006) do not provide explicit guidelines on participant numbers, they suggest that the sample size should be sufficient to achieve data saturation, a point where no new information or themes emerge. In a homogeneous sample, which was present in this study, the range of

interviews is between 5 to 25 interviews, with approximately 12 participants deemed adequate.

Sampling technique

This study employed purposive sampling, a non-probability sampling technique selected for its ability to target individuals who possess direct experience with the phenomenon being researched, thus enabling them to offer informed insights (Dibley et al., 2020). Purposive sampling was chosen because of the research question, as this study sought the subjective experiences of young women in accessing SRH clinics and services. In this research, purposive sampling specifically focuses on selecting a distinct subgroup within society – South African women aged between 18 and 25 – who have accessed SRH clinics and services located in Cape Town in the past 18 months. This deliberate concentration results in a homogeneous sample, wherein the characteristics of potential participants share notable similarities (Symon & Cassell, 2012). These participants share similarities in terms of their gender, age, racial background, residential location and equivalent access to services provided at a SRH clinic.

Sampling procedure

The identification and selection of suitable participants for this study required the researcher to collaborate with Partners in Sexual Health (PSH), where assistance was sought from the organisation in this process. PSH is an evidence-based, non-profit organisation that provides and advocates for sexual and reproductive health & rights, including HIV/AIDS and GBV prevention and support services, to women, men and particularly adolescents and youth, throughout South Africa. PSH was formally established as a non-governmental and non-profit organisation in 2009. It implements various programs regarding sexual and reproductive health and rights that are inclusive, rights-based and address the needs of young people in a holistic manner (Partners in Sexual Health, n.d.). Given its extensive network and connections with young individuals who may have visited a sexual or reproductive clinic or service, this organisation served as a valuable channel for potential candidates. Therefore, it was irrespective of which SRH clinic potential participants have been, as long as the clinic or service was located in Cape Town.

Verbal agreements were established with Ms. Patricia De Lora, the founder and chief executive officer of PSH, to facilitate the recruitment of participants for the study. In this capacity, Ms. Fahranaaz Daniels served as the designated gatekeeper for the organisation, overseeing the selection and introduction of potential participants to the research initiative.

First, the researcher provided PSH with an information sheet and consent form from her study. An example of this information sheet is presented in Appendix A: Recruitment Material. PSH, which engages 250 youth as health promotors in Cape Town, actively encouraged participation in the research initiative. Ms. Daniels, serving as the primary contact for the participants, facilitated the initial communication and coordinated the interview arrangements. PSH facilitated the recruitment of 16 individuals who volunteered to participate in interviews with the researcher. These individuals resided mainly in the Parow area, a northern suburb in the City of Cape Town. The rationale behind the selection of this area and demographic was established in the researcher's aim to explore the experiences of young women using SRH clinics and services in Cape Town. The collaboration with PSH substantially contributed to participant recruitment efforts. The interviews were conducted at the PSH national office, in a designated private room. Before the interview, the aim of the study, inclusion criteria and voluntary participation were explained. A signed consent form was obtained from the participants in order to start the interview. The consent form was explained and discussed prior to the start of the interview.

3.4 Data Collection

The utilisation of interviews for data collection is a common practice in qualitative research. Interviews offer a direct and thorough method for obtaining detailed and comprehensive information about a specific phenomenon (Barrett & Twycross, 2018). In-depth interviews, in particular, present participants with the opportunity to express and explain their understanding and interpretation of a particular experience in their own words (Knott et al., 2022).

In this research, the decision was made to employ face-to-face, semi-structured interviews. Semi-structured interviews offer the advantage of obtaining consistent core information from each participant, while also allowing flexibility to delve more deeply into the unique experiences of individual participants (Belotto, 2018). This approach facilitates the collection

of comprehensive data, and given the sensitivity of the topic, individual interviews provide participants with a sense of privacy. From the researcher's perspective, this interviewing method provides greater space to address the specific needs or preferences of participants in terms of comfort and open expression (Tisdall et al., 2009).

Throughout the interview process, specific themes were explored within the acceptability dimension of access to healthcare. Inquiries centred on participants' encounters with the respected SRH clinic or service and the nature of responses received from individuals in their immediate social circles regarding these experiences. The interview duration spanned from 45 to 60 minutes, contingent upon the time each participant was required to address the posed questions. To facilitate subsequent analysis, the interviews were recorded using the researcher's phone and later transcribed by the researcher.

16 face-to-face interviews were conducted in the boardroom of the national head office of PSH in Parow. The closed-door setting of the boardroom was deliberately chosen to ensure the privacy and comfort of the participants during the interviews. The interviews were conducted exclusively between the researcher and the participant, safeguarding the confidentiality of the shared information and discussions. Strict measures were implemented by the researcher in collaboration with her PSH contact person to prevent the entry of any other individuals into the designated room throughout the interview sessions.

Data Collection Tool: Interview Schedule

The interview schedule served as a methodological instrument to establish a standardised framework and facilitate the flexible acquirement of information. The schedule incorporated a set of pre-determined and thematically open-ended questions, strategically aligned with the research objectives. This comprehensive approach afforded the researcher a nuanced understanding of participants' perspectives on the topic. An example of the interview schedule is presented in Appendix B: Interview Instrument.

Pilot Study: Pre-test Interview

Pilot studies are integral to the research process, particularly in assessing the viability of research instruments such as interview guides or questionnaires. Serving as a pre-test, a pilot interview enables the evaluation of the effectiveness of data collection and analysis methods

(Shakir & Atteq Ur Rahman, 2022). In this study, piloting was conducted prior to data collection to assess the effectiveness of the data collection tool. The researcher conducted a pilot interview to evaluate the interview schedule, resulting in several modifications. These adjustments included reordering the questions for improved coherence and refining the language to enhance comprehension.

3.5 Data Analysis

Qualitative data analysis involves the systematic process of categorising, analysing, and elucidating qualitative data, unravelling themes and patterns inherent in the collected interviews (Lester et al., 2020; Wong & Li Ping, 2008). Given the research question and methodology employed in this study, a thematic analysis was chosen. According to Braun & Clarke (2006), thematic analysis is a data analysis method that helps a researcher to identify themes and patterns of meaning across a dataset concerning particular research questions (SAGE, 2019). Thereby, in line with deductive reasoning, the thematic analysis was framed using the socio-ecological model of health, applying this theoretical framework to the data set, as a 'top-down' approach. Consequently, the levels of the socio-ecological model serve as overarching themes for the coded categories (Bingham, 2023; Clarke & Braun, 2013).

To guide the data analysis process, Braun & Clarke's (2006) six steps were employed in this study.

1. **Familiarise yourself with your data**: The researcher employed transcription software for the transcription of the interviews. Simultaneously, throughout the review and refinement process, the researcher engaged in a thorough familiarisation with the data content. This process involved careful listening to the spoken content of the participants through multiple iterations. During this phase, the researcher actively attended to the content, capturing initial thoughts and ideas in response to the statements made by the participants.

2. **Generating initial codes**: During the initial coding process, the researcher conducted a comprehensive analysis of the entire dataset to recognise significant topics within the data content. This process aimed at structuring and organising the dataset effectively in a way that all relevant pieces of data could partly answer to the research

questions. Utilising the coding features of NVivo, the researcher systematically coded the interviews in sets of three, ensuring diligent attention to each individual interview. Ultimately, the researcher generated 42 codes, with no emergence of new codes in the final two interviews.

3. **Searching for themes**: In this stage, the researcher initiated the analysis of codes, contemplating the potential combination of distinct codes into overarching categories. Employing pen and paper, the researcher systematically organised codes into thematic clusters. The analysis of the data was contextualised within the socio-ecological model of health (McLeroy et al., 1988), serving as the theoretical framework guiding the researcher's approach. This theory suggests that health behaviour is influenced by factors at individual, interpersonal, community and organisational levels, and their interplay (Caperon et al., 2022). Under this framework, the researcher identified four overarching themes, each encompassing specific categories aligning with the respective levels. During the review of the codes, the researcher systematically categorised them into distinct groups, associating them with topics corresponding to the themes within the socio-ecological model. For instance, according to the theory, knowledge of SRH services, or lack thereof, represents a determinant at the individual level of the socio-ecological model of health. Consequently, the researcher collated all codes related to knowledge within the context of the individual level, in the category 'knowledge'.

4. **Reviewing themes**: In this phase, the researcher systematically reviewed the candidate themes along with the associated coded data extracts, evaluating the coherence of the grouped codes. For instance, in examining whether codes such as 'knowledge of SRH services,' 'SRH knowledge through school education,' 'knowledge of family planning options,' and 'importance of sexual health' collectively pertained to participants' knowledge of sexual health, the researcher opted to segregate 'importance of sexual health' and allocate it to a new theme: Self-image. After re-reading the coded extracts of the 'importance of sexual health', the researcher realised that this information fits better into this theme.

5. **Defining and naming themes**: During this phase, the researcher conducted a comprehensive examination of the core attributes of each theme. The themes and associated categories were systematically scrutinised, and the researcher started the process of organised writing, developing a coherent narrative for each theme and category. In adherence to the deductive approach employed in thematic analysis, the researcher focused on scrutinising the distribution of coded extracts into distinct categories. This scrutiny exposed that particular codes exhibited a more fitting alignment with specific categories, while others demonstrated better alignment with alternative (newly identified) categories. For instance, within the individual level of the socio-ecological framework, certain codes initially associated with 'attitudes and feelings' were reassigned to a (new) category labelled 'decision-making process.' The delineation of this code division process is illustrated in the following figure. The left column shows all codes initially aligned to ‘attitudes and feelings’, while the right column shows the codes divided into 2 ‘new’ categories.

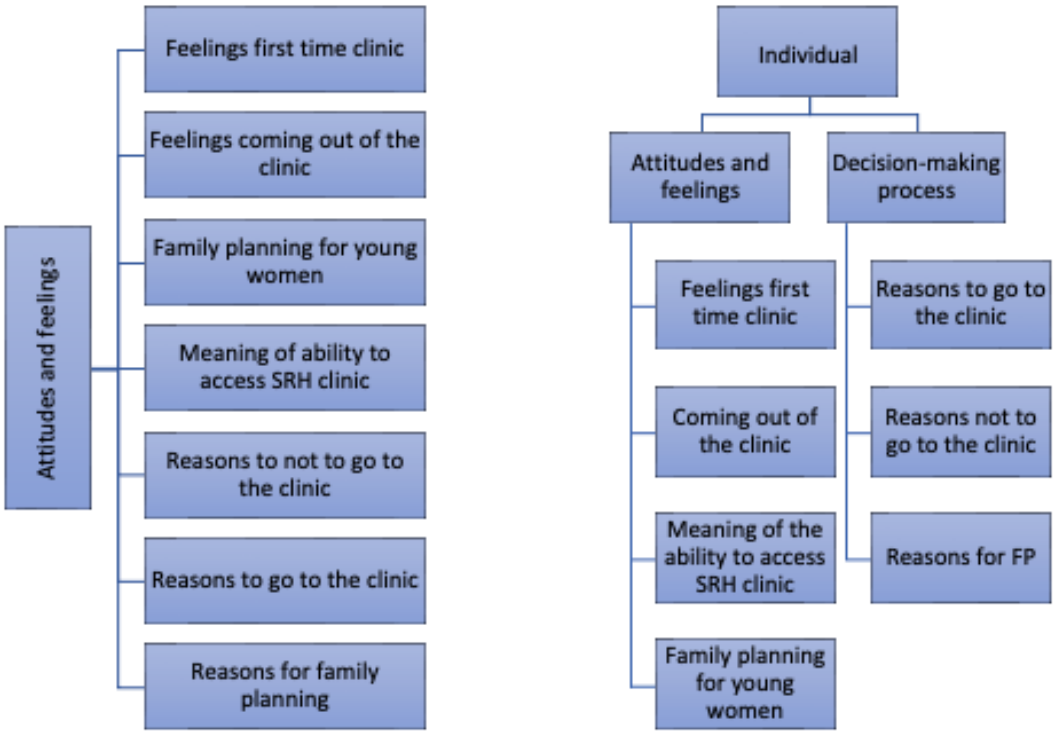

Figure 2: Division of coded extracts into new categories

As a result, the researcher defined categories and assigned them to names based on their respective narrative content. Themes and their corresponding codes are detailed in Table 1.

Table 1: Framework Analysis

Themes	Categories
Individual level	• Lack of knowledge • Decision-making process • Attitudes and feelings
Interpersonal level	• Lack of communication (at home) • Negative peer influence
Community and Social Factors	• Stigmatisation and judgement • Gendered dynamics
Organisational and Health System level	• Perception of healthcare workers • Provision of FP services • The structural organisation within SRH clinics

6. **Producing the report**: During this stage, the researcher advanced beyond the mere delineation of themes, categories, and coded extracts. Instead, she initiated a discourse on the significance of these themes within the contemporary South African context concerning sexual and reproductive health. This involved establishing connections between the identified themes and their relevance in addressing the research questions.

3.6 Data Verification

In qualitative research, data verification involves assessing the trustworthiness of the study. Following Lincoln and Guba's theory of 'trustworthiness', which parallels reliability and validity, four key aspects are considered: credibility, transferability, dependability and confirmability. These aspects serve as criteria for evaluating the overall significance, relevance, impacts and utility of completed research (Adler, 2022; Morse et al., 2002).

To establish **credibility,** researchers must ensure accurate identification and description of individuals participating in the study. This entails exclusively including participants who meet the study's inclusion criteria and excluding those who do not fulfil each criterion (Elo et al., 2014). Each interview session was digitally recorded and subsequently transcribed into

written transcripts. The researcher employed transcription software designed to precisely transcribe the recorded content. Additionally, the researcher meticulously reviewed each recording multiple times to ascertain the accuracy of the transcripts to the spoken content. This thorough process aimed to guarantee that the transcriptions faithfully represented the participants' statements, with no influence from the researcher beyond the posed questions.

Transferability involves the potential for extrapolation, asserting that results can be generalised or transferred to different contexts or groups' data (Elo et al., 2014; Forero et al., 2018). The transferability of this study is explained through a comprehensive description of the methodologies used for data collection and analysis. The applicability of these methods, along with the associated methodological decisions, extends to comparable settings and environments. Readers are provided with the means to evaluate the relevance of the study's findings to their specific situations, acknowledging potential variations contingent upon the unique contexts of their respective research attempts.

Dependability pertains to the stability of data over time and under varying conditions data (Elo et al., 2014). To evaluate dependability in this study, the inquiry of the research design, the interview schedule employed for data collection, and their application within the research study collectively facilitate the potential replication of the study in a comparable context.

The term '**confirmability**' relates to objectivity or the likelihood of consensus among two or more independent parties regarding the accuracy, relevance, and meaning of the data (Elo et al., 2014; Forero et al., 2018). The researcher employed confirmability as a means to systematically verify and reassess the data throughout the process. The dataset encompasses digital recordings, transcriptions, and observations derived from these recordings, ensuring that the necessary information for confirming the findings remains readily accessible.

3.7 Limitations of the Study

One limitation of the study pertains to the researcher's linguistic constraints, as interviews were conducted exclusively in the English language, potentially excluding South African young women who do not speak English. Another limitation is associated with the relatively small sample size and the focus solely on sexual and reproductive healthcare clinics in Cape Town, restricting the generalisability of the research findings to the broader population of the

country. Furthermore, the analysis of the study is conducted within the confines of a single theoretical framework, the socio-ecological model, which may not adequately elucidate aspects, such as the role of gender within this context.

3.8 Ethical Considerations

Verbal agreements were established with Ms. Patricia De Lora, the founder and chief executive officer of PSH, to facilitate the recruitment of participants for the study. Ethical approval was secured from the Ethics Review Committee of the Faculty of Humanities (ref #SWK-REC-2023-SR013) and the Faculty of Health Sciences Human Research Ethics Committee (HREC) (ref #757/2023), both of the University of Cape Town. Both letters of approval are available for reference in Appendix C: Letters of Approval.

Avoidance of Harm

An important ethical consideration involves ensuring the well-being and safety of research participants throughout the research process. Although qualitative research typically entails minimal risks, it is imperative not to overlook potential risks, particularly in studies addressing sensitive topics such as taboo issues, personal matters, or subjects that may pose a threat to participants. In this context, the researcher must conduct a thorough assessment of potential risks, and participants should be comprehensively informed about these risks and the benefits with their participation in the research (Wiles, 2013).

The researcher considered the potential risks that could arise, primarily concerning the emotional, psychological, or physical well-being of participants. These risks could arise from emotional responses and other effects that could emerge before, during, and after the research process. Therefore, strategies were in place to manage any discomfort or distress that participants might experience during their involvement. Participants could leave the research process feeling no more unhappy or distressed than they did when they began it (Wiles, 2013). During this study, no instances of physical or psychological harm were observed. The interviews conducted did not result in any emotional harm, as participants displayed no signs of discomfort and conveyed positive feedback, indicating a satisfactory and comfortable engagement during the conversations.

Informed Consent & Voluntary Participation

The procedure for securing informed consent and ensuring voluntary participation encompasses several key elements: participants must possess a comprehensive understanding of the study's requirements and objectives, necessitating adequate information disclosure; participants should be of legal age to provide consent; consent must be given voluntarily, without coercion; participants must have the freedom to make an autonomous decision regarding their participation, including the option to withdraw from the research at any point without facing adverse consequences (Arifin, 2018).

In this study, all participants were required to provide written informed consent. Individually approached, participants received a detailed explanation of the study's purpose and the data collection procedures. Sufficient time was provided for addressing concerns and posing questions, with a clear emphasis on the voluntary nature of participation, assuring participants that refusal or withdrawal would not result in any repercussions. Throughout the process, the researcher maintained open communication, consistently informing participants and seeking permission to ensure trust-building and adherence to ethical standards. Additionally, consent was obtained for recording interview sessions, with an explicit understanding that only the researcher would have access to the recordings. Appendix D: Consent Form for Participants is an example of the consent form that was given to the participants.

Privacy, Confidentiality & Anonymity

Privacy is an essential ethical consideration for any researcher, referring to the absence of unauthorized access or disclosure of personal data. The researcher has a duty to maintain the confidentiality and anonymity of the participants in the study (Gabor, 2017).
In research, confidentiality means that identifiable information about individuals collected during the undertaking of research will not be revealed and that the identity of participants will be protected through several procedures outlined to anonymise them, unless participants specifically choose to be identified. Moreover, it may also signify that specific information shared in the research process will not be utilised if requested by the participant (Wiles, 2014, p. 42). Thereby, anonymity serves as the vehicle through which confidentiality is put into practice. Researchers seek to safeguard participants from the accidental breaking of confidentiality through anonymisation, which takes place through the use of codes and

pseudonyms assigned to research locations, organisations, and participants (Wiles, 2014, p. 50).

Provisions for preserving the privacy, confidentiality and anonymity of participants involve constraining the data collection to the minimum necessary to accomplish the research objectives and ensuring that the procedural circumstances incorporate protective measures for the participants (Gabor, 2017). The anonymity and confidentiality of the participants will be preserved by not revealing their identities in the data collection and study findings (Arifin, 2018).

In this study, information and the consent form were provided to the participants prior to the interview, the consent form was signed and questions were answered prior to the interview. The consent forms were handed over right before the start of the interview. The consent forms were locked in a safe, only accessible by the researcher. The purpose of the meeting was explicitly kept confidential from third parties, such as family or friends, and sole access to the interview recordings was restricted to the researcher. Each interview was conducted individually in a private room in the respective facility. This room was quiet, and there was a sign stating that entry was prohibited during the interview. This precautionary measure ensured that participants were not observed, overheard, or intercepted by any external individuals.

Moreover, upon the completion of each interview session, while reviewing the recordings, the researcher took precautions to ensure the confidentiality of participants by listening to the recordings in a secluded room with the use of earphones, minimising the risk of accidental disclosure. Additionally, during the transcription of data, participants were anonymised by excluding their names and any identifiable information. In the presentation of study findings, participants were identified using pseudonyms as numerical labels to maintain confidentiality.

Deception of Participants

Deception in qualitative research refers to any deliberate decision made by the researcher to convey false information or withhold crucial details about the research process from participants (Allen, 2017). No deception of any kind occurred in this study. The researcher

ensured transparency by providing clear explanations of the research process at the beginning, throughout, and after the study.

Debriefing Participants

Debriefing, an integral element of the informed consent process, takes place following participants' involvement in the research. Typically, it involves disclosing any instances of deception that may have occurred during the research process. Since this study maintained a commitment to transparency and did not involve any deception, the risk to participants was minimal.

The researcher conducted the debriefing immediately after each interview, the debriefing served an ethical purpose, encompassing reminders of the study's objectives and rationale, guidance on where participants could access information about the study's findings, and expressions of gratitude for their contribution and time. Participants were reasserted their right to withdraw from the study during this stage (McNallie, 2017). They were also informed of their ability to request a debriefing session at PSH, with Dr. Alobwede, a qualified member of the organisation. However, none of the participants sought assistance from Dr. Alobwebe.

Publication of Findings

All data obtained during the study process is published accurately, without any alterations (Reay, 2014). It was made clear to the participants that this research is part of an academic requirement to accomplish the master’s degree in social development at the University of Cape Town.

Corporation with Contributors

When conducting qualitative, social research, it is customary to express gratitude and acknowledge the contributions made by individuals or organisations involved in the study (Anderson & Allen, 2017). The research supervisor, respective organisation and participants have been duly acknowledged and thanked for their valuable contributions to this study.

3.9 Reflexivity

Reflexivity is characterised by the researcher's cognisance of their active role in the research process and an understanding of how their involvement is shaped by the research subject.

This self-awareness enables the researcher to recognise the influence of their actions on both the research procedures and results (Symon & Cassell, 2012).

As a researcher conducting a study on young women's experiences in accessing sexual and reproductive healthcare clinics, the researcher reflected on her role and position regarding this research topic. As she is of Dutch origin, there are inherent cultural and socio-economic differences between her and the research participants, as they are from South Africa. Her Dutch background may introduce a potential cultural gap, influencing her perceptions, assumptions, and interpretations throughout the study. This awareness of her cultural background and its potential impact on the research process is crucial in acknowledging and addressing potential biases.

The positionality as an outsider to the cultural context of these young women required careful consideration. Cultural sensitivity and reflexivity are essential to navigating potential misunderstandings in language, social norms, and lived experiences. Acknowledging the existing privilege associated with being an international student enrolled in a university with access to resources not universally available, particularly in the area in this study, was a diligent consideration. This recognition was essential, given its potential impact on the researchers' perspective, motivating a dedicated commitment to approach the research with a balanced and empathetic mindset.

In assuming the role of a researcher, she remained aware of the potential of subjectivity and limitations in this study. Confronting these challenges, continuous self-reflection and regular supervision were embraced throughout the research process. This facilitated the recognition and acknowledgement of personal experiences and emotions that could have influenced data collection, analysis and interpretation, were it not for the reflective process undertaken. Consequently, a commitment was made to approach the exploration of this study with transparency, integrity and dedication to presenting an authentic representation of the experiences of young women accessing a sexual and reproductive healthcare clinic in Cape Town, South Africa.

3.10 Conclusion

This chapter elaborated on the methodology, establishing the validity of this study. This research adopted a qualitative methodology, specifically employing a phenomenological descriptive approach to explore the experiences of young women accessing SRH clinics and services in Cape Town. Semi-structured interviews were utilised to gather in-depth responses. Data analysis followed Clarke & Braun's (2013) thematic analysis method, guided by the socio-ecological model proposed by McLeroy et al. (1988). Rigorous data verification was achieved through the application of the principles of trustworthiness. Moreover, the chapter addressed the study's limitations, ethical considerations, and engaged in a discussion on the researcher's reflexivity.

4. Discussion of Findings

4.1 Introduction

This chapter discusses the findings of this study and provides an interpretation of the findings. First, the demographic details of the participants are demonstrated. Thereafter, the identified themes and categories resulting from the data analysis are presented, subsequently followed by a comprehensive discussion of these findings. The chapter concludes by summarizing the key insights derived from the discussion.

4.2 Demographic Details of the Participants

The discussion of participants' demographics is important to this study because demographic details offer contextual information about the specific group under investigation. Understanding the background of young women in South Africa can facilitate a clearer comprehension of their experiences in accessing SRH services. Table 2 shows the demographic information of the participants in accordance with the study population and the inclusion criteria of this research. To uphold the principle of anonymity, each participant was anonymised through the assignment of a pseudonym represented by a numerical identifier.

Table 2: Demographic information of the participants

Participant	Age	Gender	Race	Education level	Relationship status
1	25	F	Coloured	Grade 10	Single
2	24	F	Coloured	Grade 12	Single
3	25	F	Coloured	Grade 9	Partner
4	23	F	Coloured	BA	Single
5	18	F	Coloured	Grade 9	Partner
6	25	F	Coloured	Grade 12	Single
7	25	F	Coloured	Grade 12	Partner
8	25	F	Coloured	College Degree	Partner
9	19	F	Coloured	Grade 11	Partner
10	23	F	Coloured	Grade 12	Single
11	25	F	Coloured	Grade 9	Single
12	23	F	Coloured	Grade 10	Single
13	24	F	Coloured	Grade 12	Partner
14	25	F	Coloured	Grade 10	Single
15	18	F	Coloured	Grade 12	Partner
16	25	F	Coloured	Grade 10	Single

This study includes 16 participants who are exclusively women, aged between 18 and 25 and all residing in the same area in Cape Town. Each participant self-identified as being 'coloured' in terms of race. The demographic characteristics of the participants can be

contextualised by their residential area. The participants in this study all reside in Parow, a northern suburb of the City of Cape Town that bears historical ties to the colonial era and more recently the Apartheid era. The enactment of the Group Areas Act in 1957 compelled individuals to relocate based on their racial classification, as decided by the government in that period (Crankshaw, 2012; IOL, 2014; SAHO, n.d.). Today, Parow consists of a population of 199.462 residents and is a predominantly 'coloured' neighbourhood (58.4%) (STATS SA, n.d.). The term 'coloured' denotes individuals of mixed race, as officially defined by the South African government from 1950 to 1991, and is still used as a racial identifier to date (Pauls, 2023). The gender distribution exhibits a marginal disparity, with 48% men and 52% women within this area. A majority of residents have attained some level of secondary education or have completed their matriculation (STATS SA, n.d.). Parow confronts socio-economic challenges, marked by elevated levels of poverty and heightened incidences of violence and criminal activities.

South Africa continues to experience racial and economic segregation because of ongoing social inequality, unemployment, poverty, a heavy burden of disease and disparities in the quality of healthcare service provided (de Villiers, 2021). According to Kriel et al. (2023), elements such as gender, race and economic status influence access to healthcare. Despite existing policies like the National Adolescent & Youth Health Policy (Department of Health, 2017a), young women's inclusion in health and development remains insufficient (George et al., 2020). However, current policies may benefit from increased attention and efforts to ensure equitable access to healthcare for young women in South Africa. Thus, the demographic characteristics of the participants show that young women are a marginalised group in South Africa, leading to more vulnerability in access to healthcare (Ducray et al., 2021).

4.3 Findings

Young women in this study identified numerous thoughts, feelings and attitudes towards their access to SRH services in Cape Town. The analysis and presentation of the results are framed by the socio-ecological model of health. This theory suggests that factors at the individual level, which may include intra- and interpersonal, community and structural levels interacts and shape health-seeking behaviour (Erasmus et al., 2020; Kennedy et al., 2021; McLeroy et al., 1988). The socio-ecological model is applied in this study to offer a holistic

understanding of the experiences of young women in accessing SRH services. Utilising the socio-ecological model to generate evidence may help in the development of strategies and interventions that comprehensively address young women's experiences across multiple levels. This approach may prove to be more effective than interventions targeting only one level, thereby playing a crucial role in enhancing young women's experiences in accessing SRH services in Cape Town (Sidamo et al., 2023). Therefore, the factors that influence the experiences of young women accessing SRH services in Cape Town are discussed according to the individual, interpersonal, community and organisational levels in section 4.4: Discussion of Findings.

Table 3 presents the significant themes and categories identified through data analysis. The themes align with the levels of the socio-ecological model, while the categories are derived from the findings of this study, and are situated within the corresponding theme. This resulted in four themes and ten categories.

Table 3: Themes and Categories

Themes	Categories
Individual level	• Lack of knowledge • Decision-making process • Attitudes and feelings
Interpersonal level	• Lack of communication • Negative peer influence
Community and Social Factors	• Stigmatisation and judgement • Gendered dynamics
Organisational and Health System level	• Perception of healthcare workers • Provision of FP services • The structural organisation within SRH clinics

4.4 Discussion of Findings

This section discusses the findings of this study and provides an interpretation of the findings. Each theme and corresponding categories are systematically examined in this section, as displayed in Table 3. The findings are discussed by using significant comments from the participants and an interpretation of their thoughts, feelings and attitudes. To uphold the principle of anonymity, each participant was anonymised through the assignment of a pseudonym represented by a numerical identifier. The participants predominantly sought SRH services related to FP, pregnancy, or for testing STIs, including HIV. Therefore, the

discussions revolve around these services, and there will be no mention of termination of pregnancy or post abortion care services.

4.4.1 Individual Level

Factors that influence young women's access to SRH clinics and services at the individual level are participants' knowledge (or lack thereof) of SRH services, participants' decision-making processes regarding SRH services, and participants' attitudes and feelings towards SRH services. Although these factors act at an individual level to influence the health-seeking behaviour of young women, they are also heavily influenced by interpersonal, community and system norms and values (Golden & Earp, 2012; McLeroy et al., 1988). First, participants' knowledge is discussed. Thereafter, the decision-making processes and, attitudes and feelings are discussed.

Lack of knowledge

A prevalent theme among the participants involved a notable deficiency or absence of knowledge regarding sexual and reproductive health, which is also part of the individual level of the socio-economic model. The possession of knowledge and information plays a fundamental role in examining the experiences of young women accessing SRH services (Obisie-Nmehielle et al., 2022a). Sufficient knowledge of sexual health empowers young women to make informed decisions about their reproductive well-being and helps mitigate risks, especially in South Africa where minimising unintended pregnancies and HIV infections is crucial (Galappaththi-Arachchige et al., 2018; Sharma, 2023). Lack of knowledge about SRH services was stated by the following participants:

"I knew about HIV, that it could be transmitted through sexual intercourse and needles, but I learned that through school. When I first got my period, my mommy told me boys only want one thing, so you must be safe and make sure you are on something. But I knew nothing about birth control, so I never used protection." - Participant 11

"All I knew that was like my daddy told me that I'm to never go for injection because if I go for injection then it will maybe affect my whatever you call it the eggs or and then I won't be able to get babies or stuff, or no more babies or so. After that I only knew about the injection, pills and condoms, that's all I knew." – Participant 3

"I didn't know you can go on family planning before you get pregnant. I didn't know that. Because they were always telling me: Get your period normally don't use the injection or pills. So when I had intimacy with the guy, I got pregnant. I didn't even know about the condoms, I wish I did." – Participant 6

Participants indicated that their lack of knowledge resulted in less or no awareness of the potential consequences linked to participating in sexual activity, such as unintended pregnancies or the contraction of diseases. Lack of knowledge could also lead to relying on false information and beliefs about sexual health, such as associating the use of FP with the risk of infertility or serious diseases, as stated by Participant 3 *"Then it will maybe affect my whatever you call it eggs or and then I won't be able to get babies"*. This apparent lack of awareness of participants of the consequences of sexual activity underscores the limited preparedness of young women to engage in informed decision-making concerning their sexual and reproductive well-being.

Moreover, participants' lack of knowledge about SRH services sheds light on the perceived inadequacy of current policies aimed at providing and ensuring comprehensive sexuality education (CSE). CSE encompasses educational initiatives designed to help young individuals develop an understanding of concepts, content, values, and attitudes related to sexuality, fostering the pursuit of safe and healthy lives (Department of Basic Education, n.d.). However, previous research on CSE by Koch & Wehmeyer (2021) discovered that parents, teachers, and other stakeholders often express reservations about sex education, fearing it may encourage sexual activity among young individuals. Nevertheless, CSE proved to have positive health outcomes in terms of SRH, while programs focused on abstinence exhibit an ineffective impact on the SRH of young women (Koch & Wehmeyer, 2021).

Consequently, there is a need to shift the public narrative around sex education, emphasising that sex education is not intended to instigate sexual activity among young women and girls. Instead, its primary purpose is to create awareness and protect young women from the consequences of being sexually active, such as unintended pregnancies and HIV infections, which is particularly important in South Africa, with high levels of pregnancy, HIV infections, and stigmatisation of young women and girls (Davids et al., 2020). By doing so, the aim of sex education is to empower young people to make informed choices about their

sexual health, potentially contributing to a reduction in high levels of pregnancies and diseases (Department of Basic Education, n.d.). Therefore, CSE is crucial for empowering young women to make informed-decisions regarding their sexual health and well-being.

Besides addressing knowledge deficiency, the aforementioned comments also highlight the dynamics of communication between parents and children. However, this falls within the interpersonal level of the socio-ecological model and will be further discussed in the next section. Alongside the significant factor of knowledge deficiency at the individual level, another important aspect that emerged was young women's decision-making process regarding accessing SRH services, which is discussed next.

Decision-making process for accessing SRH services

The decision-making process belongs to the individual level of the socio-ecological model, although the decision-making process could be heavily influenced by people close to the individual, and community values and norms, which are part of the interpersonal and community levels of the socio-ecological model (Caperon et al., 2022). The decision-making process of young women regarding sexual and reproductive healthcare highlights the significance or lack thereof attributed to the utilisation of SRH services and contraceptive practices. This provides insights into the values placed by young women in South Africa on their agency over sexual and reproductive rights. The exploration of these perspectives is integral to this research, offering a nuanced understanding of the daily emotional experiences carried by young women concerning their health status (Ahinkorah et al., 2018). Multiple factors influenced the decision-making process of participants concerning whether to seek services at the clinic, at the individual level, as stated by participants below:

"The reason why I went for family planning because I was still young and I don't want to support the baby, the end of the day and now they say so. Please me but to sit with that and you know you can have a future outside, you want still want to do this? You want to have a better job. Now I must sit with the baby and I don't want to upset my parents at the young age like they have to support a child." – Participant 8

"I just decided the three months because I don't want the loop or implant because I don't know how it works. They didn't tell me, and they just decided for me I must take the three

months. But there is something to it like take the two months or three months injection you lose hair, you lose weight, you gain weight, and what if you get cancer or stuff. So it was a bit risky to just go and because I didn't want to lose weight, or you know." – Participant 7

"I didn't want to go to the clinic. You know, the aunties and uncles at the clinic, they all gossiping and like I wanted to do it. It's my privacy, so I don't want anyone to know, like see me at the clinic or whatever. So I decided not to go anymore." – Participant 10

The quotations offer insights into the significance attached to accessing SRH services, and the meaning of fertility, pregnancy, and contraceptive use. The comments explain the rationale of the participants to either access SRH services or not. Some participants see opting for contraceptives as a proactive step in taking responsibility for their reproductive rights and a better future. For example, participant 8 states: *"… and you know you can have a future outside…"*. On the contrary, other participants express reasons to abstain from contraceptives, predominantly citing concerns about numerous side effects of birth control. Another significant factor for not accessing SRH services is because of the fear of gossip and judgment by community members. Based on these attitudes, it is evident that some participants prioritised the utilisation of birth control, while others considered factors such as FP side effects and community judgement more important.

First, knowledge and a decision-making process are closely aligned with each other, as knowledge acts as a guiding force in the decision-making process, shaping the way individuals perceive, evaluate and respond to various situations (Obisie-Nmehielle et al., 2022b). Therefore, the importance of making well-informed decisions intersects with the domain of knowledge possession explained in the preceding section. Furthermore, it is essential for young women to take charge of their sexual and reproductive healthcare decisions, considering both their individual rights and the potential benefits for society. Individual and societal benefits may include improved health outcomes, reduced gender inequality, and increased opportunities for personal and professional growth (Erasmus et al., 2020; Karp et al., 2020), in the South African context. In light of this, Karp et al. (2020) argue that special attention to empowering young women to access SRH services is critical for improving access, stemming from the idea that a decision-making process evolves from the existence of a choice, to the exercise of that choice, ultimately achieving the desired outcome of that choice. As a result, young women's empowerment to make their own

decisions regarding their sexual health and well-being is crucial for their access to SRH services.

Attitudes and feelings towards accessing a SRH clinic

Attitudes and feelings towards accessing a SRH clinic are the last factor at the individual level of the socio-ecological model. The exploration of attitudes and feelings of young women holds significance in this research, as it provides insights into the behavioural dynamics of young women concerning sexual health. First, participants indicated that they experienced several feelings by accessing SRH services for the first time:

"I was very nervous, very shy, because I didn't know how they going to use this stuff, where they going to put it in my body. I didn't know anything. And I was shy because of the people, because of what they may be thinking." – Participant 3

"I was scared. Because there is maybe people that my family knows. So they going to ask, what are you doing here? Why are you here? That kind of questions." – Participant 7

Participants' responses revealed that a predominant sentiment among them was one of fear, shyness, nervousness and apprehension. These emotional reactions primarily stemmed from a lack of familiarity with the clinics' procedures and the fear of potential recognition by individuals, particularly community members, within the clinic premises. For example, participant 7 states: *"Because there is maybe people that my family knows…"*. These feelings, together with a lack of social support and social stigma in the community, could potentially affect the mental health and overall well-being of young women (Duby, et al., 2021). According to Duby et al. (2021), poor mental health and low self-esteem are associated with negative sexual and reproductive healthcare outcomes for women, such as unintended or early pregnancy, and increased risk for HIV. Therefore, there is a need to acknowledge and address the mental health challenges faced by young women, recognising the implications for their vulnerability in accessing SRH services.

Nevertheless, when asked about the meaning of being able to access SRH services, the prevalent sentiment among participants was optimistic:

"It means a lot because at the end of the day I know my status. I know my health and every part of it. Like, maybe you'll have something that you don't know about. Now you go to the clinic, maybe for a check-up, come for everything. So in this moment where you find out. Oh, I'm having this, this disease so. So I think it's a good idea to have a clinic in the community." – Participant 12

"It's amazing. It's great that there are clinics out there, that can help you. Well, at least if you were planning for a baby. Go to the clinic, say I want a baby in five years. OK. You can take this birth control and then by the time we take it out you will have a baby." – Participant 11

Regarding the meaningfulness of having the opportunity and capability to access SRH services, the predominant response of participants emphasised the high importance attributed to sexual health, primarily rooted in the belief that being aware of one's health status holds paramount significance and it is good to have the opportunity to plan a pregnancy, avoiding unintended pregnancies at a young age. For example, participant 12 states: *It means a lot because at the end of the day I know my status…"*. Positive attitudes contribute to a proactive approach to one's sexual well-being, fostering a sense of responsibility and agency. When young women possess favourable attitudes towards SRH, they are more likely to seek information, access services, and make informed decisions about their reproductive health. Positive attitudes could enhance overall well-being by promoting mental and emotional health (Jonas et al., 2017). Thus, it is crucial to address mental health challenges among young women and foster positive attitudes towards SRH services to improve SRH outcomes for young women in South Africa.

4.4.2 Interpersonal Level

The interpersonal level of the socio-ecological model includes relationships with partners, family and friends, along with the reactions from these individuals regarding young women's engagement with SRH services (McLeroy et al., 1988). The factors at the interpersonal level include a lack of communication at home and negative peer influence. Lack of communication at home and negative peer influences interact with the individual level when they result in personal feelings and with the community level when negative influences are

related to community norms and values. The opinions and attitudes of family members and friends heavily influenced most of the participants regarding the utilisation of SRH services.

Lack of communication (at home)

Participants' interpersonal relationships with family heavily influenced participants' decisions to access SRH services. Looking into the communication dynamics between young women and their parents at home contributes substantively to understanding the experiences of young women accessing SRH clinics and services because it elucidates the daily challenges associated with communication and familial expectations that young women may encounter at home. Young women's reluctance or discomfort in discussing sexual health within the family setting can potentially be an obstacle for young women in accessing SRH services. Conversely, a supportive family environment that encourages open communication can empower young women, fostering a sense of agency in making informed decisions concerning sexual health (Mastro & Zimmer-Gembeck, 2015). Most participants expressed difficulty in sharing their sexual and reproductive healthcare needs at home, as stated below:

"I did think that she would maybe tell me to pack my bags and leave and she would beat me. So I was scared. But her reaction (to the pregnancy) wasn't what I thought it would be. She was like it's fine, you work, you sort yourself out and so on." – Participant 12

"I think she (mother) would have stopped me. Because I just feel like, she is strict. That's why I decided I'm going to tell her afterwards, because I already had it (birth control), so she cannot do anything about it. But she was actually fine with it." – Participant 10

"I never told them about it. My father don't play, my father will hit me like a man. So I was feeling like I'm going to keep my stuff to myself." – Participant 3

Young women's difficulties in sharing their sexual and reproductive healthcare needs at home sometimes resulted in a delay in disclosing the sexual and reproductive healthcare need, as stated by Participant 10: *"That's why I decided I'm going to tell her afterwards…"*. In other cases, young women do not feel comfortable at all to share their sexual and reproductive need at home. For example, participant 3 states: *"I never told them about it."*. However, the majority of participants reported experiencing normal or positive reactions

from their parents, contrary to their expectations. Participants' responses highlight the absence of guidance or an open space for discussions about sexual health, which indicates an apparent lack of communication at home, underscoring the complexity of the home environment of these young women.

Research suggests that parent-child discussions about sexual health contribute to improved health outcomes for young women (Duby et al., 2022; Mastro & Zimmer-Gembeck, 2015). However, both Duby et al. (2022) and Mbarushimana et al. (2022) argue that parents' reluctance to engage in conversations about sex with their children often stems from their own lack of knowledge and skills, perceived inadequacy in effective communication, adherence to socio-cultural norms surrounding sexuality communication, and the fear that such communication may encourage sexual behaviour. This emphasises the need for increased attention to communication within the family environment, aligning with the goals outlined in the National Strategic Plan for HIV, TB, and STIs. Enhancing communication at home could serve as a crucial element in facilitating young women's access to and utilisation of SRH services (Department of Health, 2017b; Duby et al., 2022). In short, conversations between parents and children about sexual health may be a critical component for enhancing the utilisation of SRH services by young women, as such discussions are associated with the development of protective attitudes, a tendency toward fewer sexual partners, delayed sexual debut, and increased ability to discuss sexual risks with partners (Duby et al., 2022; Mastro & Zimmer-Gembeck, 2015; Mbarushimana et al., 2022).

Negative peer influence

Besides communication at home, interactions with friends and acquaintances regarding sexual and reproductive healthcare could also affect young women's access to SRH services. On that account, negative peer influence is also considered a component of the interpersonal level of the socio-ecological model. Young women's interactions with their peers is of importance to this study because negative peer influence can significantly affect the decision-making processes of young women regarding SRH services. Peer influence plays a role in shaping attitudes, beliefs and behaviours and negative influences may contribute to the formation of limited support networks, leading to reluctance of young women to access SRH services (Mbarushimana et al., 2022). During the interviews, a majority of the participants

expressed a deliberate choice to maintain a limited social circle, as stated by the following participants:

"Nothing to my friends. I was scared they might judge me and all that, I didn't talk to my friends about that (family planning). I wasn't outspoken with them because I don't know what they will tell the other people. I can't really trust them. Because nowadays, you can't trust a lot of people, they will stab you in the back. Like they will talk behind your back and people will just laugh at you. So, I don't talk a lot to other people." – Participant 8

My friends, I don't have friends, friends in your face they will be nice, but behind your back they're like talking bad about you. So that's why I don't tell anything to anyone about my business." – Participant 15

Participants cited a purposeful decision to refrain from having many friendships and having limited trust in individuals within their immediate social milieu, as stated by Participant 8*: "I can't really trust them."* These statements suggest a prevalent lack of trust within peer relationships. In this study, negative peer influences contributed to a reluctance among young women to engage in open discussions about sexual health, intensifying their focus on maintaining privacy and confidentiality among friends and acquaintances (Ngwenya et al., 2020). Emphasis on privacy and confidentiality stemmed from concerns about potential stigmatisation by their communities, linking this factor to the community level of the socio-ecological model. However, Mastro & Zimmer-Gembeck (2015) suggest that open conversations between peers often result in more positive outcomes regarding sexual health, including a delayed sexual debut and better protection during sexual intercourse. Thus, negative peer influence contributes to the reluctance of young women to access SRH services, underscoring the significance of fostering open communication between peers to promote more positive sexual and reproductive healthcare outcomes among young women.

4.4.3 Community and Social Factors

Throughout this study, participants underscored the impact of community and social factors on young women's access to SRH services. The community-level factors include stigmatisation and judgement, and gendered dynamics. The impact of these factors was noted to intertwine with both the individual level, specifically in terms of attitudes and feelings, and

the interpersonal level, where community norms and values could contribute to complex relationships within the participants' homes and among friends.

Stigmatisation and judgement

Stigmatisation and judgement regarding young women accessing SRH services is a substantial factor at the community level of the socio-ecological model. Examining the stigmatisation and judgement of young women is important to describe their experiences in accessing SRH services in South Africa because it provides insights into the societal attitudes and perceptions that young women face on a daily basis. The predominant sentiment among participants was a fear of judgement and stigmatisation by community members:

"Because the people in the community, they stereotype on girls and family planning. Like she takes because she sleeps with different men and she takes to get fat and all that stuff." – Participant 9

"Like in our community, it's like, if you HIV positive, it's like you sleep with 1000 men and now you HIV positive. They don't think about, OK, maybe you have a boyfriend, he could have taken your virginity and then he could have been HIV positive. They don't think about that, they always just focus on the negative stuff." – Participant 4

"I was also judged going there, with the tummy, you see because they're saying you still a child and now you're getting a baby. You should be married first, now it's a sin." – Participant 2

Participants' responses indicate that the overall stigmatisation of young women accessing SRH services is rooted in the notion that those who use FP are engaging in sexual activity, or if someone has HIV, that person must be involved in promiscuous behaviour. For example participant 9 states: *"... because she sleeps with different men"*, and participant 4 states: *"... it's like you sleep with 1000 men..."*. Conversely, if young women refrain from accessing SRH services and experience an unintended pregnancy, a negative judgement is also cast upon them, as stated by Participant 2: *"... you still a child and now you're getting a baby"*. This reflects a negative judgement from the community towards young women seeking SRH services, which highlights the challenging situation for young women in the community,

where societal perceptions seem to disapprove of their choices regardless of the path they take.

In South Africa, cultural taboos and moral positions surrounding young women's sexuality significantly influence the delivery of SRH services. This literature indicates that the importance of addressing community norms and recognising the role of tradition, cultural beliefs and religious faith is important to promote sexual health among young women (Erasmus et al., 2020; Gillespie et al., 2022; Jonas et al., 2019). Nyblade et al. (2022) argue that societal stigma towards young women accessing SRH services is frequently grounded in conservative beliefs concerning female sexuality, purity and virginity, as well as imbalances of power within sexual and social relationships in South Africa. Moreover, Gillespie et al. (2022) found that, in many communities, community members perceived abstinence messages directed at young women as sufficient, undermining government-led campaigns. This means that there continues to be a gap between policies and guidelines and the implementation of effective strategies to reduce stigma and discrimination in healthcare settings (Bohren et al., 2022).

Therefore, there needs to be a shift away from the community judgement and stigmatisation of young women accessing SRH services. Instead of perpetuating a narrative that negatively influences the sexual behaviour of young women, the focus should be on creating awareness regarding the importance of young women accessing SRH services. This involves supporting young women and empowering them with the authority to make their own choices concerning their sexual health (Erasmus et al., 2020; Gillespie et al., 2022). Furthermore, participants' comments not only highlighted issues of stigma and judgement but also shed light on gender dynamics within the community, which is discussed next.

Gendered dynamics

The community level also includes gendered dynamics arising from community norms and values regarding gender. Gendered dynamics in the community offer insights into the specific challenges confronted by young women in South Africa in their pursuit of SRH services, which is important to this study. During the interviews, participants reflected on the observed disparities in behaviour between men and women.

"A woman should protect her body, never go from boyfriend to boyfriend, because that's how you get sick. This is not what a girl should do, it's slutty for a girl. A man is a man, they can do whatever." – Participant 13

"When it comes to sex, the boy is the one who can decide, the girl just has to do what the boy wants. They're forcing the girls. He can just calm down and not give her the feeling she has to do something with you." – Participant 3

"Most of the time, the girl wants to use protection, and the boy doesn't want to. It's a big fight, but you have to give, then you have a chance to get pregnant. Also, it's good for the boys, like getting the girls, but when a girl is being sexually active, you are labelled a whore or something like that." – Participant 11

Participants outlined various factors contributing to gendered dynamics within their familial and community contexts, particularly in situations involving sexual activity. Participants observed societal expectations that often allow men to have multiple partners, while women are anticipated to adhere to standards of modest behaviour and personal cleanliness. For example, participant 13 states: *"This is not what a girl should do, it's slutty for a girl. A man is a man, they can do whatever"*. In addition, participants highlighted a prevailing norm where men are perceived as decision-makers, and women are expected to comply with men's decisions, especially in matters such as engaging in sexual activity or the decision to use protection or contraceptives, as stated by participant 11: *"It's a big fight, but you have to give…"*.

Studies indicate that sexual health is grounded in Connell's (1987) theory of gender and power, which acknowledges persistent power imbalances between men and women, affecting a woman's autonomy to make decisions regarding sexual activity (Closson et al., 2022; Nduna, 2020). For instance, a study conducted by Duby, Jonas, et al. (2021) revealed that young men often interpret requests from young women to use condoms as signals of mistrust rather than care, feeling entitled to make decisions about condom use based on their gender. As a result, these dynamics shed light on the prevailing gender norms in the South African context, underscoring the limited access and autonomy young women have concerning their sexual health and well-being (George et al., 2020). Consequently, concerted efforts are

imperative to achieve gender equality and enhance the autonomy of young women in making informed decisions about their sexual health (Rao Gupta et al., 2019).

4.4.4 Organisational and Health System Level

The organisational and health system level of the socio-ecological model includes the influences of institutions on individuals in the society, and society as a whole (Scarneo et al., 2019). In this study, the organisational and health system level consists of the SRH clinics and services, and the factors included in this level are participants' perceptions of healthcare workers, the provision of FP services and clinic services. Policy guidelines and strategies impact organisational level factors from the public policy level, while clinic environments influence the individual, interpersonal and community levels.

Perception of healthcare workers

The first factor of the organisational and health system level is the participants' perceptions of healthcare workers providing SRH services. Participants' perceptions of healthcare workers are involved in examining the experiences of young women in accessing SRH services, because of the substantial impact healthcare workers can have on young women. Positive interactions can foster a comfortable environment and supportive patient-provider relationship, encouraging young women to access SRH services. On the contrary, negative interactions may contribute to a reluctance among young women to seek such services (Sewpaul et al., 2021). Participants shared insights into their interactions with healthcare workers when seeking SRH services:

"Sometimes nurses are very rude. They when you come and you say you coming for the injection. They look at you, they ask: So you're sexual active and all that stuff. And then they inject you so fast, so they can do something else." – Participant 12

"I went to the reception lady and she was like, why didn't you guys come for family planning? And she was like to my mother, why didn't you tell your child to go on family planning to help her not to get pregnant? It didn't feel right for her to judge us like that." – Participant 5

"Because it's very bad. They don't treat us as people like we need the help. Actually, that's what we came here for, but they don't respect us. Because it doesn't mean for you as a nurse to take it out on a patient, you see. There was one nurse, she was very rude and she even swore at the patient." – Participant 2

On a side note, not all nurses exhibit bad behaviour towards participants. Some participants also expressed comfortable experiences with nurses, as stated by Participant 16: *"I learned a lot from that nurse. Yeah. What she told me about babies because I didn't know how to raise a baby, but then she came and she told us more, how to take care of a baby, what the baby must drink and eat, when it's time to eat, how to make them sleep. She came there out of kindness and give us that information."*

Participants' responses revealed diverse perspectives on the conduct of healthcare workers and the overall staff at the clinic. The participants' perceptions of healthcare workers were that healthcare workers were predominantly rude, judgemental and disrespectful because of various personal beliefs that consider young women too young to use contraceptives or to be pregnant. Participants also spoke about instances where nurses exhibited aggressive behaviour, by yelling and swearing at patients, as stated by Participant 2: *"There was one nurse, she was very rude and she even swore at the patient"*. Judgemental and negative behaviour from nurses can discourage young women from accessing SRH services, undermining young women's agency in making informed choices about their sexual health (Pillay et al., 2019; Stuthers et al., 2012). This is particularly concerning as it contradicts objective 3 of South Africa's SRHR Policy: ensure access to respectful and non-judgemental SRHR services (National Department of Health, 2019), which shows the ineffectiveness of this policy's efforts to create comfortable access to SRH services.

In conclusion, negative perceptions of healthcare workers held by young women could have significant consequences. Therefore, strategies should properly address negative behaviour from nurses, which may involve initiatives to educate nurses on the importance of separating personal norms and beliefs from professional responsibilities, aiming to ensure the provision of respectful conduct towards young women accessing SRH services (Gillespie et al., 2022).

Provision of FP services

Another factor on the organisational and health system level of the socio-ecological model is the provision of FP services. The ability of SRH clinics to provide adequate FP information and services is important to the examination of the experiences of young women in accessing SRH services because a well-functioning FP system is essential for fostering positive sexual and reproductive healthcare outcomes among young women in South Africa (Kriel et al., 2021). During the interviews, participants repeatedly spoke about their experiences related to FP services:

"I need more of their support in this family planning, because they don't tell us in the clinic what side effects are. Sometimes we have mood swings, sometimes we lose our hair, sometimes people get thin, some people get weight. So they must tell us step by step, because they only inject us, then you go." – Participant 2

"They just asked me what I wanted. They didn't inform me about what that was, what that was. I asked, but they didn't voluntary inform me on the side effects or what else. – Participant 9

"They just decided for me I must take the three months. Where is my consent? They didn't ask me anything. I asked them if there's more, but they only say no three months." – Participant 7

Participants' comments about the provision of FP services revealed that young women often lack sufficient information about their FP options, including the workings of the contraceptive methods and potential side effects. Participants expressed a sense of being pressured by healthcare workers to make hasty and uninformed decisions, which compromised their autonomy in making well-informed decisions regarding their sexual health. For example, participant 7 states: *"Where is my consent? They didn't ask me anything"*.

Inadequate provision of FP services could imply deficiencies in the knowledge and skills of nurses regarding contraceptive methods or a lack of recognition of the importance of properly informing young women about their contraceptive options (Jonas et al., 2017). Moreover, Kriel et al. (2021) state that several factors contribute to young women having limited

autonomy in their contraceptive choices and method preferences in South Africa. These factors encompass the absence of technically trained providers and service integration at the organisational level, as well as deficiencies in counselling and information exchange at the interpersonal level (Kriel et al., 2021). Insufficient provision of FP services highlights the inefficacy of South Africa's SRHR Policy, specifically objective 4.3: Ensure healthcare providers have the skills and knowledge to deliver integrated SRHR services (National Department of Health, 2019). Thus, there is a need for greater focus on the knowledge and skills of healthcare workers in SRH clinics to better equip them in supporting young women in matters related to FP.

The structural organisation within SRH clinics

The structural organisation within SRH clinics is a component of the organisational and health system level of the socio-ecological model, as it offers an image of the clinic's functioning. The structural organisation of a clinic is crucial for examining the experiences of young women in accessing SRH services because it directly influences the quality and effectiveness of healthcare delivery. Participants shared their perspectives on the clinic's organisation:

"By my experience at a clinic, it's always you sit long. You have to stand outside in long lines. The people that come after you, they will get help first." – Participant 6

"It's not very private. There's people when you come, when you come for the injection, there's other people also in the room where you get injected. I don't think that's very safe or hygienic." – Participant 9

"Not enough staff. So some nurses can't do everything because they help us in one room, like the family planning, the babies. I feel like there's no space or privacy." – Participant 2

The participants' comments highlight deficiencies in the facility management and organisation of SRH clinics, due to long waiting times, a lack of privacy and shortage of staff. Participants specifically mention a lack of privacy in the clinic, attributed to limited space and insufficient rooms for nurses to provide services. For example, participant 9 states: *"There's people when you come for the injection, there's other people also in the room…"*.

These issues align with the availability dimension of access to healthcare and are consistent with the findings of Kriel et al. (2023), who argue that long waiting times in clinics pose a significant challenge in South Africa. Long waiting times are often the result of staff shortages, where a small team of nurses struggles to accommodate the high volume of patients, and the requirement to prioritise school children over adult clients. Consequently, long waiting times could lead to the discontinuation of using clinic services (Kriel et al., 2023).

Although the South African government has implemented strategies to address these challenges, such as the SRHR Policy with objectives "4.1 Providing quality SRHR services at the primary healthcare level" and "4.2 Ensuring interrupted supply of SRH commodities and drugs in all facilities" (National Department of Health, 2019), and the Ideal Clinic Manual (National Department of Health, 2018), these strategies seem ineffective. A well-organised clinic contributes to a positive and supportive environment, ensuring timely services, safeguarding privacy and providing enough staff to meet the demand (Department of Health, 2017a; Kriel et al., 2023). Conversely, a poorly organised clinic with long waiting times, limited privacy and staff shortages can hinder the overall experiences of young women, potentially leading to dissatisfaction, reluctance to seek services, or discontinuation of sexual and reproductive healthcare. Therefore, understanding and evaluating the structural organisation of SRH clinics is essential for improving the accessibility and quality of SRH services for young women in South Africa (Kriel et al., 2023).

4.5 Conclusion

This chapter presents the demographic details of the participants, and the research findings followed by an in-depth discussion of the findings. Guided by the socio-ecological model, the data was systematically organised in four themes and ten categories. Each theme and corresponding categories have been discussed by identifying the meaning of the findings within the South African context. Therefore, this chapter provided valuable insights into the experiences of young women's access to SRH services in Cape Town.

5. Main Conclusions and Recommendations

5.1 Introduction

This chapter presents the main conclusions and recommendations of this study. The conclusions are drawn to address each objective. Thereafter, recommendations are made.

5.2 Main Conclusions

The purpose of this study was to describe the experiences of young women in accessing SRH services. The findings show that multiple factors at multiple levels influence the experiences of young women in accessing SRH services. This study employed McLeroy's (1988) socio-ecological model of health to comprehensively explore the thoughts, feelings and attitudes of young women regarding their access to SRH services in Cape Town. The findings revealed a nuanced understanding of the factors influencing young women's experiences at different levels; individual, interpersonal, community, organisational and public policy. By identifying significant themes and categories aligned with the socio-ecological model, this research provides a holistic framework for addressing the multifaceted challenges faced by young women in accessing SRH services. The objectives of this study have been achieved and will be discussed in relation to the findings and conclusions which can be deduced from the findings.

5.2.1 Objective 1: To describe the experiences of young women who have accessed SRH services

This study revealed a wide range of components that influenced the experiences of young women's access to SRH services, influenced by individual, interpersonal, community and health system factors. These components range from the participants' knowledge of SRH services to their interactions with healthcare workers in SRH clinics. This variation of components highlights that many different aspects influence the experience of young women in accessing SRH services in South Africa.

The foundation of any positive experience begins with possessing adequate knowledge about the services one intends to access, in this case, the experience of young women accessing SRH services. When young women have sufficient knowledge about SRH services, they are

better equipped to make informed decisions regarding their sexual health (Karp et al., 2020). However, the findings of this study revealed that young women in South Africa face challenges in accessing accurate information about SRH services and are therefore often left unprepared to make well-informed decisions about their sexual health. Limited knowledge about SRH services negatively influences the decision-making process of young women in accessing SRH services, leading them to believe misconceptions from family, friends and the community. Along with lack of knowledge about SRH services, the attitudes and feelings that young women have towards accessing SRH services, also influence their experiences in accessing SRH services. The findings of this study showed that attitudes and feelings of young women are greatly influenced by multi-level factors, such as the lack of communication (at home), negative peer influences (on the interpersonal level), stigmatisation and attitudes and gendered dynamics (at the community levels) and the often negative perceptions of healthcare workers (at the health system level). The findings of this study show that each factor is influenced by another factor from a different level, e.g. the lack of communication at home is influenced by the community's norms and values regarding young women accessing SRH services. Moreover, the interaction with nurses and the experiences of physically accessing the SRH clinic are also part of young women's experiences in accessing SRH services. This study revealed that young women participating in this study mostly experienced rude and judgemental behaviour from healthcare workers in the clinic, resulting in a barrier for young women to access the clinic.

Therefore, the findings of this study revealed that various factors at various levels influence the experiences of young women accessing SRH services. This study particularly emphasises that these factors - lack of knowledge, and negative influences from family, friends, community members and healthcare workers – undermine the autonomy of young women to make informed decisions regarding their own sexual health. This highlights the need for CSE, not only for young women themselves, but also for their families, communities and healthcare workers. In this way, CSE should focus on making young women aware of the consequences of engaging in sexual activity, such as unintended pregnancies or contraction of diseases, and the ways to protect themselves against such consequences. Parents and members of the family should learn how to have open discussions about accessing SRH services, as well as peers. In the community, sex education should focus on shifting away from stigmatisation and judgement of young women accessing SRH, and creating awareness of the importance of young women accessing SRH services. By having CSE on different

levels and for different members of the community, young women's experiences in accessing SRH services could become positive, with sufficient knowledge and social support for them.

5.2.2 Objective 2: To understand the meaning of the ability to access SRH services and make informed decisions about young women's fertility, use of contraceptives, and safe and healthy pregnancy and termination

The findings of this study underscore the significance of accessing SRH services and making informed decisions regarding sexual health, which comes down to young women's belief in their autonomy over such decisions. Despite the often negative influences from family members, peers, community members and healthcare workers in this study, young women in this study were optimistic about the presence of a SRH clinic in their neighbourhood. The young women in this study recognised that access to the clinic empowered them to take control and responsibility for their sexual health and well-being. Additionally, the findings underscored the challenge of inadequate provision of FP services for young women, which hindered their ability to make informed decisions about contraceptive use. Nevertheless, awareness among the participants about the insufficient provision of FP services highlights their recognition of the importance of contraceptives. Therefore, these findings emphasise the significance young women attribute to their ability to access SRH services, underscoring the importance they place on their sexual health.

5.2.3 Objective 3: To understand the effects of the experience of young women's access to SRH services on their daily lives

The findings of this study shed light on the daily challenges young women encounter in making decisions about their sexual health. This study found that despite young women's personal optimism about making decisions regarding sexual health, factors such as lack of communication at home, negative peer influences, and stigmatisation and judgement due to norms and values in the community have an impact on their daily lives. These challenges – lack of communication, negative peer influence, and stigmatisation – often result in young women's reluctance to discuss or disclose their SRH needs, ultimately affecting their mental health and overall well-being. This underscores the importance of education on sexual health for young women, as well as the necessity of raising awareness among families, friends and

community members about the crucial role of social support for young women to make informed decisions about their sexual health.

5.3 Recommendations

The implications of these findings underscore the need for interventions and strategies that address the diverse factors influencing young women's access to SRH services. By recognising and targeting these factors at multiple levels simultaneously, policymakers and healthcare providers can develop more effective and holistic approaches. This study advocates for a shift from single-level interventions to comprehensive strategies that consider the interconnected nature of the individual, interpersonal, community, organisational and public policy factors. Such an approach, as suggested by the socio-ecological model holds promise in enhancing the overall experiences of young women in accessing SRH services in Cape Town. As future initiatives and interventions are developed, this research provides a valuable foundation for creating impactful and inclusive strategies that promote the well-being of young women regarding sexual health in South Africa.

5.3.1 Recommendations for Policy Makers

In response to the expressed needs of young women to access SRH services, addressing knowledge gaps through comprehensive sexuality education is crucial for empowering young women to navigate their sexual health effectively. Interventions should consider the unique challenges faced by marginalised communities, emphasising the importance of culturally sensitive and community-specific approaches. In light of the findings of this study, there is a call for a shift in public discourse on sex education, emphasising its role in informed decision-making rather than instigating sexual activity. Policies should aim to bridge the existing gaps and ensure equitable access to healthcare for young women, acknowledging their specific needs and challenges.

Furthermore, the findings of this study underscore the importance of multi-dimensional interventions that encompass family dynamics, peer relationships and community attitudes to enhance the experiences of young women. Education campaigns, both within families and peer groups can dispel myths and misconceptions, fostering a more supportive environment. Additionally, targeted programs addressing communication at home and negative peer influence should focus on building trust and encouraging open communication. Creating safe

spaces where young women can freely discuss sexual and reproductive healthcare concerns without fear of judgement is crucial for dismantling barriers and fostering a sense of community support.

Moreover, efforts to reduce stigmatisation and judgement should extend beyond healthcare settings and into the broader community. Community-based awareness campaigns can challenge prevailing stereotypes and promote a more inclusive and understanding environment. Encouraging open conversations about sexual health and dispelling myths can contribute to destigmatising SRH services and fostering acceptance. Addressing gendered dynamics necessitates a comprehensive approach that challenges societal norms perpetuating inequality. Educational programs and community dialogues can play a pivotal role in dismantling ingrained gender stereotypes and empowering women to assert control over their sexual and reproductive well-being. Advocacy for policy changes that promote gender equality and women's autonomy is integral to creating an environment where young women can freely access SRH services without facing discrimination or societal constraints.

5.3.2 Recommendations for SRH Clinics and Healthcare Workers

This study recommends that SRH clinics to prioritise enhancing the structural organisation of their services. This entails providing greater privacy for clients through clinic expansion and the provision of multiple rooms for service delivery. Additionally, efforts should be made to improve the professionalism and conduct of healthcare workers, with a focus on delivering respectful, patient-centred care. Healthcare providers should also be equipped to offer clients comprehensive knowledge about sexual and reproductive health, for young women to make informed decisions about contraceptive use, tailored to their individual needs and preferences.

5.3.3 Recommendations for Partners in Sexual Health

As PSH is an organisation that provides and advocates for sexual and reproductive health and rights, it should emphasise the importance of comprehensive sexuality education to important stakeholders in the field. The findings of this study show that there is a need for CSE for young women so that they can make informed decisions about their sexual health. Furthermore, there should be strategies and programs to strengthen communication between young women and their parents. Parents should be made aware that sex education is not

aimed at instigating young women into sexual activity, but to create awareness of the consequences of sexual activity, thereby informing them of ways to protect themselves from unintended pregnancies and the contraction of diseases. In the community, there should be programs to decrease judgement and stigmatisation against young women, by making community members aware that it is a good thing for young women to access SRH services. PSH should also confront institutions such as healthcare clinics and their healthcare workers about ways to improve the experiences of young women in accessing SRH services. Clinics should be made aware that young women need more privacy when accessing the clinic and there should be more space for the healthcare workers to provide services. With regards to healthcare workers, strategies should address the negative behaviour of nurses to ensure the provision of respectful conduct towards young women. Nurses should also be educated about providing sufficient information and considering all the options for young women with regards to FP, in order for young women to make the rights decisions according to their individual needs regarding sexual health.

5.3.4 Recommendations for Future Research

For future research, the following suggestions are proposed:

The current study focused on young women in Parow, a middle-class-income area in the City of Cape Town. This study explored a restricted sample of 16 young women who accessed SRH services in Cape Town. Given the limitations of this small sample size, it is crucial to recommend further research on young women's experiences in accessing SRH services on a broader scale, covering various areas and communities. Conducting research on a larger scale would enhance the robustness and applicability of the findings allowing for a more comprehensive understanding of the needs of young women accessing SRH services throughout South Africa.

Furthermore, while the present study outlined the experiences of young women accessing SRH services broadly, future research could benefit from adopting a gendered perspective. Although this research briefly addressed gendered dynamics regarding sexual and reproductive health, conducting a study through a gendered lens could yield valuable insights into the experiences of young women accessing SRH services in the South African context.

5.4 Closing Remarks

This study as a whole highlighted the importance of understanding young women's experiences in accessing SRH services in South Africa. By exploring various factors across different levels, the study revealed a wide range of influences on young women's experiences in accessing SRH services. This study emphasised the crucial role of autonomy in enabling informed decisions about sexual health among young women. However, this study also identified several barriers to this autonomy, including a lack of knowledge and social support. Therefore, there is a significant need for CSE to enhance young women's understanding of their sexual health, improve communication within families and among peers, and shift community attitudes towards recognising the importance of sexual health among young women. By addressing these areas and providing support, the experiences of young women in accessing SRH services can be improved, empowering them to make informed decisions and fostering a supportive environment in accessing SRH services in South Africa.

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Appendix A: Recruitment Material

Information Sheet PSH

My name is Maud Vievermans, I am a master's student in Social Development at the University of Cape Town. I am conducting a study to describe and understand young women's experiences in accessing a sexual and reproductive healthcare clinic or service in Cape Town.

The aim of this study is to describe the experience of young women who have accessed sexual and reproductive healthcare clinics; to understand the meaning of making informed decisions about their fertility, use of contraceptives, safe and health pregnancy, and termination, and; to understand the effects of the experience of accessing a sexual and reproductive healthcare service on these young women in their daily lives. The purpose of this study is to gain new knowledge about the accessibility of sexual and reproductive healthcare services for young women in Cape Town. The findings of this study may be significant for the following reasons: the study may contribute to new knowledge for healthcare services institutions and workers, working with young women, and; the study may contribute to research in barriers to accessing healthcare services in South Africa.

Who is eligible to participate in this study?

Any South African women aged between 18 and 24, who has accessed a sexual and reproductive healthcare clinic or service in Cape Town, in the last 18 months. This woman should speak English and have a phone.

The purpose of the visit could range from family planning (FP) and counselling; to prenatal as well as postnatal care and delivery; to termination of pregnancy (TOP) and post abortion care (PAC); to treatment and prevention of STIs, including HIV, to; information and counselling services to human sexuality.

Voluntary participation

Participation in this study is strictly voluntary and consensual. This will be confirmed through consent forms, signed by each participant before participating in this study. Participants are

free to withdraw from this study and have their information withdrawn at any time, without prejudice.

What will the participant be asked to do?

Participation in this study involves a one-on-one interview with the researcher, which will last approximately 45 minutes to an hour. With the participants' permission, this interview will be recorded, by using a phone and by taking notes. The interview will take place in a secure and private room, in one of the offices of Partners of Sexual Health. Possible data or travel expenses will be reimbursed by the researcher.

Are there any risks?

During the interview process, the participant will be able to pause or terminate the interview if you feel emotionally uneasy or overwhelmed. The participant will not be forced to answer any questions or discuss any experiences. If she experiences any emotional distress, the researcher will provide referrals for you to access appropriate support.

How will it be published?

The recording will be transcribed and used for the results of this study. Privacy and confidentiality will be strictly protected by the researcher, as she will make sure that participants will remain completely anonymous by removing their names and any other significant aspects of their identities.

Who do I contact?

The researcher can be contacted through the following channels:

WhatsApp: +31611962985

Phone: 072 689 3807

Email: vvrmau002@myuct.ac.za

Appendix B: Interview Instrument

A. INTRODUCTION

My name is Maud Vievermans and I am a master's student in Social Development at the University of Cape Town. The purpose of this interview is to describe/ understand your experience on accessing a sexual and reproductive healthcare service in Cape Town.

Before we start I will explain the ethical considerations: voluntary participation; anonymity, confidentiality & privacy, and; the audio recording for this interview. There will be no right or wrong answers to my questions.

B. PARTICIPANT DEMOGRAPHIC INFORMATION

What is your name?
What is your age?
How do you identify in terms of gender?
How do you identify in terms of race?
What is your education level?
What is your occupation?
Where in South Africa are you from and where do you live now?
(Which clinic have you accessed in Cape Town? If you do not want to specify, in which area?)

C. SEMI-STRUCTURED INTERVIEW QUESTIONS

1. You know that I am interested in learning about your experience when you accessed a SRH clinic or service. Can you tell me what comes to mind if you think about that experience?

- What comes to mind if you think about sexual health?

2. Can you tell me about your experience of finding out that you needed information or treatment from this clinic?

- Before needing information or treatment from this clinic, what was your knowledge about the services and treatments from this clinic?
- What is your knowledge about these services now?

3. Can you tell me if you informed any of your family/ friends that you were going to visit this service?

- If yes, how did they respond to that news?
- If no, why not?
- How did you make the decision to access the clinic?

4. How did you feel about coming to the SRH clinic?

5. Could you share experience with the staff at the clinic?

- Can you tell me any good things?
- Can you tell me any bad things?

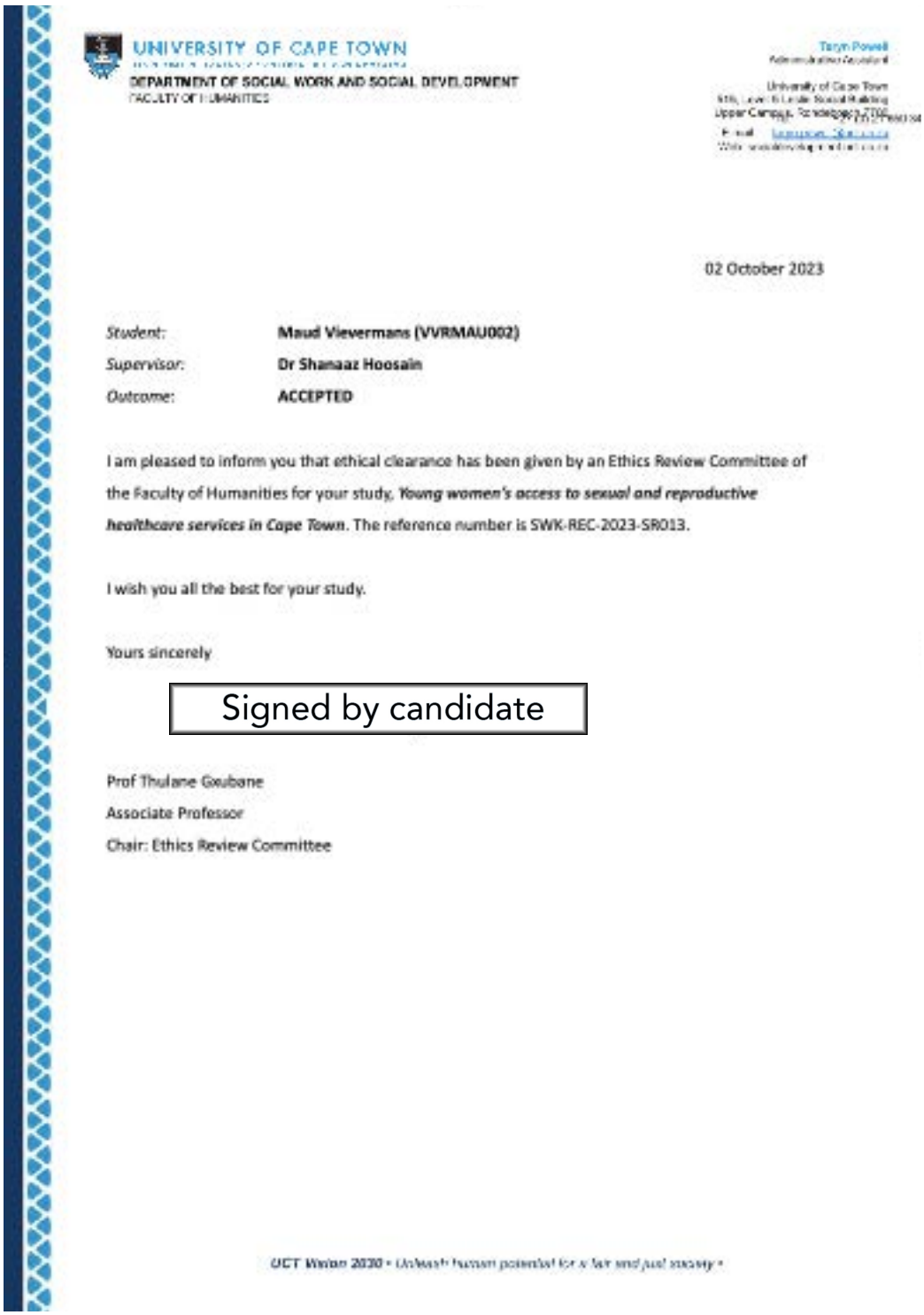
6. How did you feel when you walked out of the clinic?

7. How do you feel/ think that your community would respond to your visit to the clinic?

8. Looking back at the experience, how do you feel about it now?

- What does it mean for you to be able to access this clinic?
- Is it something you still think about?
- Do you feel like it is still affecting you in any way?
- Do you feel like there is anything you needed more support with?

Appendix C: Letters of Approval



UNIVERSITY OF CAPE TOWN

DEPARTMENT OF SOCIAL WORK AND SOCIAL DEVELOPMENT
FACULTY OF HUMANITIES

Taryn Powell
University of Cape Town

02 October 2023

Student: **Maud Vievermans (VVRMAU002)**
Supervisor: **Dr Shanaaz Hoosain**
Outcome: **ACCEPTED**

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, ***Young women's access to sexual and reproductive healthcare services in Cape Town***. The reference number is SWK-REC-2023-SR013.

I wish you all the best for your study.

Yours sincerely

Signed by candidate

Prof Thulane Gaubane
Associate Professor
Chair: Ethics Review Committee

UCT Vision 2030 • Unleash human potential for a fair and just society •

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room 45 E-52-E-Floor- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-submissions@uct.ac.za
Website: www.health.uct.ac.za/home/human-research-ethics

30 November 2023

HREC REF: 757/2023

Dr S Hoosain
Department of Social Development
Email: Shanaaz.hoosain@uct.ac.za
Student:VVRMAU002@myuct.ac.za

Dear Dr Hoosain

PROJECT TITLE: YOUNG WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES IN CAPE TOWN-
(MASTERS' CANDIDATE-MAUD VIEVERMANS)

Thank you for your response letter received 28 November 2023, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 November 2024.

Please submit a progress form, using the standardised Annual Report Form (FHS016) or FHS017 if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Maud Vievermans will also be involved in this study.

Please quote HREC REF 757/2023 in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

Signed by candidate

PROFESSOR M BLOCKMAN
CHAIRPERSON, FACULTY OF HEALTH SCIENCES HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637. Institutional Review Board (IRB) number: IRB00001938 NHREC-registration number: REC-210208-007
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South

Appendix D: Consent Form for Participants

University of Cape Town

Faculty of Humanities

CONSENT FORM

Title of research project:

Young women's access to sexual and reproductive healthcare services in Cape Town

Principal researcher:

Maud Vievermans

Department address:

The Department of Social Development, 5th Floor, Robert Leslie Social Science Building, University Avenue, Upper Campus, University of Cape Town

Telephone:

072 689 3807

Email:

vvrma002@myuct.ac.za

Name of the participant: _____

Nature of the research:

These questions are part of a research that is designed to study young women's experiences in accessing sexual and reproductive healthcare services in Cape Town. This study is done as part of the fulfilment of the researchers master's degree in Social Development at the University of Cape Town.

Participants involvement:

What is involved:	Open-ended questions will be asked during an interview to describe the experiences of young women who have accessed sexual and reproductive healthcare services in Cape Town.
Risks:	The participant may find that some questions can evoke emotions, however the researcher will minimize any discomfort during the interview, and there is a qualified practitioner (Dr. Alobwede) available as soon as reasonably possible for emotional support during the course of, or after the interview, if necessary.
Benefits:	This study will gain new knowledge about the accessibility of sexual and reproductive healthcare services for young women in Cape Town, from which the findings are currently very limited. The study may contribute to new knowledge for healthcare service institutions and workers, working with young women, and; the study may contribute to research barriers in accessing healthcare services in South Africa.
Costs:	None
Payments:	None

- I agree to participate in this research project.
- I have read this consent form and the information it contains and had the opportunity to ask questions about them.
- I agree to my responses being used for education and research on condition my privacy is respected, subject to the following:
    - I understand that my personal details may be included in the research/ will be used in aggregate form only, so that I will not be personally identifiable.
    - I understand that I am under no obligation to take part in this project.
    - I understand that I have the right to withdraw from this project at any stage.
    - I understand that this research might be published in a research journal or book. In the case of dissertation research, the document will be available to readers in a university library in printed form, and possible in electronic form as well.

Signature of Participant: _____

Name of Participant: _____

Signature of person who sought consent: _____

Name of person who sought consent: _____

Signatures of principal researcher: _____

Name of principal researcher: _____

Appendix E: Transcription of Interview

Speaker 1: Researcher

Speaker 2: Participant

Speaker 1: I'm just going to put it here. OK, what's your name?

Speaker 2: My name is [redacted]

Speaker 1: And how old are you?

Speaker 2: [redacted]

Speaker 1: And how do you identify in terms of gender?

Speaker 2: I am a female. Yeah.

Speaker 1: And how do you identify in terms of race?

Speaker 2: I am coloured.

Speaker 1: Coloured. And what is your education level?

Speaker 2: [redacted]

Speaker 1: And what did you do after that?

Speaker 2: [redacted]en

[redacted]

Speaker 1: [redacted]

Speaker 2: [redacted]for

[redacted]d

[redacted]

Speaker 1: OK. And how long have you been here?

Speaker 2: A year and a half.

Speaker 1: Do you like it here?

Speaker 2: Yes, very much.

Speaker 1: OK, so you work there every day?

Speaker 2: Yes. Every day.

Speaker 1: OK. And what what is your like? What do you do?

Speaker 2: [redacted]

Speaker 1: OK. OK, nice. OK. So where in South Africa are you from and where do you live now?

Speaker 2: [redacted]

Speaker 1: And have you been there all your life?

Speaker 2: Yes.

Speaker 1: And what is your relationship status?

Speaker 2: Single.

Speaker 1: Single. No relationship, no boyfriend?

Speaker 2: [redacted]

Speaker 1: I hope you feel better. OK, so for what services have you accessed the sexual reproductive healthcare clinic?

Speaker 2: The birth control birth control. That's the only thing I did.

Speaker 1: OK, so birth control, did you maybe also do HIV testing with it?

Speaker 2: Yes, I did HIV testing, but only once.

Speaker 1: OK. So is it OK for you if we talk about the both of those things, birth control and HIV tests?

Speaker 2: Yes.

Speaker 1: OK. So then we will go on with like the more open questions, OK, so. You know that I'm interested in learning about your experience at the clinic? So can you tell me what the first thing was that you thought when I started talking about all this? What were you thinking about? What came to your mind?

Speaker 2: I was nervous. I didn't know what to.

Speaker 1: You were nervous. Why were you nervous?

Speaker 2: First time being interviewing and asked about these questions.

Speaker 1: OK. And how do you feel now?

Speaker 2: I'm. I'm OK.

Speaker 1: You're OK? Cause you can tell me if you're not.

Speaker 2: I'm OK.

Speaker 1: But other than that, if you think about like sexual health or sexual and reproductive health, what do you think about? What comes to mind?

Speaker 2: I think it's important.

Speaker 1: And why is it important?

Speaker 2: I think it's important for a lady to know her status. And to look after herself a body. And health, that's really important for them.

Speaker 1: OK. And in what way to look after yourself?

Speaker 2: Then I would say your birth control if you're sexually active. At the young age. And at the oldest age you go for. Your pap smears. When you're sexually active or have the baby. You have a baby. You go for pap smears.

Speaker 1: OK. And why do you think the pap smears are important?

Speaker 2: For yours, for any cancers down there.

Speaker 1: OK, so for your health. OK, and birth control. Why is that important to you?

Speaker 2: Yes, because you don't want to have a unplanned baby, OK?

Speaker 1: So you feel like a baby should be planned. Why do you think that?

Speaker 2: Maybe you're not really at that time you're not. Where you are. Where you wanted to be. So it's better if you plan it out, yeah.

Speaker 1: OK, so let's see, when was the first time you went to the clinic. Do you remember?
Speaker 2: My first time was probably 2019.
Speaker 1: 2019, and what did you go for?
Speaker 2: I went for birth control, and the pill.
Speaker 1: The pill. So you're on the pill?
Speaker 2: Yeah, I was. Not anymore. The brand I found out that they weren't good. They have a lot of after effects. Yeah, yes.
Speaker 1: The brand?
Speaker 2: Yeah. Yes.
Speaker 1: OK. And how did you find out?
Speaker 2: I did research. Tik Toks showed me a few videos about these girls that got blood clots sort of getting blood cloths of taking the birth control, so I stopped.
Speaker 1: You stopped. And do you think you will, like, try something else or?
Speaker 2: Maybe I'll do. The injection. I'll try the injection.
Speaker 1: OK. OK. So before the first time you went to the clinic, like, how did you? Like, what did you know about the clinic or what did you know about birth control for example?
Speaker 2: I knew nothing about birth control.
Speaker 1: You knew nothing. Nothing. So. How did you make the decision to go?
Speaker 2: My flow was, actually, my period. No, I used to bleed like for three weeks nonstop. The nurse said I should go on that and then I stopped for a while and then I went back on it when I had a boyfriend. Sorry, I went back on the birth control when I had a boyfriend.
Speaker 1: OK. And you stopped for a while that the bleeding, was it okay?
Speaker 2: Yeah, yeah, yeah. I brought my bleeding under control.
Speaker 1: So you actually were on birth control for your bleeding.
Speaker 2: Yeah.
Speaker 1: So like medical reason?
Speaker 2: Yes. I went to the clinic for the bleeding.
Speaker 1: OK. And before that, what did you know about family planning?
Speaker 2: Nothing.
Speaker 1: And about other services?
Speaker 2: I knew about HIV. I knew that it could be transmitted through sexual intercourse and needles, but I learned that through school.
Speaker 1: OK. Do you think you learned a lot from school?
Speaker 2: Not that much. They never gave us that much sexual education in school.
Speaker 1: So how did you know? Who told you?
Speaker 2: My mother, my mother, was the one that educated me.
Speaker 1: And, what did she tell you about it?

Speaker 2: She said once I first got my first period, she said the guys only want one thing. They only want one thing, so it's you must always be safe, OK? And make sure you are on something. Sorry, you must make sure you're on something, if you ever sexually active.
Speaker 1: OK, so your mom was very like, if you're going to be active, then you need to make sure you are on birth control. Great and. OK, so how did you know about birth control?
Speaker 2: My mom.
Speaker 1: And what did you know about other services?
Speaker 2: No. Nothing.
Speaker 1: OK, so would you say you know a lot more now about sexual and reproductive healthcare?
Speaker 2: Yes.
Speaker 1: So how do you feel about it? Or how, if you think about it, that when you were younger, you didn't know about all these options and now you do. So how do you feel about that?
Speaker 2: I wish I knew about it like then.
Speaker 1: Yeah, and why?
Speaker 2: Then I would have been more safe over myself. Sometimes more safe, yeah.
Speaker 1: Do you feel like you've been in unsafe situations because of that? And can you tell me in what way?
Speaker 2: Sexually active. I've never used protection.
Speaker 1: You never used protection. Why not?
Speaker 2: I did, but the person never wanted to use.
Speaker 1: OK, but did you want to use them?
Speaker 2: No.
Speaker 1: OK, so both of you didn't want to use it. Do you feel different about that now?
Speaker 2: Yeah, because condoms protect you from like STD's and stuff. But I didn't know you could get it from someone else that already has it. So yeah.
Speaker 1: So the first time you went to the clinic, it was for birth control. So how did you feel when you went there?
Speaker 2: I felt alright and anxious. Yeah, this was it. Just anxious.
Speaker 1: And why were you anxious?
Speaker 2: What would these people? Think of me being on birth control so young.
Speaker 1: And you were scared about what they would think of you. And why would you be scared about that?
Speaker 2: I know people like to judge.
Speaker 1: OK, they like to judge in what way?
Speaker 2: Like why you sexually active so young? Because that's the only reason why they would think you're getting birth control for.
Speaker 1: OK. So they think the only reason girls go family planning is?

Speaker 2: Because they are sexually active.
Speaker 1: And how do you feel about?
Speaker 2: That it's not because of that. No, because it's also because of medical things. Yes.
Speaker 1: So how do you feel about the judgements?
Speaker 2: It’s stupid, it’s not the only reasons why girls go on family planning.
Speaker 1: OK, so when you walked in, you were a bit anxious because of the people. And then when you walked out of the clinic, how was it?
Speaker 2: It was all right.
Speaker 1: Yeah. How did you feel?
Speaker 2: Good. Felt good.
Speaker 1: Yeah. And why did you feel good?
Speaker 2: At least I'm looking after myself.
Speaker 1: OK, that’s good. Could you share your experience with the staff at the clinic?
Speaker 2: Sometimes they're friendly and sometimes they're not friendly.
Speaker 1: Sometimes they're friendly and sometimes..
Speaker 2: They not friendly.
Speaker 1: OK. And what is friendly for you?
Speaker 2: How they greet you. Sometimes they will interact with conversations with you. I mean other days. It's just nothing. There's nothing, and then they're not friendly.
Speaker 1: OK. And who told you to go on the pill?
Speaker 2: The nurse, she said we should just try it out and see if it's going to work.
Speaker 1: OK. But was she specifically talking about the pill or about birth control in general?
Speaker 2: I mean, she was basically speaking about the pill. It was not an option to like trying the injection, it was just the pill.
Speaker 1: OK. And then when you came to the clinic, did the nurses like, how was their interaction with you? Did you feel like you could share your concern?
Speaker 2: No, because I could feel they don’t have that sense of welcome spirit that I can talk to you about anything. But if you have problems or anything like that.
Speaker 1: OK, so they didn't really try to make you feel comfortable. How do you feel about that?
Speaker 2: Not it's not nice. For lady, for women that has problems they would like to speak to someone, and try to get help.
Speaker 1: OK. Do you have any idea why the nurses act like that?
Speaker 2: I just feel like they just wanna work and get their work done and go home.
Speaker 1: Yeah, but in what way?
Speaker 2: They supposed to help the people. But I don't feel like they are helping.
Speaker 1: So can you tell me more about it?

Speaker 2: I can't remember. But I just know, like when you walk in that sometimes they welcome you and sometimes they not.
Speaker 1: How was the interaction?
Speaker 2: They spoke to me and then. Do you know how to use it? But they didn't speak about other options.
Speaker 1: OK, so sometimes they are nice, sometimes they are not nice. But like if you look at the when they're nice when they're not nice, are they more nice or more unfriendly?
Speaker 2: I would say more, more nice.
Speaker 1: OK so you told me, that your mom, she told you in the beginning already that if you are sexually active, you need to be on something. Can you tell me more about that?
Speaker 2: No, that's what why mom said and I don't share it with anyone.
Speaker 1: OK, so when your mom told you that, how did you feel about it?
Speaker 2: I was shy. Why? I asked why you telling me this?
Speaker 1: OK, and now if you think about it?
Speaker 2: Now, yeah. She actually had a reason. She had a reason.
Speaker 1: OK, so how do you feel about her telling you that?
Speaker 2: I'm grateful that you told me, OK, at a young age. Otherwise I would have been sitting with a baby. My mom was open to me.
Speaker 1: But you don't share it with anyone, did people ever share their concerns with you?
Speaker 2: My one friend spoke to me about her birth control, but she's not here. She's overseas now.
Speaker 1: OK, so when she started speaking about it, how did you respond?
Speaker 2: I was like, she had a boyfriend and they've been dating for years, so. I told her, girl go for it. I was supportive.
Speaker 1: OK. So within your family and friends because you didn't really share it with anyone at home, why not?
Speaker 2: I don't know. I'm not sure.
Speaker 1: You're not sure, but your mom talks about it?
Speaker 2: Yeah. And my sister, she's not on anything. She hasn't been on birth control. She had her boyfriend.
Speaker 1: OK, so how do you feel about it that she's not?
Speaker 2: What goes for me goes for her as well. So why don't you go on birth control.
Speaker 1: So you feel like she should be on it? Why is that?
Speaker 2: Yeah. Because of my mom.
Speaker 1: What's your opinion about girls being sexually active and being on birth control?
Speaker 2: I think that's a good thing. I know it's a lot of side effects for the birth controls. The weight gain, the stress that comes the depression. But it's better than not being on birth control.
Speaker 1: But do you ever talk to your sister about it. Or does she talk to you?

Speaker 2: No, she doesn't. Actually, no.
Speaker 1: But do you know why you don't speak about it at home because your mom is pretty open?
Speaker 2: I have no idea. I don't know why. I don’t like to speak about it.
Speaker 1: And is there a reason why you don't like to speak about it? Or why you don't feel the need to like be open about it with other people?
Speaker 2: I think everyone has an opinion on their own body. What they should do with their body. So I think my sister has her own choice on what to do.
Speaker 1: And do you feel like you know everything about sexual health?
Speaker 2: No, not really.
Speaker 1: Would there be someone you would speak to if you had any questions?
Speaker 2: Yes, there would be.
Speaker: And who would that be?
Speaker 2: The nurses. So I would ask them questions. About like if I wanted the baby, is there a way for me to find out? Can I conceive? So is there a test or, you know, clinically that I'll do testing to see if you have a chance of falling pregnant?
Speaker 1: If you're like fertile?
Speaker 2: Yeah, if you fertile.
Speaker 1: What do you think that they think about sexual health?
Speaker 2: They don't say much. No, nothing.
Speaker 1: They don't say much about it. OK. Then we also have the Community, of course, because you told me that like for example, the judgment of other people or nurses or something, that's all people like from your community. How do you feel that right now, like in this year, people are thinking about a sexual reproductive health care clinic?
Speaker 2: Some will think it's bad because they will see a lot of youngsters coming and then some more think it’s good because there's older females that has problems.
Speaker 1: And why do you think people think it's bad?
Speaker 2: I have no idea why. Just they're young, they're young girls and they are already sexually active. That's their thinking. That's what I've heard.
Speaker 1: OK, but what? What do you think about that yourself?
Speaker 2: It's not like that.
Speaker 1: It's not like that. At least they're looking after themselves.
Speaker 1: But how do you feel that people in your community apparently think it's a bad thing? Bad thing that young people are going there? What is your opinion about that?
Speaker 2: Can you ask me the question again please?
Speaker 1: Yeah, sure. So, you know, like people. You said that you hear that people think it's a bad thing that young people are going to the clinic. But what? How do you feel about those people judging those young people to go to the clinic? What is your opinion about that? Do you agree with them?

Speaker 2: I disagree. Because they were also young at this stage, maybe they didn't have the facility at that stage, but now the young girls have it now that they can use it. So what's the problem now?
Speaker 1: What does it mean for you to be able to go to a clinic like that?
Speaker 2: It's amazing. It's great that there are clinics out there, that can help you. It's a. Good thing.
Speaker 1: OK. Why is it a good thing?
Speaker 2: Well, at least if you were planning for a baby. OK, now, go to the clinic. Say I want a baby in five years. OK. You can take this birth control and then by that time we take it out you will have a baby.
Speaker 1: So with the family planning and how do you feel about the HIV testing?
Speaker 2: It's good.
Speaker 1: OK. Let's see. So you think it's a good thing that people are able to access this clinic, OK? So you also told me you didn't really know a lot about the sexual health before going to the clinic. How do you feel about that?
Speaker 2: Expand yes, it needs to grow more. Yeah, a lot of young girls. There's a lot of young girls out there that needs to know about the clinic.
Speaker 1: Why do they need to know?
Speaker 2: I feel like a lot of girls don't know that they can go on birth control at the young age. From 12 from the age of 12. It's your right.
Speaker 1: Yeah, exactly. So you think that's important?
Speaker 2: Girls get raped up here, so I feel like just anything can happen. So they can protect themselves.
Speaker 1: You're talking about girls. But do you also feel boys need to go there? Or need to do something?
Speaker 2: I wish they made birth control for men. So boys can take their responsibilities.
Speaker 1: How do you think men would react to that?
Speaker 2: It's not the same.
Speaker 1: And why is it not the same?
Speaker 2: The one wants protection, the other one doesn't, and then it's a big fight at the end of the day the big fight.
Speaker 1: OK, but if someone wants it?
Speaker 2: You have to give.
Speaker 1: And why do they fight?
Speaker 2: Maybe because other person don't like it with a condom and this one wants it because she needs the protection.
Speaker 1: So you, you mean like mostly the boys?
Speaker 2: Yeah, they won't like it with a condom.
Speaker 1: But how do you feel about that?

Speaker 2: It's bad. Because it's the STI's and STD's. And HIV.
Speaker 1: So it's not only for being pregnant. But it's also for diseases and everything. OK. And do you think that your community has like a different view on boys and girls being sexually active?
Speaker 2: Yes.
Speaker 1: In what way?
Speaker 2: Like it's good for the boys to be like getting the girls, like getting all the girls and then when it comes to the girls being sexually active, you labeled a whore or something like that.
Speaker 1: OK. And how what is your opinion on that?
Speaker 2: It's the same. It's the same both sexually active.
Speaker 1: Yeah. So you don't agree with boys being like this and girls? Do you know why people think like that?
Speaker 2: I want to. I wish I knew. I wish I knew the answer to that one. I don't know.
Speaker 1: OK. So let's see if you look back at your experience, because we talked about like why you were there and how it was with the nurses, with your family, friends, community. So if you look back at it or if you think about it, how do you feel about it? Like being able to be on birth control to go to the clinic, things like that.
Speaker 2: When I was on birth control, it was a nightmare.
Speaker 1: Why?
Speaker 2: Because, I picked up weight, I got fat and in depression.
Speaker 1: So the birth control because you also stopped now because you did research. Do you want to go on birth control again?
Speaker 2: Yes, I would. I'm going to try the injection 3 months. I'm not doing the pills anymore.
Speaker 1: Because they gave you weight and depression?
Speaker 2: Yeah.
Speaker 1: OK. Yeah, I get that and it's that's really not nice if it has that those kind of effect effects. So in the beginning like before you went on the pill, did you get explanations about the pill?
Speaker 2: No. I had to read out the box page.
Speaker 1: OK, so the nurse also didn't tell you about it?
Speaker 2: You know, they don't tell you anything about the side effects.
Speaker 1: How do you feel about that?
Speaker 2: It's wrong.
Speaker 1: Why is it wrong?
Speaker 2: Because you should tell tell a female that. Then once you take this pill, your body is gonna go through changes. Are you ready?
Speaker 1: So in terms of like being educated right about sexual health and about your options and everything. How do you think it should be in your opinion?

Speaker 2: I would say schools, in schools, educate young people in these schools. Because in the clinics they only give you so much information.
Speaker 1: So what do you think the clinics should do?
Speaker 2: Give you more information. They should give you all the information you need. And I think it should start off by school as well. The sexual and reproductive health rights and HIV. Your STD's and STI's. How are they transmitted? How you get it? And family planning. And from what age you can start getting it. Side effects side effects as well. And I'll tell them which brand to go for because I think it's the brand.
Speaker 1: OK. I understand. So is there anything you would like to add to what you just told me or anything you would like to say?
Speaker 2: No.
Speaker 1: OK. And is there anything you would like to ask before we stop?
Speaker 2: No.
Speaker 2: OK. Then I'm going to stop the recording.

Appendix F: Language Editor Certificate

Mzansi Writers

CERTIFICATE OF EDITING

THIS IS PRESENTED TO

Maud Vievermans

This is a confirmation that professional editors at Mzansi Writers have proofread and edited your research paper. Changes were made towards the accuracy of language, sentence structure, punctuation and grammar ONLY.

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EDITOR'S SIGNATURE