Department of Social Development

An explorative descriptive study of social and religious barriers affecting access of young Black women to sexual and reproductive healthcare in Cape Town.

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ABSTRACT

This explorative descriptive study used a qualitative inquiry method to explore the social and religious barriers impacting young Black women's access to sexual and reproductive healthcare in Cape Town. Previous research studies have been conducted on barriers limiting access of women to sexual and reproductive healthcare. These studies are important as women have the right to be in control of their own healthcare decisions. However, limited attention has been given to the manner in which social and religious barriers impact young Black women's access to sexual and reproductive healthcare. Fifteen participants who follows Christian norms and values were purposively sampled, and in-depth interviews were conducted to gather qualitative data. The data was thematically analysed and the process revealed various barriers affecting the access to sexual and reproductive healthcare of young Black women. The findings emphasise that access is impacted by obstacles such as a lack of communication in families, community judgment, religious doctrine, and poor attitudes from healthcare providers. The findings further highlight that schools, digital platforms and peer groups are significant channels where sexual and reproductive healthcare information can be accessed. Based on the findings of this study, recommendations include developing family communication programmes to facilitate familial discussions about female healthcare. Interventions within church settings that encourage balancing religious principles with young women's healthcare needs could also assist to address the challenges voiced by participants. Overall, this study highlights the need to protect the rights and dignity of women to access sexual and reproductive healthcare services.

CHAPTER 1
INTRODUCTION

1.1. STATEMENT OF THE PROBLEM

Various socio-religious barriers hinder young Black women from accessing adequate sexual and reproductive healthcare (SRH). These barriers include religious norms and values (Mbarushimana, Conco and Goldstein, 2022), lack of knowledge or education about SRH, inefficiency of healthcare professionals and the fear of stigmatisation and judgment (Pillay, Manderson and Mkhwanazi, 2020). Geary et al. (2014) found that a lack of knowledge relating to SRH can also lead to a lack of insight into the use of condoms and other contraceptive methods and the age at which young women have their first sexual encounter. In 2011, 9% of the total 26,418000 women in South Africa (Statistics South Africa, 2011) reported that they had sex before the age of the 15 years (Geary et al., 2014). Not surprisingly, HIV prevalence in 2005 among women aged between 15 and 24 years in South Africa was estimated to be between 15% and 25% (Muula, 2008). On the other hand, in 2009, about 60% of unsafe abortions in Africa was experienced by women below the age of 25 (Wodajo et al., 2017). Although some young women use abortions out of the fear of motherhood and economic reasons, experiencing unsafe abortions can cause negative emotional and psychological health experiences (McLean, 2023). Barron et al. (2022) also note that between 2017 and 2021 that there was a 17.7% increase in the number of births occurring amongst South African women between the ages of 15 and 19 years. Pregnancy during young age has been closely linked with complications during labour, underweight infants, and an increase in infant mortality (Cinar and Menekse, 2017). These factors can add further stresses on young mothers as it can require finances to cater for emergencies as well as other medical and health related demands (Babughirana, 2022).

Information and education related to SRH are crucial to empower young women to access reproductive healthcare (Eriksson et al., 2014). Moreover, the lack of knowledge of SRH can further negatively shape ideas, reactions, and attitudes of young women towards accessing SRH (Erasmus, Knight and Dutton, 2020). The lack of knowledge reduces exposure to important SRH information and education and underlies the formulation of biases towards SRH knowledge that is already known (Saha et al., 2022). Biases can also be created through information shared by peers (Mbarushimana et al., 2022). Information received from friends, along with peer pressure can result in women engaging in early sexual activities (Mbarushimana et al., 2022). Additionally, social media acts as a source of diverse SRH

information that can increase prejudices towards accessing SRH and healthcare decision-making (Zhou, Zhang, Yang and Wang, 2018). A study by Ochieng (2023) also found that young people in recent times are becoming more reliant on social media for SRH related information. A plethora of information makes it difficult for young people to select appropriate or relevant information which consequently can expose them to harmful outcomes (Mbarushimana et al., 2022). Martin (2017) confirms that young people are doubtful of obtaining accurate SRH related information on online platforms.

1.2. RATIONALE AND SIGNIFICANCE OF THE STUDY

Present in various communities and societies are stereotypical views and social norms which have led to the stigmatisation of women, neglecting of their rights and decisions that they can make towards their own health (Erasmus et al., 2020). This is significant for the undertaking of this research since this situation has created opportunities to control women's health and it has also impacted their access to medical services (Chatters, 2000). Despite the SRH challenges experienced by young women, and the strong influence of the Christian community on society's way of life (Eriksson et al., 2014), limited attention has been given to the manner in which social and religious barriers impact young Black women's access to SRH (Bawn, 2022). On the other hand, raising the awareness and the understanding of SRH will empower women to advocate for their health needs and dignity (United Nations, 2023).

This study is significant since researchers (Geary et al., 2014; Smit et al., 2012; Lince-Deroche et al., 2015) have usually explored the provision of quality SRH services and economic obstacles impacting the access to SRH instead of socio-religious barriers. With 43 000 Christian communities in South Africa, investigating this problem is also essential as these communities could function as influential and positive drivers for social change (Erasmus, 2005). Moreover, the results yielded in this research can assist in forming the basis for further research on how women's SRH needs can be prioritised. This can be initiated by adopting and strengthening policies and strategies that bestow young women the right to make their own decisions concerning their health (Vukapi, 2020). Mbarushimana et al. (2022) believe that addressing factors related to the social development of young people can have a positive impact of improving their access to SRH related services.

Furthermore, Mbali and Mthembu (2012) suggest that South African religious women tend to not be fully informed about the options and rights that are at their disposal with regards to their access to SRH. The beliefs of religious women differ from secular or modern knowledge

related to various gender matters (Burke, 2012). Factors like religious and social beliefs, lack of adequate information as well as the limited knowledge of professional healthcare workers also stand in the way of better SRH outcomes (Arousell and Carlbom, 2016; Nketsia et al., 2022). Thus, this study can lead to the understanding of participant's experiences and needs of SRH and encourage engagement between policymakers and religious bodies to expedite SRH awareness and support (Nketsia et al., 2022). Furthermore, the research topic is located within the social development sphere as it is linked to the 2030 Agenda on Sustainable Development Goals (SDGs) (Fund, 2015). According to the United Nations (2023), SRH education has the potential to accelerate the empowerment of women through helping them to realise their human rights. Moreover, in promoting women's' rights, the research study can contribute to the SDG 3 and SDG 5 that aims to ensure adequate SRH services by 2030.

1.3. RESEARCH TOPIC

An explorative descriptive study of social and religious barriers affecting access of young Black women to sexual and reproductive healthcare in Cape Town.

1.4. MAIN RESEARCH QUESTION

What are the social and religious barriers affecting access of young Black women to sexual and reproductive healthcare in Cape Town.

1.5. AIMS OF THE STUDY

The aim of this research study is to explore the social and religious barriers affecting access of sexual and reproductive healthcare of Black women in Cape Town.

1.6. BROAD RESEARCH QUESTIONS

1.6.1. What are the social barriers that affect young Black women's access to sexual and reproductive healthcare?

1.6.2. What are the religious barriers that affect young Black women's access to sexual and reproductive healthcare?

1.6.3. What are the challenges and experiences that affect young Black women when accessing sexual and reproductive healthcare services and information?

1.6.4. What recommendations can young Black women make to strengthen access to sexual and reproductive healthcare?

1.7. BROAD RESEARCH OBJECTIVES

1.7.1 To explore and describe the social barriers that affect young Black women's access to sexual and reproductive healthcare.

1.7.2 To explore and describe the religious barriers that affect young Black women's access to sexual and reproductive healthcare.

1.7.3 To explore and describe the challenges and experiences that affect young Black women when accessing sexual and reproductive healthcare services and information.

1.7.4 To explore and describe recommendations by young Black women to strengthen access to sexual and reproductive healthcare.

1.8. MAIN ASSUMPTIONS

1.8.1 The main assumption is that the qualitative design of the study will permit the researcher to explore the diverse, socially constructed, and full realities of the participants.

1.9. CLARIFICATION OF TERMS

1.9.1 *Young Black women*: This refers to young Black women who are between the ages of 18 and 35 years and whose ethnicity is African. African refers to individuals with an African cultural heritage (Awoniyi, 2015). This excludes women categorised as Coloured or Indian. Coloured refers to individuals with mixed ancestry (Nilsson, 2016). Indian refers to an individual with an Indian ancestry (Mihesuah, 1998).

1.9.2 *Christian*: In relation to this study, this refers to people who have been members or adherents of a Christian church for a least 3 months. This means that they are followers of Christianity and its religious values and norms. Usmani (1995:14) and Otu Nyarko (2020) describe Christianity as the belief that there is one God which is comprised of three divine persons or "Tri-Unity." According to Usmani (1995:14) "the essence of God referred to as the father; the attribute of the word of God referred to as the son; and the attributes of life and love of God referred to as the Holy Spirit" can each be considered God.

1.9.3 *Christian values and norms*: In this study this refers to elements such as adherence to the institute of marriage, reverence for human dignity, justice, equality, respect for elders and authority, morality, a sense of community engagement, promotion of strong human interaction, and value for human life, as it permits followers of the Christian faith and their behaviour to be acceptable to their Creator (Guanah, Anho, and Nkala, 2020).

1.9.4 *Sexual and reproductive healthcare* (SRH): This refers to the provision of services that meet people's needs and rights in relation to factors like reproduction, contraception, safe abortion as well as sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) (World Health Organization [WHO], 2011).

1.10. ETHICAL CONSIDERATIONS

This research study is informed by the University of Cape Town's ethical guidelines in order to ensure safety for both the participants and the researcher. In using ethical guidelines, the researcher is able to conduct ethically informed research which promotes the integrity of the study and builds trust between the participants and researcher (Creswell, 2014). The following ethical guidelines informed this research study.

Avoidance of harm: The aim of this guideline is to protect the participants from any emotional or physical harm (De Vos et al., 2005). Pandey, Seale and Razee (2019) agree that topics about SRH are sensitive and can evoke unintended reactions from participants. These unintended reactions can take the form of psychological harm. Psychological harm is defined as the potential impact of research interviews to trigger unpleasant or painful memories (Seedat et al., 2004). These memories can cause the participants to relive or recall their past emotional experiences and thus evoke emotions like anger, shame and fear (Seedat et al., 2004). A debriefing session was provided to the participants in this study in order to reduce the impact of psychological harm if it occurred. In addition, throughout the interview process the researcher regularly checked in with the participants to confirm their willingness to proceed (Jewkes, Dartnall and Sikweyiya, 2012). More so, participants were reminded that they do not have to answer questions that they feel uncomfortable to answer. The participants were further informed about all the potential risks and benefits of participating in the study. This provided them with a chance to withhold their participation if they were not comfortable to be part of this study (De Vos et al., 2005). More so, the researcher was prepared to provide participants who express emotional discomfort during the interview with the contact details of The Trauma Centre, Hope House Counselling Centre and Cape Mental Health to ensure that they receive appropriate counselling support.

Informed consent: Informed consent was required to ensure that participants express their willingness and consent to participate voluntarily in this research study (De Vos et al., 2005; Hardicre, 2014). Participants were required to sign a consent form (Appendix I) before the researcher started collecting data from them. Informed consent was important in order to allow

the participants the right to withdraw at any time if they did not wish to participate, thereby respecting their safety and decision to engage in this research study (Hardicre, 2014). The researcher also informed participants about the goals, the procedures to be followed as well as the benefits and disadvantages of participating in this research study (De Vos et al., 2005). Wood, Daley-Moore and Powell (2019) mention that informed consent allows the participants to share information that they are comfortable to disclose.

Furthermore, the researcher explained to the participants that their data will only be used for research purposes and that their information will be retained until the final submission of the thesis is made, and then it will be destroyed (World Medical Association, 2024). More so, the researcher explained to participants that after the interview process, they will not have access to the audio recordings and transcriptions to adjust the data (World Medical Association, 2024). This is due to academic time constraints on the researcher.

Anonymity: Anonymity suggests that participants in the study will not be identified and that the collected data will not be able to be linked to any specific individual (De Vos et al., 2005). The researcher therefore informed the participants that pseudonyms will be used in the compiled dissertation to enforce anonymity (Halai, 2006). Moreover, according to De Vos et al. (2005) most individuals consider topics that are related to sexual behaviour to be private. Thus, the use of pseudonyms encouraged the participants to comfortably share information without the fear that their identity will be exposed (Opara, Spangsdorf and Ryan, 2023). More so, it was also explained to the participants that any other personal identifiers will be changed in order to ensure that their identity remains anonymous. The researcher also took additional precautions to safeguard the anonymity of participants when recruiting them for the study. These precautions include using a private setting to discuss the details of the study. The identity of those who agreed or declined to participate in this research study was also protected as they provided their decision to participate in a private manner. The researcher also ensured that their decision was not shared with a third party. Furthermore, only the researcher had access to the names and contact details of participants who consented to be contacted by the researcher for the purposes of the study. To further secure anonymity, the researcher ensured that ample time was arranged between each interview so that participants did not see each other during the data collecting process. Additionally, the researcher was obligated to gain consent from church leaders to conduct the research at their organisations, but the researcher excluded them from the sampling process to further safeguard the identity of participants.

Privacy: De Vos et al. (2005) and Maldonado-Castellanos and Barrios (2023) define privacy as the right and freedom to disclose information without scrutiny and judgement from unwanted observers. Privacy in this research study meant that a private room was secured during interviewing so that interviews could be conducted without any interruption to ensure that no one listened or were exposed to the details of the conversation (Maldonado-Castellanos and Barrios, 2023). In order to ensure that privacy was maintained, the researcher arranged to conduct the interviews in a private room in each participating organisation. In addition, the researcher ensured that only the researcher and the participant were present in the space at the time of the interview so as to minimise factors impacting on the collection of data.

Confidentiality: This has been defined as an obligation made by the researcher to the participants, to protect their private information (Gubrium et al., 2012). The data collected, including process notes, was therefore only accessible to the researcher, and were kept in a cupboard that was locked. Additionally, all electronic devices that were used were password protected to ensure that the participants' information remained secure (Kamanzi and Romania, 2019). The researcher also refrained from sharing any of the information gathered from the participants with anyone. The details surrounding confidentiality were communicated to the participants verbally before the data collection process began so as to promote transparency and to ensure that the participants were well informed how their information would be safeguarded (World Medical Association, 2024).

Debriefing: After collecting data from each participant, the researcher gave them an opportunity to discuss their experience to try and reduce any unpredicted harm that may have happened (De Vos et al., 2005). The researcher was prepared to provide the participants with contacts of counselling service providers if they need emotional support after the interview. In addition, the researcher also planned to debrief participants who withdrew from the study during the interview in order to address any concerns or discomfort that they may have experienced. In relation to this research study, none of the participants withdrew and none of the participants expressed having experienced any emotional or physical discomfort as a result of being interviewed.

CHAPTER 2
LITERATURE REVIEW

2.1. INTRODUCTION

This chapter discusses previous literature and research studies related SRH, as well as policies, legislation, and relevant theoretical frameworks on the topic. The chapter concludes by presenting a summary of the main points under discussion.

2.2. REVIEW OF LITERATURE

2.2.1. THE LACK OF SEXUAL AND REPRODUCTIVE INFORMATION

According to El Gelany and Moussa (2013) SRH is regarded as a sensitive topic, and this heightens the lack of information amongst young women as individuals are not open or readily available to discuss this subject in depth. This can affect the ability of women to make informed decisions related to SRH (El Gelany and Moussa, 2013). However, young women tend to get SRH information from other sources, like their peers (Agu et al., 2020). On the other hand, Agu et al. (2020) also note that personal biases of their peers can lead young women to access unsafe SRH practices. In addition, families and communities shape the norms and values of an individual and these standards can function as a source of SRH information (Agu et al., 2020). Karp et al. (2020) indicate that this enforces certain expectations on the choices young women can make with regards to SRH. This subsequently limits their autonomy when it comes to their own wellbeing (Karp et al., 2020).

Like El Gelany and Moussa (2013), a qualitative study conducted by Zuma et al. (2020) to explore the sexual experiences of young women and the reproductive health interventions in rural KwaZulu-Natal, found that a lack of knowledge of SRH information can hinder young people from making informed decisions. Lince-Deroche et al. (2015), in their mixed methods study argue that SRH is available to young people, but young people have a tendency not to seek appropriate SRH information. According to Lince-Deroche et al. (2015), Delany-Moretlwe et al. (2015) and Müller et al. (2016) this tendency is caused by stigma which young people experience when they try to seek SRH related information as it would indicate that they may be sexually active. Furthermore, seeking SRH related information may not be acceptable in certain communities that believe that topics related to sexual health should not be discussed before marriage (Eriksson et al., 2014; Mbotho et al., 2013).

Mbarushimana et al. (2022) believe that families promote teachings and information that have a positive effect on the behaviour of young people. Zuma et al. (2020) however found that

participants in their study showed concern that parents find it difficult to discuss issues related to SRH such as pregnancy, HIV/AIDS, and sexual intercourse with their teenagers. This subsequently exposes young people to unhealthy sexual behaviours. In a web-based survey by Zou et al. (2022) sexual communication with adolescents was found to be associated with a reduced risk of unhealthy sexual behaviours. Moreover, Holt et al. (2012) and Lince-Deroche et al. (2015) emphasise the importance of families as social systems that can support young people and strengthen their willingness to seek SRH related knowledge through educational channels, such as trainings and workshops. Thus, parents play an important role in encouraging young people to be well-informed about their health. Similarly, parents can attend trainings and workshops that empower them to support young people (Lince-Deroche et al., 2015). Therefore, in encouraging young people to seek SRH related knowledge it becomes vital to also acknowledge the role that can be played by the family.

In addition, in a qualitative research study by Njenga (2019), school-based education was found to be a positive channel for empowering young people to access SRH information and knowledge about their SRH rights. Batra (2013) and Riley (2019) point out that schools play a major role in helping young people develop a sense of self. Aibangbee et al. (2024) also identify in their qualitative research that school environments play a significant role in the process of identity formation amongst young people. Thereby providing a platform to gain SRH related information which can empower them in making better SRH related decisions (Aibangbee et al., 2024). However, the use of age-appropriate and accurate SRH information is encouraged by the WHO (2009b) and Njenga (2019) in order to ensure that the information is understandable and shares experiences that are relevant to young people. In addition, Obach et al. (2022) explain that school-based information can assist in raising SRH awareness, particularly about the prevention of STIs and the impact of sexual abuse. A review by Heron and Eisma (2021) and a mixed method research study by Ivanova, Rai and Kemigisha (2018) likewise found that feelings of shame and humiliation cause women who experience abuse to suffer a lack of access to SRH. School based education can thus play a vital role in empowering young women to feel comfortable in accessing SRH and discussing their health risks and vulnerabilities.

2.2.2. SEXUAL AND REPRODUCTIVE HEATHCARE SERVICE PROVISION FROM HEALTHCARE WORKERS

The behaviour and attitudes of healthcare professionals play a significant role in shaping the access of SRH for young Black women. Participants in a Cape Town based qualitative study

by Jonas et al. (2018) put forward that the unprofessionalism of healthcare workers can negatively affect the SRH outcomes of young women. The negative treatment of patients is influenced by the personal norms and values of healthcare workers (Jonas et al., 2018). Chilinda et al. (2014) also suggest that the personal norms and values of nurses can influence the way that they provide SRH services. Moreover, negative treatment from healthcare professionals may lead young women to feel ashamed and stigmatised when they seek SRH (Jonas et al., 2018). This is supported in a qualitative study by Omollo et al. (2022) who found that participants felt judged or stigmatised by healthcare providers. Aspects like building rapport with young people were highlighted as assisting patients to feel comfortable and satisfied with SRH services received (Omollo et al., 2022). A qualitative study by Lewis et al. (2016) amongst Black African American adolescent females likewise found that negative attitudes from healthcare professionals deterred them from accessing further SRH. The participants in a Soshanguve based qualitative study by Maeko (2024) expressed that negative interactions with healthcare providers cause them to avoid seeking SRH services at clinics. Maeko (2024) found that such interactions can lead young people to access unsafe and illegal SRH methods, like unsafe abortions.

A qualitative study by Holtman et al. (2024) also found that healthcare professionals have a tendency of not adequately guiding young people when they seek SRH. A qualitative study that was conducted in sub-Saharan Africa by Jonas et al. (2017) yielded results that suggest that a lack of adequate skills and knowledge amongst healthcare professionals limits their provision of quality SRH. According to Jonas et al. (2018), healthcare professionals fail to provide comprehensive SRH services since they often lack adequate knowledge about SRH guidelines and policies. This can be an outcome of hiring individuals with only basic general information to aid in SRH provision, rather than well trained healthcare workers (Jonas et al., 2018). This situation, along with nurses who persuade adolescents not to abort their pregnancies, was found by Jonas et al. (2018) to undermine the rights and preferences of young women.

Moreover, discouraging treatment of healthcare workers has also been shown to affect the willingness of young people to seek SRH related information (Erasmus et al., 2020; Pillay et al., 2020). For example, healthcare professionals tend to be unfriendly and to ask many uncomfortable questions of young women who seek SRH (Chilinda et al., 2014). This in turn deters young women from accessing approved SRH methods or services (Jonas et al., 2018). In addition, Jonas et al. (2017) identify unconstructive behaviour and attitudes amongst

healthcare workers in public institutions as a significant problem. Aikman (2019) also suggests that insufficient funding of public healthcare institutions, a lack of resources and inadequate equipment can negatively impact staff morale. This can result in poor service provision and negative behaviours towards patients (Aikman, 2019). Jonas et al. (2017) note that poor service delivery is more prevalent in public healthcare centres than private healthcare organisations. Poor healthcare provision can negatively impact younger women's SRH outcomes (Jonas et al. 2017). Jonas et al. (2017) indicate that healthcare professionals can undermine patient's right to respect by their dismissive and harsh attitudes. Holt et al. (2012) and Lince-Deroche et al. (2015) recommend the need to provide workshops and trainings for healthcare workers that focus on addressing how personal beliefs can impact positive SRH services to young women. Jonas et al. (2018) allude that training can assist healthcare workers to adjust their values and norms so that they provide services that are beneficial to all service users.

2.2.3. THE IMPACT OF RELIGIOUS NORMS ON YOUNG BLACK WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEATHCARE

Young Black women's access to SRH can be influenced by religious norms and values that often contradict their constitutional right to healthcare. The Constitution of the Republic of South Africa Act No. 108 of 1996, in Section 27 enshrines every citizen the basic human right to access adequate health care services including SRH, regardless of factors like religion (Republic of South Africa, 1996). However, Gillespie et al. (2022) suggest that religious and moral positions in South Africa play critical roles in shaping the service delivery in healthcare institutions. For example, some healthcare practitioners will not perform abortions owing to religious based notions (Mahlati, 2000). Mahlati (2000) therefore suggests that it is necessary for the moral, religious and value systems of society to be in alignment with health-related policy concerns so that the right to SRH can be fully recognised. When society is not supportive of women's rights and healthcare, various misconceptions and difficulties can impact the way healthcare professionals provide their services (Aniteye and Mayhew, 2013). Braeken and Rondinelli (2012) and the WHO (2018) suggest that policymakers can ensure that the autonomy and rights of young women are recognised by making SRH related services easily accessible to women.

Despite religious socialisation against early sexual engagement, results of a qualitative study by Eriksson et al. (2014) in Cape Town concluded that out of their 1102 participants approximately 31% attending an Anglican Church had engaged in sexual activities between the ages of 12 and 19 years. As religion speaks against sexual activities before marriage

(Mbotho et al., 2013), women who do not adhere to this often feel judged, and fear being stigmatised as they are perceived to have deviated from the norm (Erasmus et al., 2020). Moreover, unmarried young women who adhere to Christian religious values and principles can also feel that the church is unsupportive of their decisions if they are found to be accessing SRH services, such as collecting contraceptive medication or enquiring about abortion (Mosley et al., 2021). Young women are also not encouraged by some Christian church organisations to access SRH as they are not expected to be sexually active before marriage (Munakampe, Michelo and Zulu, 2021). However, Eriksson et al. (2014) found Christian adolescents to be engaging in premarital sex. Refraining from accessing SRH can cause young women to rely on secret and unsafe healthcare methods (Levandowski et al., 2012; Godia et al., 2014). More so, Mashau (2011) indicate that the increase in premarital sex amongst South African Christian youth is linked to the increase in adverse health outcomes such as unwanted pregnancies and STIs. A qualitative study by Eriksson et al. (2013) that was conducted in KwaZulu Natal also found that the failure of teachings in the church to address SRH topics exposes young people to various health risks, such as misinformation from peers.

Moreover, churches can shape the identity, values, and beliefs that its adherents have towards SRH (Eustace, 2022; Tsara, 2019). This can be done through communication and teachings that describe sexual activity as a topic that can only be discussed in the sanctity of marriage (Tsara, 2019). It consequently discourages young people from bringing questions related to SRH to the family or church leaders (Tsara, 2019). More so, Powell et al. (2017) in their qualitative study amongst Black African American adolescents found that church leaders fear that SRH discussions in church might be opposed by older members of their congregation. Older persons regard topics related to SRH as morally inappropriate and unsuitable for the church to address (Powell et al., 2017). Clucas (2017) explains that historically, owing to the fear of being judged and conservative religious notions, most churches have not given individuals a safe space for discussing topics related to sexuality. Such beliefs and values have left a gap in both social and emotional development of young women (Tsara, 2019). Similarly, a qualitative study by Gondwe (2024) in the Church of Central Africa Presbyterian Synod of Livingstonia found that the conservativeness of church doctrines can also supress discussions around SRH. Gondwe (2024) explains that various religious doctrines can lead religious leaders to avoid addressing SRH related topics, particularly with young unmarried individuals. More so, a Ugandan qualitative study by Nayebare and Omona (2021) also confirms that religious leaders can face difficulties in addressing SRH concerns as their primary role is to spread

spiritual teachings. This consequently positions SRH as a taboo topic that must be avoided in religious discussions by church leaders (Nayebare and Omona, 2021). This in turn can cause young unmarried people to feel uncomfortable to discuss SRH related issues with their church leaders (Gondwe, 2024; Gennrich, 2017). Therefore, it becomes important to have positive relationships between church members and their leaders so that they can feel free to discuss SRH topics (Gennrich, 2017).

Jonas et al. (2018), like Eustace (2022) and Tsara (2019) emphasise that the SRH of young people can be affected by the perceptions advocated by religion. In their qualitative study on healthcare workers' (HCWs) in Cape Town Jonas et al. (2018) found that religious perceptions of HCWs undermine the prioritisation of SRH for young people. Some nurses in the study advised young women to continue their pregnancies instead of discussing termination options because of their religious beliefs (Jonas et al., 2018). Similarly, a qualitative study conducted by Mosley et al. (2021) found that the termination of pregnancies is not acceptable in Christianity because it is perceived as sinful. However, this undermines young people's rights to SRH, and it heightens the use of unsafe SRH methods (Jonas et al., 2018). This can cause young women to be stigmatised and to experience social discrimination as they might face reproductive problems which make it evident that they have gone against social and religious norms (Mezzina et al., 2022). This subsequently has the potential to impact their freedoms and rights, as well as heighten their social exclusion (Mezzina et al., 2022). Mosley et al. (2021) recommend the need to apply an assets-based framework as well as strength-based approaches in order to build collaboration between health and socio-religious sectors. Mosley et al. (2021) asserts that the use of these frameworks can aid in finding existing assets and strengths like policies, funding and organisations that can work to promote and strengthen the SRH of young women and encourage empowerment as well as social inclusion.

A study by Eriksson et al. (2014) found that social and religious factors can undermine health concerns in favour of emphasising the moral aspects of sexuality. However, moral constructs often make young women feel that accessing SRH healthcare is immoral (Gondwe, 2024). Young women thus become reluctant to access SRH as they fear being humiliated in public (Pillay et al., 2020). It is noteworthy that SRH is more problematic to young women even though it interferes with the health of both sexes (Desrosiers et al., 2020). Women are more likely to have to cope with the consequences of unwanted pregnancies and contracting HIV/AIDS and other sexually transmitted diseases in young adulthood (Lince-Deroche et al., 2015). Despite the advancements initiated by the South African government that protect people

from having their access to healthcare restricted, various factors like religious and social constructs continue to impact the manner in which healthcare is accessed (Eriksson et al., 2014).

2.2.4. THE IMPACT OF FAMILY ON YOUNG BLACK WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEATHCARE

Mbotho et al. (2013) suggest that access to SRH is influenced by the social and religious viewpoints held by social systems surrounding young people. Young women in some communities or social settings like families are expelled from these spaces as punishment for getting pregnant at an early age (Erasmus et al., 2020). Ndugga et al. (2023) in their qualitative study also found that the fear of being punished can deter individuals from discussing their SRH concerns. The fear of retribution disconnects young women from their families as well as the support and care that is available in these systems (Erasmus et al., 2020). A qualitative study by Baker et al. (2023) found family support is required since young individuals often depend on their parents' money to buy reproductive healthcare material like condoms. Considering their financial dependence, being expelled from the family could mean that their SRH needs are not fully met (Erasmus et al., 2020).

In relation to the family system, Mbarushimana et al. (2022) mention that SRH topics are avoided by some parents as they fear that it will stimulate sexual activities in their children. However, Moodley et al.'s (2014) research study found that social support is available to young women through their grandparents and other family members. On the other hand, Govender et al. (2019) found that there is still a need for young women to receive more fervent social support and care from parents and healthcare workers in order to facilitate positive SRH outcomes. The participants in a Kenyan based qualitative study by Godia et al. (2014) support this as they expressed that they felt that access to SRH related guidance and advice should be available from their parents. Govender et al.'s (2019) cross-sectional study in KwaZulu-Natal concluded that a lack of adequate support leads to a lack of knowledge and skills to negotiate safe SRH practises. A conceptual review by Farahani (2020) revealed that a lack of family support and guidance regarding SRH, is a factor that can expose young people to unhealthy SRH practises. Narker (2022) also found that a lack of a supportive structure can lead to the passing of myths from one generation to the next. In addition, Jokioja and Pohan Simangunsong, (2022) share the view that tradition, culture, and myths may be responsible for promoting negative healthcare behaviours which lead to unsafe practices. Tohit and Haque (2024) also allude that there is an attached moral and religious significance to SRH which

makes it difficult for young people to access SRH without feeling stigmatised and judged. More so, a research study by Bekele et al. (2022) also found that SRH topics are viewed through moral and cultural lenses. The study further found that older people tend to find it difficult to freely communicate about SRH and support the SRH needs of young people. Older people's moral and religious viewpoints generally make young people feel that sex is a taboo subject that cannot be spoken about and may therefore find it difficult to discuss matters related to sex (Tohit and Haque, 2024; Hall et al. 2018). Eriksson et al. (2014) suggest that social development interventions should be considered an important strategy for ensuring that social systems, like families, are able to focus on all areas of SRH.

2.3. THEORETICAL FRAMEWORK

2.3.1. ECOLOGICAL SYSTEMS THEORY

Mnisi (2021) suggests that social and religious norms and values can lead to an increase in SRH related risks, like early pregnancy and higher HIV/AIDS infections. These barriers impact an individual's knowledge about and access to SRH (Mnisi, 2021). Interventions are therefore needed to address all levels from which potential barriers can emanate from. For example, these interventions can be conducted at the community, religious and policy levels (Turner, 2011). Individuals are therefore affected by various interconnected spheres in which they are embedded (Turner, 2017). This is linked to the systems perspective, which Turner (2017) and Becvar, Becvar and Reif (2023) suggest provides a foundation to observe interconnectedness of components and how the relationships between these elements can affect the status quo in each system. Systems theory recognises that in order to understand a situation, interactions in all parts of the system should be understood in order to get a holistic picture of events (Turner, 2011; Becvar et al., 2023).

Homan (2016:37) alludes that systems theory provides a framework for understanding how communities operate and interact. In relation to this study, this provides an understanding of how the interplay between factors like social, religions, environmental and individual factors can shape young women's outcomes in relation to SRH. Maeko (2024) also supports the idea that complex relationships in different parts of the system like funding constraints, cultural norms, relationships between healthcare providers and young women seeking SRH can shape young Black women's experiences relating to SRH. Homan (2016:42) also notes that, "…Anything that restricts access to a needed resource represents a faulty connection…" in the system. Thus, it is evident that complex factors existing across multiple systems can affect the development of individuals.

Urie Bronfenbrenner expanded the systems theory with the Ecological Systems Theory in 1970 in which he proposed five systems in which human development occurs (Guy-Evans, 2024). According to Krebs (2009) and Guy-Evans (2024), the theory recognises the importance of various interactions in the microsystem, mesosystem, exosystem, chronosystem and macro level in facilitating human development. This theory posits that changing one part of the system will lead to changes in other parts of the system (Turner, 2017). Guy-Evans (2024) suggest the microsystem involves the part played by an individual's immediate relations. Thus, the Ecological Systems Theory suggests that this particular system is made up of immediate relationships and environments like an individuals' family. Currie (2020) alludes that adolescents' SRH related behaviours are associated with the experiences from micro systems which are responsible for shaping their lives, for example through family which offers guidance and support or even trusted healthcare services that are made available to individuals.

The meso system is focused on the relationships between two or more microsystems (Guy-Evans, 2024). This system particularly portrays how relationships between microsystems can impact the growth or development of an individual. For example, the interconnectedness of factors from microsystems like the family and healthcare providers can contribute to the quality and access of SRH at an intermediate level (Chimwaza-Manda et al., 2024; Guy-Evans, 2024). This means that it becomes crucial for systems like churches and healthcare centres to familiarise adolescents and young women about SRH information as this can empower them to make informed decisions that align with SRH policy goals (Mutea et al., 2020). According to Mutea et al. (2020) this creates opportunities to increase young people's awareness and engagement with these policies.

Likewise, the macro level relates to how an individual develops in the environments that are present in the micro and meso systems (Guy-Evans, 2024). The macro system is made up of elements that include policies, healthcare systems as well as varying religious perspectives (Guy-Evans, 2024). At the macro level, policies and legislation play a pivotal role in shaping the determinants of SRH outcomes (Guy-Evans, 2024; Lamaro Haintz, Hanna, and Taket, 2023). More precisely, the macrosystem explores the cultural and religious influences that can shape one's development (Krebs, 2009). In relation to this study, this includes how various cultural and religious beliefs, values and social conditions have shaped and dictated expectations that impact young Black women's autonomy and decision making regarding SRH (Guy-Evans, 2024; Krebs, 2009).

Urie Bronfenbrenner in his theory also includes the exosystem (Guy-Evans, 2024). Krebs (2009) and Robinson (2016) allude that this particular system relates to other external environments like the resources that indirectly affect the lives of individuals even without an individual's direct contact with that particular environment. In relation to this study, the portrayal of SRH through various social media platforms can influence opinions towards SRH related issues, such as the use of contraception or seeking SRH assistance (Guy-Evans, 2024). In addition, the chronosystem is also included in Bronfenbrenner's theory (Guy-Evans, 2024; Krebs, 2009). Guy-Evans (2024) suggests that this particular system includes environmental developments over a lifetime. Krebs (2009) explains that it relates to how historical contexts or past experiences impact the lives of individuals. In relation to this study, generational and cultural changes over time can impact the way that SRH related concerns are discussed in the family.

2.3.3. AMARTYA SEN'S CAPABILITIES APPROACH

According to Robeyns (2003:6) the Capabilities Approach relate to "doings" which describe what individuals are able to do or access. It also concerns "beings," which relates to aspects like health, which people require in order to live their desired lifestyles. Thus, this theory relates to the wellbeing and freedoms of individuals that facilitate human development. Robeyns (2003) suggests that the wellbeing of individuals can be understood by focussing on their functionings and capabilities. Kuhumba (2018) defines 'capabilities' as an individual's ability to do basic acts in order to reach a certain goal and to function as expected. For example, to be able to attend to health-related needs that promote positive health development. In addition, 'functionings' have been described as the living conditions or states as well as activities which allow human beings to take part in society to lead their desired lifestyles (Kuhumba, 2018). Thus, functionings can be influenced by various social, economic and policy opportunities (Kuhumba, 2018).

Robeyns (2003) alludes that the Capability Approach plays a role in assessing how policies impact on people's wellbeing, development, and capabilities. For example, according to Salais (2003) an imbalance in policy implementation leads to capability deprivation which impacts on the way an individual functions or chooses to develop. In context of this study, basic functionings can be affected when adequate SRH information is not easily accessible (Robeyns, 2003). This may result in individuals experiencing "social exclusion," which in turn reduces their ability to make informed healthcare decisions and gain personal development (Sen, 2000; Bhalla and Lapeyre, 1997:414). On the other hand, the right to access SRH related needs is

enshrined in the Constitution of South Africa, 1996 (Republic of South Africa, 1996). At a policy level, the National Youth policy 2020-2030, also promotes interventions that heighten the provision of SRH information and challenges factors like stereotyping and misconceptions (Department of Women, Youth and Persons with Disabilities, 2020).

Bhalla and Lapeyre (1997:414) define social exclusion as a complex notion that relates to 'social disqualification or social disaffiliation' which affects the relationship between an individual and the society by reducing an individual's sense of freedom. According to Robeyns (2003) this implies that the well-being and development of people are dependent on the opportunities and freedoms that are provided to enable them to live a life they desire. Sen (2000) states that freedoms and opportunities allow individuals to exercise their civil rights including the right to access SRH (Sprague, 2009). On the other hand, SRH access and rights are still restricted by various barriers, such as lack of knowledge about SRH, inefficiency of healthcare professionals and the fear of stigmatisation (Memon et al., 2023; Sprague, 2009). This creates a situation whereby young Black women are deprived from their right to '…appear in public without shame…' (Sen, 2000:4).

Robeyns (2003) suggests that people's concepts on how to live their lives are influenced by family, religion, and other social factors. Elements within these systems can exert judgment on women's SRH decisions and hence shape their access to these services as they try to avoid being stigmatised (Robeyns, 2003). Robeyns (2003) notes that any deviation from accepted social and religious values can lead to potential punishment or exclusion (Robeyns, 2003). Unlike these barriers and restriction on freedoms, Robeyns (2003) links the Capability Approach to the liberal philosophical school of thought which values an individual's autonomy and freedom.

2.4. POLICY AND LEGISLATION

2.4.1. THE NATIONAL INTEGRATED SEXUAL REPRODUCTIVE HEALTH AND RIGHTS POLICY (2020).

According to the National Department of Health, the National Integrated Sexual and Reproductive Health and Rights Policy (NISRHR policy) regards factors such as contraception, fertility, the choice to have an abortion and sexual pleasure as elements of sexual health (National Department of Health [NDoH], 2020b). According to the NDoH (2020b), the policy creates an opportunity for all individuals to receive quality SRH. The NISRHR policy tries to recognise and improve an individual's unmet needs, human rights, and their autonomy in

relation to SRH choices (NDoH, 2020b). Therefore, in relation to this study, this policy aids in recognising the limited autonomy that is often awarded to young women in relation to SRH (Groenewald et al., 2023). Limited autonomy has increased due to various barriers affecting the access to SRH like lack of adequate information (Tanabe et al., 2015). Moreover, partner, family, and community expectations about fertility, knowledge about contraceptive methods, stigma, discrimination, socioeconomic status, and rural residence are some SRH barriers that have been identified in the NISRHR policy (NDoH, 2020b). The policy gives both clinical and policy guidelines which direct various policies to ensure that SRH services are adequately accessible and that human rights associated with SRH are met (NDoH, 2020b). For example, the National Contraception Clinical Guidelines, 2019 (NDoH, 2020a) focuses on providing all women with information on all methods of contraception. This empowers women to make individual choices in relation to fertility and thus directly promotes positive economic and social opportunities for women (NDoH, 2020a) This supports a rights-based strategic approach that ensures that the SRH rights of women are met and that the provision of integrated services occur at all levels of healthcare (NDoH, 2020b).

According to the NDoH, (2020b), the policy's objectives include empowering people so that they can make informed SRH decisions and to guarantee that SRH rights are safeguarded, valued and fulfilled. Willan et al. (2020) identify that unwanted pregnancies, early motherhood, and higher HIV/AIDS statistics are all outcomes of the lack of adequate information on SRH. However, the provision of adequate information can provide women with the ability to make informed decisions (Willan et al., 2020; Ashcraft and Murray, 2017). The policy also aims to ensure adequate and quality SRH services for people of all age groups (NDoH, 2020b). A goal of this policy is to ensure that services are offered in a respectful manner to priority groups and that these services are free from judgemental attitudes and behaviour (NDoH, 2020b). The policy also aims to enhance the health system to offer integrated SRH services. Smit et al. (2012) mention that integrated service delivery, can improve service utilisation, which can in turn enhance SRH related health outcomes in South Africa. Lastly, the NDoH (2020b) intends to ensure that there is collaboration with service providers to ensure a sustainable rights-based service delivery (Lamaro Haintz, Hanna, and Taket, 2023). The NDoH (2020b) therefore aims to provide access to SRH in a holistic manner.

2.4.2. THE PROMOTION OF EQUALITY AND PREVENTION OF UNFAIR DISCRIMINATION ACT 4 OF 2000 (PEPUDA, 2000).

Alomair et al. (2020), Godia et al. (2013) and Lince-Deroche et al. (2015) found that SRH remains a health challenge for young women despite the South African's constitutional aim to end various forms of discrimination. In contrast, the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA, 2000) (Republic of South Africa, 2000) echoes section 9 of the Constitution of the Republic of South Africa, 1996 (Republic of South Africa, 1996) whose aim is to fight against, and end issues related to discrimination, harassment, and hate speech. PEPUDA, 2000 (Republic of South Africa, 2000) aims to promote equality and eliminate unfair discrimination. Equality has been defined in Chapter 1 of the PEPUDA, 2000 (Republic of South Africa, 2000:55) as "…the full and equal enjoyment of rights and freedoms...". It goes further by describing discrimination as "any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly (1) imposes burdens, obligations or disadvantage on; or (2) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds" (Republic of South Africa, 2000:4). One of the goals of this Act is subsequently to ensure that all persons have access to every right and freedom that are bestowed on them (Republic of South Africa, 2000). In relation to health, and in context of this research topic, it is important to note that the Constitution of South Africa, 1996 (Republic of South Africa, 1996) has stipulated healthcare as an individual right available to all.

Chapter 2 of PEPUDA, 2000 (Republic of South Africa, 2000) emphasises that discrimination based on gender is prohibited. Among other things, the Act prohibits any convention, including religious, traditional, and customary actions that may undermine the wellbeing and dignity of women and young girls. Additionally, the Act also disallows limiting women's access to social services or benefits, such as healthcare. schooling and social security. Moreover, Section 8 of the Act also highlights that policies and actions that restrict women to access any resource are prohibited (Republic of South Africa, 2000)). The Act aims to promote an inclusive and egalitarian South African society (Kok, 2017). However, Kok (2017) suggests that this goal could be compromised if strong religious beliefs are left to supersede the aim of the Act in every circumstance. Kok (2017) highlights that the Act primarily sets out to address socio-economic disparities and to establish a more equal and nurturing society. In relation to religion, this would generally mean prioritising diversity and different perspectives over hegemonic religious practices (Kok, 2017). These measures are significant as religious, traditional, and

customary concerns continue to play a part in shaping people's views about SRH related issues (Johannes Malesa, 2022).

Chapter 5 of the PEPUDA, 2000 (Republic of South Africa, 2000) encourages the state to audit, address and eliminate discriminatory policies and practices so as to foster equality. Some strategies that have been given by the Act in order to foster equality include adopting equality plans as well as ensuring that non-governmental and community-based organisations, and traditional institutions promote equality in their interactions in various partnerships that have the same aim. Jokioja and Pohan Simangunsong (2022) suggest that organisations can offer activities that promote equality, such as educative community-based workshops and training for healthcare workers which can aid in correcting any misconceptions about SRH. In addition, in Chapter 5, the Act encourages the state as well as every citizen to be responsible for the promotion of equality by developing awareness of the rights that can facilitate the promotion of respect, dignity and equality (Republic of South Africa, 2000). Therefore, the Act encourages the collaboration between individuals, organisations and the state to work hand in hand to ensure that all citizens can equally enjoy respect, equality and access to their fundamental human rights.

2.5. CONCLUSION

This chapter presented a review of previous literature and studies that relate to the research topic being explored. In addition, the chapter emphasised that various social and religious barriers can limit positive SRH outcomes of young Black women. SRH is also influenced by different systems, such as the church, family and community. The impact of these systems can shape young Black women's views and norms that are related to SRH. Thus, showing how individual freedoms are shaped by complex systems that influence young Black women's access to SRH. More so, this section also highlighted the impact of policies in safeguarding the SRH needs of young Black women. Ultimately, the chapter illustrated that access to SRH is a crucial element that supports the respect, human rights and dignity of young women.

CHAPTER 3
METHODOLOGY

3.1. INTRODUCTION

This chapter outlines the research procedure that was followed in this research study. The discussion includes a description of the research design that was used in this study. In addition, the chapter discusses the population and sampling, the data collection procedure, and the instruments that were used in carrying out the study. This chapter also highlights the data verification methods, as well as the limitations of the study and reflexivity of the researcher.

3.2. RESEARCH DESIGN

Creswell (2014) defines a research design as a framework that guides the procedures and approaches used in research studies. This study made use of an exploratory descriptive research design (Hunter, Howes and McCallum, 2019). An exploratory descriptive research design is closely associated with qualitative research (Hunter, Howes and McCallum, 2019). Hunter, Howes and McCallum (2019) explain that exploratory descriptive qualitative research is appropriate to explore topics related to healthcare that have largely been disregarded by researchers. Villamin et al. (2024) also agree that descriptive research is used to obtain information on topics that have not often been explored, making it suitable to identify areas needing change. This research design also provides researchers with the flexibility to incorporate different research approaches that permits the research problem to be explored and described (Hunter, Howes and McCallum, 2019). Being descriptive allowed the researcher to describe the research phenomenon in depth from the perspective of the individuals who had experienced it (Villamin et al. 2024). Villamin et al. (2024) allude that a descriptive design also allows researchers to be guided by theoretical frameworks since it can inform the selection of research methods, and how data is collected and analysed. Descriptive research further allows researchers to describe a social phenomenon by collecting data that highlights factors shaping the lives of individuals (Furidha, 2023). This is aligned with the qualitative nature of this research study since “the aim of qualitative research is to gain a comprehensive understanding of the social phenomena in their natural environments” (Ugwu and Eze, 2023:20).

Creswell (2014:32) defines qualitative research as “…an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem....” Muzari, Shava and Shonhiwa (2022) and Alharahsheh and Pius (2020) state that qualitative research is grounded in the interpretivist and constructivist paradigm which prioritises in depth understanding and descriptions that reflect the viewpoint of participants. This paradigm

portrays reality as a subjective experience which is built on individual interpretations and meanings (Muzari et al. 2022). Thus, a qualitative research approach enables researchers to explore the experiences and perceptions of participants through descriptive data obtained by generating information from participants through written or spoken words (Creswell, 2014). This approach is applicable to this research study as it enabled the researcher to make use of interviews as a method of inquiry to explore the research topic from the viewpoint of the participants (Creswell, 2014). Interviews also provided a chance for the researcher to identify themes and patterns in the collected data (Villamin et al. 2024; Furidha, 2023; Lambert and Lambert, 2012). Qualitative research therefore provides the opportunity to study and understand the values, attitude, and beliefs of the participants regarding the research topic (Creswell, 2014). Understanding the different attitudes, feelings, ideas, and perceptions of participants assisted the researcher in describing the SRH reality of young Black Christian women in Cape Town (Creswell, 2014).

Villamin et al. (2024) claim that a descriptive research design is prone to researcher bias which can impact the findings of the research study. However, a descriptive research design allows for the incorporation of elements from other research approaches (Villamin et al., 2024). An element of phenomenological research, namely bracketing was employed in this study to set aside any biases held by the researcher (Ahmed, 2024). This involved the researcher reducing the influence of their assumptions and biases, so that it did not impact the description of the phenomenon under investigation (Umanailo, 2019). The researcher therefore had to cast aside personal prejudices to accurately describe the experiences of the participants and then think about the descriptions in context of the theories that were used in this study (Ho and Limpaecher, 2022). The researcher's reflection on personal biases is fully clarified in section 3.6. Reflexivity.

3.3. POPULATION AND SAMPLING

3.3.1. STUDY POPULATION

De Vos et al. (2005) define a population as the total group from which the participants of a particular study are chosen from. The population for this study included young Black women living in Cape Town. On the other hand, a study population has been defined as a subset of the population (De Vos et al., 2005), from which the sample was drawn (Andrade, 2021). The study population for this research were young Black women living in Cape Town and attending Christian churches in the city.

This study focusses on Christians as Mokhoathi (2017) has identified that Christians are the largest religious group in South Africa. According to Mokhoathi (2017) 85.6% of the population in South Africa identified as Christians in 2013. The youth constituted 70% of the population that identified themselves as followers of Christians norms and values in 2013 (Mokhoathi, 2017). Thus, the focus of this study is on young Black women between the ages of 18 and 35 years who are members or adherents of Christian churches in Cape Town. As highlighted in Chapter 1, this refers to young Black women of African ethnicity and cultural heritage (Awoniyi, 2015). This excludes young Black women categorised as Coloured or Indian. According to Nilsson (2016) the term Coloured refers to individuals with mixed ancestry. Mihesuah (1998) relates the term Indian to an individual with an Indian ancestry. Moreso, this research focused on the women between the ages of 18 and 35. Zuma et al. (2020), Eriksson et al. (2014) and Mokhoathi (2017) identify that women in this age range are at risk of experiencing SRH issues like unwanted pregnancies, STIs as well as other SRH related complications.

The researcher received consent from two different Christian leaders to conduct the research study at their churches. Thus, the participants came from the surrounding areas in Cape Town, such as Strand where Church A is located. The area of Strand is located in the Eastern suburbs of Cape Town. Moreso, some participants of this study also came from the surrounding areas of Blouberg where Church B is located. Blouberg area is located in the Northern suburbs of Cape Town. These churches serve a diverse population which include young Black Christian women. The researcher was aware of Church A as the researcher had briefly attended some of their church services approximately 5 years ago. The researcher felt that there was no conflict of interest in conducting the study in this context as the researcher has not attended this church in the past 5 years, is also not familiar with the church leadership and its members and is not a member of the church. In relation to Church B, the researcher was never a member or adherent of this organisation. The researcher was knowledgeable about this church as it is located in a suburb that is familiar to the researcher. The sample consisted of fifteen young Black Christian women between the ages of 18 and 35 years who attended either Church A or Church B. Mason (2010) states that fifteen participants in qualitative research are sufficient to ensure that enough in-depth data and varying opinions are obtained during the data collection process. Moreover, the sample size is justified as Janighorban et al. (2022) used a comparable sample size of sixteen participants in order to collect rich information in a similar study.

3.3.2. SAMPLING TECHNIQUE

A purposive sampling method was used by the researcher (De Vos et al., 2005). De Vos et al. (2005) define purposive sampling as a type of sampling where the study population is determined by the researcher based on the criteria of the study. Etikan, Musa and Alkassim, (2016) describe purposive sampling as a method used in qualitative studies to gather in depth information by intentionally selecting participants who possess the qualities, knowledge or experience that match the research needs and criteria. In relation to this study the researcher used a purposive sampling method to select a homogenous sample. Etikan et al. (2016) claim that homogenous sampling focuses on participants who share similar characteristics like religion and age.

3.3.3. SAMPLING PROCEDURE

Oppong (2013) describes sampling procedure as the process of selecting the participants who can provide relevant information that informs a research study. The researcher telephonically contacted the church leaders of both Church A and Church B to set a meeting with each one. The researcher had a telephonic meeting with the leader of Church B in which the researcher explained the purpose of the research and criteria of the participants. The researcher was given permission to visit the church and was provided with a contact at the church who helped the researcher to arrange private interview spaces at the organisation. On the other hand, an in-person meeting was held with the leader of Church A where the researcher explained the details of the study and assessed available spaces to conduct the interviews. During each meeting, the researcher explained the study to the church leader and received permission to conduct the research study at the organisation. The researcher further sought written permission from each church leader indicating their consent for the researcher to conduct the study at their respective organisation (Appendix II and Appendix III). An information sheet (Appendix IV) was provided to both church leaders describing the details of the study. A hard copy was provided to the leader at Church A while the researcher provided the leader at Church B with an electronic copy via WhatsApp.

During the meetings held with the church leaders, the researcher enquired about any regular gathering or programme at the churches, like youth groups, that the researcher can attend in order to introduce themselves and to discuss all aspects of the research study with potential participants. The researcher also explained to the church leaders that any person in a leadership position at the church will not be included in this meeting to prevent participants feeling that they are obligated to participate. After a few weeks, the leader of Church A requested that the

researcher attend a Sunday church service where the researcher could engage with potential participants. On the other hand, the leader at Church B asked the researcher to attend a worship team practice as most people fitting the age criteria would be available then. The researcher requested that the church leader of Church B inform all persons leading these practices about the researchers' presence at these meetings.

At both churches, the researcher only spoke to the women fitting the research criteria in a separate room in order to maintain privacy. At Church A the researcher therefore requested that all Black women who met the age criteria to meet in a different space with the researcher. After the researcher introduced themself, explained the study to everyone and allowed for questions to be asked, the women were given an information sheet (Appendix IV) as well as a short form (Appendix V) to indicate if they wanted to participate in the study and if the researcher could contact them at a later date to arrange a face-to-face interview. At both churches participants who refrained from participating in the study were only required to mark one box showing their disinterest, while those who agreed were required to add more details, like their names and contact details. The researcher provided 15 minutes for participants to complete their form. Subsequent to this step, the researcher personally collected the forms from each participant. All the participants were asked not to return the forms to the researcher themselves as those withholding their participation could complete and return the form before those agreeing to engage in the study. Thus, revealing those who consented to participate in the study. This strategy prevented those consenting to participate to be exposed and subsequently strengthened the privacy and anonymity present in this study.

At Church B, when the researcher arrived at the venue, the researcher met with the leader of the worship team. The worship team leader asked women fitting the age criteria of this research study to follow the researcher into a private space. The researcher then introduced themselves, explained the details of the study and provided the potential participants with an information sheet (Appendix IV). The participants were also given time to ask questions if they needed to clarify anything pertaining to the research study. Thereafter, the researcher asked everyone to complete a form (Appendix V) to indicate their willingness to participate in this study and to be contacted by the researcher. Unlike Church A, participants at Church B were not allocated a specific time to complete the form as some women arrived late to the team practise. Those who arrived late were directed by the worship team leader to the room where the researcher was meeting with the other participants. The researcher introduced themselves to those who arrived later and repeated the instructions to complete the form (Appendix V). The researcher

had less time to verbally share details of the study with them, but they were also provided with an information sheet (Appendix IV) and given time to ask questions related to the research study. Everyone personally returned their forms to the researcher when they had finished since participants arrived at different times. It is important to note that there was a short space of time between each participant returning their form to the researcher. This meant that no one was able to distinguish between the participants who had indicated that they wanted to be contacted to participate in this research study and those who had withheld their consent to be contacted for participation. Despite variations in the procedure followed at Church B, those agreeing to participate were only known to the researcher and thus privacy and anonymity were maintained.

At a later time, the researcher telephonically contacted each participant from both Church A and Church B who had agreed to participate in the study to arrange a date and time for an interview. The interviews were conducted at each church in a safe and private space. On days that there was more than one interview, the researcher ensured that the time for each interview was set an hour apart to prevent participants from seeing each other and learning who had consented to participate in the research study.

3.4. DATA COLLECTION

3.4.1. DATA COLLECTION METHODS

In order to facilitate this research, the researcher collected data via in-depth interviews. Rutledge and Hogg (2020) define an in-depth interview as a technique used by qualitative researchers to obtain sufficient data on the experiences of participants about the research topic. In-depth interviews can be done through various ways including face-to-face interaction (Rutledge and Hogg, 2020). This research study made use of face-to-face in-depth interviews, which assisted the researcher and participants to build rapport (Rutledge and Hogg, 2020). In addition, this gave the participants freedom to respond and tune in to the conversation fully and opportunities for the researcher to clarify parts of the details provided. According to Rutledge and Hogg (2020) and Wilson (2012) this technique assists researchers to also take note of non-verbal cues that can portray the participants' experience. Moreover, to encourage a detailed discussion, the researcher used open-ended questions, inductive probing as well as follow-up questions to fully understand the perspectives of the participants (Rutledge and Hogg, 2020). DiCicco-Bloom and Crabtree (2006) have further indicated that open ended questions can lead to the emergence of other questions in the dialogue between the researcher and participant.

The researcher conducted in-person interviews that adhered to a semi-structured interview layout. Semi-structured interviews supported the researcher to generate qualitative data that explored the thoughts, feelings, and perceptions of participants on the research topic (De Vos et al., 2005). De Vos et al. (2005) define semi-structured interviews as interviews that focus on the research topic but also allows flexibility to follow up on details or information given by the participants. These interviews matched the focus and requirements of this study as it allowed the researcher to describe the problem from the viewpoint of the participants through the narration of their own experiences (De Vos et al., 2005). The researcher also created a warm and safe setting which assisted the participants to freely express themselves and to share their experiences (Karnieli-Miller, Strier and Pessach, 2009).

3.4.2. DATA COLLECTION INSTRUMENT

A semi structured interview guide (Appendix VI) was used as a tool for conducting the interview. Turner (2016) notes that a semi structured interview guide contains queries that aim to answer the research questions. In addition, it is constructed with non-leading questions in informal language that makes it easy for participants to understand. Moreover, Jamshed (2014) defines an interview guide as a schematic presentation of questions which the research needs to address. These questions were derived from the main research questions as well as the themes brought up in the literature review. Using a semi structured interview guide ensured that all the participants were asked the same questions, and subsequently made the data obtained comparable (Naz, Gulab and Aslam, 2022).

3.5. DATA ANALYSIS

De Vos et al. (2005) define qualitative data analysis as a process of analysing and bringing meaning to the raw information collected during research so that conclusions can be drawn. This study made use of thematic data analysis. Liamputtong (2009:135) describes thematic data analysis as a method that aids in "identifying, analysing and reporting patterns." In relation to this study, Tesch's 8 stages of analysis were used to analyse the collected data. According to Tesch 1990's stages, (as quoted by Creswell and Creswell, 2018) the first step required the researcher to read all the transcriptions for understanding and to get a sense of the data obtained. The second stage involved understanding the meanings of the interviews. This was done by initially making use of one interview and writing down thoughts that clarified what the underlying meaning of the data was about (Tesch 1990 as quoted by Creswell and Creswell, 2018). In stage three, after going through this process with all the interviews, the researcher made a list of all the topics and placed topics that relate to each other together. In stage four,

the researcher took this list and returned to the data. The researcher then made use of codes that came from abbreviating the topics. These codes were written next to suitable portions of the copy (Tesch, 1990 as quoted by Creswell and Creswell, 2018). In the fifth stage, the researcher used the most descriptive words for the topics and converted them into categories. To minimise the number of categories, the researcher grouped together associated topics. The sixth stage required the researcher to make a final decision on what abbreviations were used for each category and thereafter these codes were alphabetised. The data associated with each category was brought together in one location and the researcher conducted an initial analysis in the seventh stage. If it had been required, the eighth stage would have involved recoding the data (Tesch, 1990 as quoted by Creswell and Creswell, 2018). However, this step was not required in this study.

3.5. DATA VERIFICATION

Creswell (2014) defines data verification as a process of ensuring the study's validity. Creswell (2014) and Avenhaus and Canty (1996) mention that this process is meant to assess if the study is aligned with qualities such as coherence and trustworthiness. Securing coherence meant that the researcher ensured that the research method used, and the research questions contained a sense of alignment (Morse et al., 2002). Ahmed (2024) alludes that it is important to ensure the trustworthiness of qualitative research in order to guarantee the credibility and reliability of the findings. Kasirye (2021) agrees that trustworthiness safeguards the credibility of the study. Ahmed (2024) mentions transferability as a crucial aspect of trustworthiness which refers to how the findings can be applied to other contexts. The researcher therefore ensured that detailed and comprehensive descriptions were provided in order to facilitate transferability (Ahmed 2024). Qualitative research also permits a degree of variability in the findings if a similar study is conducted in the further (Leung, 2015). However, Leung (2015) emphasises that variations in richness and quality is acceptable on condition that the methodological and epistemological strategy always produce results that are similar in different contexts.

In order to test whether the data collected in qualitative research at multiple times is consistent, it has to adhere to the concept of dependability. Ahmed (2024) explains that dependability assumes that findings remain stable over time. Anney (2014:278) also defines dependability as the "the stability of findings over time". This stability is determined by evaluating the research findings and methodology to ensure the consistency of results if the same method or study were repeated (Anney, 2014). To guarantee reliability and dependability of findings, the researcher therefore documented every step of the research process (Anney, 2014). Reliability has been

defined as the extent to which the same results from a study can be yielded if the study was conducted again with the same conditions or methods (Leung, 2015). For this research study, the researcher therefore evaluated the methodology and the results and ensure that both were aligned.

It is also important to ensure confirmability in a research study. Confirmability describes the researcher's attempt to ensure the impartiality and objectivity of the findings by reducing any personal biases that may impact the research findings (Ahmed, 2024). Methods like reflexivity and peer briefing can be used to improve confirmability of the research findings (Ahmed, 2024). Reflexivity assisted the researcher to document their personal biases and to maintain a high degree of objectivity. According to Ahmed (2024), acknowledging personal biases may assist researchers in bracketing them and consequently focus on the voices of participants while collecting, analysing and describing the collected information. According to Chan, Fung and Chien (2013) bracketing entails suspending previously held biases about a phenomenon so that the researcher does not distort the participant's insight and knowledge of the research topic being explored. Ahmed (2024) also suggest that peer debriefing can assist in reducing bias. Conducting this study required the researcher to have supervision sessions with the research supervisor which held a peer debriefing component of seeking feedback on various aspects of the study, including the methodology used and description of the findings. This ensured that the researcher maintained rigor in this qualitative research study (Ahmed, 2024).

Morse et al. (2002) identifies the development of a dynamic relationship between sampling, data collection and analysis as a verification strategy. According to Morse et al. (2002) data verification can ensure that the information that is gathered provides insights into the gaps present in the information that has been obtained in other research studies that relate to the phenomenon explored in this study. In addition, thinking theoretically has also been identified by Morse et al. (2002) as a verification strategy. This involved the researcher justifying the information obtained from the data by using various existing perspectives. Theory development focuses on comparing existing data on the phenomenon with the collected information from participants in this study (Morse et al. 2002). The use of theory also provided the researcher with a stance that informed the questions posed in this research study and which also eventually directed how the data that was gathered and analysed informed the research recommendations (Kasirye, 2021). Kasirye (2021) also suggests that theory allows researchers to gather and organise pertinent data that is significant to review in a research study. Thus, in using these

strategies in this research study, the researcher guaranteed important research elements, such as validity, reliability, and rigor (Morse et al., 2002).

3.6. REFLEXIVITY

Creswell (2014) and Dodgson (2019) define reflexivity as the researcher's examination of their own perceptions and ideas on factors like culture, values, personal background, and how these can influence the direction of their study. To counter this, the researcher reflected on their personal beliefs and ideas (Patnaik, 2013). Patnaik (2013) suggests that self-reflection can aid in understanding how the researchers' own values, beliefs and biases can impact the data analysis process. Self-reflection is seen as an effective tool and an ongoing process that counter the researchers' biases and assumptions and thus retain focus on the research strategy and participants (Patnaik, 2013). The researcher realised that they strongly feel that the church community plays a major role in shaping young women's perception about SRH. Moreover, the researcher also realised that as a young Black Christian woman, sex and SRH related topics are considered taboo discussion subjects in both the church community and family systems that they are located in. The researcher therefore had to consider how this impacted their own perceptions of the research topic so that the study could be formulated and conducted in a manner that prioritised the voices of the participants. Sinfield et al. (2023) agree that the phenomenological element of bracketing supports researchers to set aside their personal biases and preconceptions in order to maintain objectivity. Thus, the researcher entered the data collection process open-minded and created a 'listening space' where participants could feel comfortable to share their actual thoughts and experiences (Sinfield et al., 2023:5). This meant that the researcher collected richer data than expected and therefore it took longer than anticipated to analyse. This prolonged data analysis process caused anxiety for the researcher, but more time was needed to fully describe and analyse the voices of the participants (Sinfield et al., 2023).

Power imbalances could also exist between the participants and researcher. The researcher may be regarded as an authority figure or expert by participants, especially by those younger than the researcher, which can cause them to feel obliged to share detailed information that they may not have been willing to share otherwise (Olmos-Vega et al. 2023; Schelbe et al., 2015). The researcher in this study gave this consideration as younger participants often treat older people as authority figures (Schelbe et al., 2015). To counter the outcome of this potential power dynamics during the process of informing participants of the details of the project, the researcher emphasised that participants do not have to disclose any information that they deem

is too personal or sensitive to share (Wood et al. 2019; Olmos-Vega et al. 2023). More so, rapport was built between the participants and the researcher in order to allow the participants to share their experiences without being silenced and to ensure that participants do not feel judged or intimidated (Sinfield et al., 2023).

3.7. LIMITATIONS OF THE STUDY

This study collected data from women between the ages of 18 and 35 years which left the voices of younger women unrepresented. Therefore, future research can aim to include younger women as Geary et al. (2014) have also identified that the sexual debut of women in South Africa is at approximately 15 years of age. Additionally, the researcher had to meet academic deadlines which restricted the extent to which the research could be conducted. Furthermore, the study only explored the lived experiences of women and left out the perceptions and experiences of the other relevant systems such as healthcare practitioners, community and religious leaders, and family members. Including these elements can assist in identifying further healthcare barriers that restrict the rights and development of women. The researcher also experienced delays in recruiting the targeted population. These delays left no time for the researcher to pilot the interview. On the other hand, Malmqvist et al. (2019) suggest that the significance of piloting may be diminished in small scale exploratory research studies like the one conducted by the researcher. However, it is important to acknowledge that piloting an interview can assist researchers to identify elements that are influential to the research study, such as the effectiveness and relevance of the interview guide (Naz et al. 2022). Although piloting the interview could not be conducted, the researcher still managed to obtain rich data from participants who had knowledge on the research topic.

3.8. CONCLUSION

This chapter discussed the research methodology that allows for an ethical and logical exploration of the topic in question. This chapter showed that an exploratory descriptive design suits this research study since it can yield quality descriptive data which reveals the views and experiences of the participants. More specifically, an exploratory descriptive research design supported the capturing of rich data from participants lived experiences ensuring the research problem is explored and described in depth. The study's limitations, such as the restricted age range of the participants were also acknowledged. Overall, this study's methodology provided a framework for exploring the genuine SRH experiences and perceptions of young Black women in Cape Town.

CHAPTER 4
FINDINGS AND DISCUSSION

4.1. INTRODUCTION

This chapter presents the findings from in-depth interviews conducted with 15 participants and sheds light on the social and religious barriers that impact young Black women's access to SRH. The chapter begins by providing an overview of the demographic profile of the participants and the framework of analysis. The subsequent sections delve into the findings of the research, offering a detailed examination of the ways in which social and religious factors shape young Black women's SRH outcomes.

4.2. PROFILE OF RESPONDENTS

TABLE 1: DEMOGRAPHIC PROFILE OF PARTICIPANTS

Participants	**Age**	**Gender**	**Race**	**Religion**	**Employment Status**	**Marital Status**
Participant 1	22	Female	Black	Christian	Unemployed	Single
Participant 2	25	Female	Black	Christian	Employed	Single
Participant 3	25	Female	Black	Christian	Employed	Single
Participant 4	23	Female	Black	Christian	Unemployed	Single
Participant 5	23	Female	Black	Christian	Student	Single
Participant 6	20	Female	Black	Christian	Unemployed	Single
Participant 7	23	Female	Black	Christian	Unemployed	Single
Participant 8	25	Female	Black	Christian	Employed	Single
Participant 9	25	Female	Black	Christian	Employed	Single
Participant 10	27	Female	Black	Christian	Unemployed	Single
Participant 11	21	Female	Black	Christian	Student	In a relationship
Participant 12	26	Female	Black	Christian	Employed	Single
Participant 13	19	Female	Black	Christian	Employed	Single
Participant 14	24	Female	Black	Christian	Unemployed	Single
Participant 15	28	Female	Black	Christian	Employed	Single

4.3. FRAMEWORK OF ANALYSIS

The table that follows outlines the main themes, categories and sub-categories that arose through the analysis of the data.

TABLE 2: DISCUSSION OF FINDINGS

Research objectives	**Themes**	**Categories**	**Subcategories**
To explore and describe the social barriers that affect young Black women's access to sexual and reproductive healthcare.	Social barriers	Communication	Lack of open family communication and support
		Fear of judgment	Fear of judgment from family members
			Fear of judgment from the community
		Generational differences	Cultural taboos
To explore and describe the religious barriers that affect young Black women's access to sexual and reproductive healthcare.	Religious barriers	Impact of religious doctrine	Sexual abstinence before marriage
		The church environment	Stigma related to accessing contraception
			Lack of SRH discussions in church
		Judgement	Judgment from the church community
To explore and describe the challenges and experiences that affect young	Accessing SRH services and information	Barriers to accessing SRH services	Poor treatment from healthcare professionals

Black women when accessing sexual and reproductive healthcare services and information.			Varied treatment between public and private healthcare institutions
			Privacy and confidentiality concerns
		Sources of SRH information	School-based SRH education
			SRH information from peers
			Digital information sources

4.4. SOCIAL BARRIERS

Research question 1: What are the social barriers that affect young Black women's access to sexual and reproductive healthcare?

4.4.1. COMMUNICATION

4.4.1.1. LACK OF OPEN COMMUNICATION AND SUPPORT FROM THE FAMILY

Most participants described a lack of open communication about sexual and reproductive health within their families as a significant social barrier in relation to SRH.

Participant 12: *"…To be honest, I think negative because there's always a stigma around it. There was once that my mom found my birth control pills and I told her I'm using it for my skin, um, which helped because I had acne at the time, and it was helping for my skin…"*

Participant 7*: "So, it might be different with others, but mine, you just cannot talk about your sexual health at any moment. Um, but of course with my sister we have that open communication. But in overall, it's difficult for me to speak about my struggles when it comes to sexual health. Or even in just like relationship issues in general. So when it, for example, if you have STI and then you then go and tell them that I explained this, it's not really, and there's also I think that stigma in that because it's, it's not an, um, in conversation that you can just start on and it also like label you in some way… you are not being, um, a person*

who is following the norms of the Africans… when it comes to the general family, it's just like you need to focus on your books. You need to graduate. After graduating, that is when you're going to talk about…"

Participant 14: "*…So, because I can't openly ask my mom to take me to like visit a gynae or something like that. Because she will start to think that I'm indulging in sexual activity, which she's not exactly for it so. Because of that I feel like I'd have to do it in secret. Yeah, which is also difficult because I'm dependent on my parents for health care and things like that, so I'd have to find a way to bridge that gap to talk to her about it and to be able to access it…"*

Participant 10: *" Not open. Not very open. Like, I don't remember a day where I've sat with my family, and we spoke about sexual and reproductive health care… I don't know, it just creates fear within me because if I have a problem I can't go to my family. I can't go to my mom and be like, Mom, I have a problem. So, I get scared to, you know, engage in such conversations or initiate such conversations because it's like, let's not talk about it, you know, yeah. It's wrong to talk about this, so, yeah…."*

4.4.1.2. DISCUSSION

The above findings are similar to those of Robinson (2016) that show that there is limited SRH communication within the family, which in turn could make it difficult for young women to seek information and support from their families. The Ecological Systems Theory emphasises the importance of various interactions in all parts of a system in promoting human development (Krebs, 2009; Guy-Evans, 2024; Becvar et al., 2023). The family according to the Ecological Systems Theory is found in the micro level (Guy-Evans, 2024). The interactions and relationships in the family system play a crucial role in the overall development of a human being (Krebs, 2009; Homan, 2016). This is significant as this study's findings show that young Black women experience a lack of adequate familial nurturing and support in relation to SRH. This could expose young women to difficult situations such as unwanted pregnancies, the use of harmful measures to terminate pregnancies, and the use of incorrect SRH related medication, which could possibly have adverse impacts on the body (Godia et al., 2014). This study's results are further supported by Bekele et al. (2022) who found that SRH communication and support is limited as both parents and their children often feel embarrassed to communicate freely about sexuality. Findings in a research study Zou et al. (2022) also show that a lack of

sexual health communication with young people can lead to an increase in unhealthy sexual behaviours. Although positive family support and communication may not be the norm it still plays a crucial role in facilitating better access to sexual and reproductive healthcare for young Black women (Ashcraft and Murray, 2017). Successful family support could provide valuable insights for developing interventions to improve family communication and support around SRH. It becomes important to encourage conversations on topics relating to sexual health in the home in order to promote positive development, healthy relationships as well as to enable young women in making informed decisions in relation to SRH (Ashcraft and Murray, 2017).

4.4.2. FEAR OF JUDGMENT

4.4.2.1. FEAR OF JUDGEMENT FROM FAMILY MEMBERS

Fear of judgment from family members emerged as a significant barrier to accessing SRH. Most participants expressed concern about being judged by their families if it was revealed that they required SRH services.

Participant 3: *"If I would mention to my family I'm seeking reproductive health care, and they'd be like, for what? You're not married… So, I feel like it would be more dismissive than supportive or educational… "*

Participant 12: *"There was a time when my dad told me, my dad is very straightforward, and he doesn't want any negative issues being linked to our family name. He once said that 'if you come home pregnant, in fact, don't come home…"*

Participant 8: *"…they're not really open about it, but like if I go to them asking questions …but it's not something that they will educate. As about, like, it's not something that is spoken about at home… when I was younger, it was kind of difficult, because then, I also felt like I was going to get judged, or they would say something if I asked about, I don't know, sexual health, or, you know. It felt very weird and uncomfortable having to talk about it to my parents…"*

Participant 2: "*… Well, growing up in a Black Christian family, they have this perception that you are not sexually active…it kind of puts you in a space where even if you want to use those services you have to hide that you are using them… like I said that the time that I used it was because the doctor prescribed that I had to, not because I wanted to. So even if, let's say now, I wouldn't go to my family and say that I want to go and use contraceptives. Because they would be like "why? Are you sexually active and I would have to answer all*

of those questions. Ya, I am still a child... I am not comfortable with me sharing the information that I will be using contraceptives because I have to give the reason why. Why am I preventing? So, I am not comfortable because I know that they might judge and ask uncomfortable questions…"

4.4.2.2. DISCUSSION

The responses show that the perception of the family of SRH can contribute to how SRH needs of young Black women are addressed. For example, young women initiating SRH related conversations with their family can experience a lack of support and criticism from their family. The responses from Participants 2, 3, 8 and 12 as shown in the above quotations reflect that their needs are invalidated by their parents. Moreso, the above quotations also show that the fear of being criticised hinders the participants from talking about SRH related topics. On the other hand, young women are also expected to be married before it is acceptable for them seek SRH. Results from studies by Eriksson et al., (2014), Mbotho et al., (2013) and Munakampe, Michelo and Zulu (2021) also indicate that SRH topics are related mostly with married couples, rather than unmarried individuals. It is important to note that a different view is taken at policy level since the NISRHR policy emphasises in Section 6 that the family needs to support all young people and adolescents to access SRH (NDoH, 2020b). Tohit and Haque (2024) point out that family traditions, beliefs and norms could act as a barrier to young Black women's access to SRH. Similarly, participants in a study by Ndugga et al. (2023) explain that fear of punishment, harsh language as well as cultural norms can cause young people to shy away from having SRH conversations as they avoid being judged for their SRH related decisions. Thus, there is a great need to raise awareness and education around the topic in order eliminate misconception and stigma around SRH. This can ultimately reduce judgmental attitudes that can hinder young Black women from making informed SRH related choices.

4.4.2.3. FEAR OF JUDGEMENT FROM THE COMMUNITY

The narratives below reveal community judgment as a significant barrier to accessing SRH. Most participants described feeling stigmatised within their communities when seeking healthcare services.

Participant 1: *"…like people always have to hide the fact that they are going to get help, or that they don't know how to go and get information. The stigma around it… that if you go there suddenly you are sleeping around. That's just how it is in a lot of African communities, suddenly, we want to know, because you want to know, what is the pill, what*

contraceptives are, because you're curious, suddenly, you are sleeping around you're doing this and this with boys…"

Participant 3: *"...At least I'm not in my hometown. At least I don't have to bump into people from church. Like if I ever want to get like sexual reproductive health stuff, I can easily go to the store and get it because I know I won't bump into anyone."*

Participant 12: *"…You know, specifically Black women, I feel like it is more difficult for them emotionally. I mean, you know, the, um, how can I say, the act of actually getting the contraceptives or health care, that's fine. The doctor's not gonna judge you, but if you're sitting there in the waiting room, there's a section for, you know, a family planning. What is a Black girl with no ring on her finger doing sitting there, you know? Um, so that is quite difficult. Um, for me, I've never really sat at the family planning. I would go to a pharmacy instead. Because for all you know, I could be getting Allergex...."*

4.4.2.4. DISCUSSION

These findings underscore the role of community judgement in hindering young Black women's access to SRH. Hall et al. (2018) similarly report that Black women's experiences of reproductive healthcare are often shaped by community norms. The responses show that the community beliefs surrounding sex and SRH can perpetuate community judgement. Community judgement can further silence young Black women as participants in a study by Holtman, Bimerew and Mthimunye (2024) reveal that community stigma can lead young women to conceal their SRH needs. The participants' narratives in this study reinforce these findings, illustrating that community judgement can perpetuate stigma and silence around SRH. This is further supported by Maeko (2024) who explains that community judgement can also lead to ignorance and fear amongst young people regarding the importance of prioritising SRH which in turn affects youth SRH outcomes. Therefore, it becomes important to address community prejudices and biases in relation to SRH in order for women to access SRH without any fear of judgment.

4.4.3. GENERATIONAL DIFFERENCES

4.4.3.1. CULTURAL TABOOS

The narratives below reveal that cultural taboos pose a significant barrier to finding support and guidance about SRH. Most participants expressed that it is not the norm to speak about SRH with older generations.

Participant 15: "**…***I think culturally, looking at like the cultural Black family and now giving them the Black family, family stereotype, I think we are still a bit behind because information, um, especially with the older generation, such things were frowned upon. You cannot come to your parents and talk about sex. Why are you engaging in sex?... like, the boy talk was like stay away from boys and that was that. Now that I am of age, she's expecting me to be so free to talk about boyfriends or to like, when are you having a child? I'm like, woman… I would, um, I would, I would encourage, um, like, the elderly or to, um, to support us as youngsters. When we say we're active, or when we say we want to get ourself tested…, normally we get chucked out or we get chased away, but I would encourage actually elderly, because they're more experienced than what we are…"*

Participant 2: *"You know how when you're in a Black household, this is something that is very taboo. They don't speak about these things. Um, you kind of have to go out there and try and figure it out yourself…"*

Participant 7: *"I think also with them, cause there's generational gaps...Things, those things that we are being experienced to, they never experienced it…because they know that if their father or someone is going to find that out, they're going to be very mad at them. So, um, because their teachings are more autocratic, it's like, I don't want to hear what you will say, just that's the norm, that's what you have to do, and that's the end of the story. So, it just, um, to some extent, because we are Africans, we want to do that norm of like, you do sex after marriage, and you get married. But in this generation, they are more open minded, and they watch this thing, for example, before even reaching high school, they have phones, they have access to pornography, and all those things. So, it's, we need to educate them more than just like, this is bad…"*

Participant 4: *"… it's not a topic that older people like my sister who's 40 something and my mom who is 60 something, we get to talk about it. Just sit and talk about sex. No, because it's not age appropriate. I can talk to my sister's kids about it because our age is not that big. But then my other sister cannot be talking to me or my mom about those things unless she's married…"*

4.4.3.2. DISCUSSION

From the above responses from the participants, it is clear that cultural taboos negatively impact young women from getting adequate SRH support from their family, especially from the older family members. The narratives are aligned with findings by Coast et al. (2019) that show that

young Black women communicating about their SRH needs has not been normalised across all generations as certain aspects of SRH are regarded as taboo or culturally inappropriate. Nevertheless, this research study's findings do not correspond with the research outcomes of a study by Moodley et al.'s (2014) that suggest that young women are able to access social support from their grandparents and broader family network. The quotations from Participants 2, 4, 7 and 15 explicitly show that talking about SRH with older people is not widely acceptable. The participants in this research study emphasise that cultural norms related to sex and SRH in Black households can cause young women to feel stigmatised and embarrassed when they raise the topic in their family. Gondwe (2024) also echoes these findings as he describes that such cultural norms can foster shame and ultimately discourage open discussions about SRH topics thus impacting SRH related outcomes of young women. More so, this can cause young Black women to delay accessing SRH related services (Tohit and Haque, 2024). Therefore, there is a need for dialogue and educational sessions to be conducted with older generations so that they can understand and support the SRH needs of younger generation.

4.5. RELIGIOUS BARRIERS

Research Question 2: What are the religious barriers that affect young Black women's access to sexual and reproductive healthcare?

4.5.1. IMPACT OF RELIGIOUS DOCTRINE

4.5.1.1. SEXUAL ABSTINENCE BEFORE MARRIAGE

Most participants agreed that religion is a significant factor in shaping young Black women's beliefs about sexual and reproductive healthcare. The "no sex before marriage" doctrine emerged as a dominant religious influence for most participants. The narratives below reveal that religious doctrines and beliefs, like sexual abstinence before marriage, can generate internal conflicts for young women attempting to navigate their health needs within religious frameworks.

> **Participant 3:** *"It's a whole thing of, like, just don't have sex until you get to, until you're married. Like no sex before marriage. Is a very strong belief of that in Christianity, especially in Catholicism… So now if I'm, if I'm not married, I can't engage in sex. so, now I don't have to engage in sex at all. That whole idea, I don't think it's fair on the people who do not want to get married. Like, I can engage in sex and still not want to get married, you know. Or I can have kids and still not be married, you know. What if I want to have sex with a lot of partners? Like it's very limiting. Yeah, and it's not accommodative to everyone…"*

Participant 10: *"The conflicts would be more that I'm a sinner, you know? If I have sex outside of wedlock, I would need to take contraceptives, whether it be, condoms or auto contraceptives. Um, I'm not on that anymore, so condoms would be a thing. Um, but in religion. So firstly, as a Christian, and as someone that grew up in a Christian home...God, made sex to be for a man and a woman who is married. So that would be the definite conflict in there…"*

Participant 11: *"Based on our religion, um, and Christianity, we obviously have the idea, the ideology of, um, practicing safe sex, but also that being going with no sex before marriage. So, it does shape my understanding of what, what is the point of getting that sexual reproductive health care if I need to wait until I'm married..."*

4.5.1.2. DISCUSSION

These findings suggest that the 'no sex before marriage' doctrine could reinforce stigma around premarital sex. More so, it can also suppress young Black woman's rights to access SRH services (Tohit and Haque, 2024; Mbotho et al., 2013). According to Gondwe (2024) religious factors can hinder women from accessing comprehensive SRH services. Gondwe (2024) suggests that the assumption that everyone will conform to this doctrine causes Christians who do not conformed to this religious principle to feel uncomfortable about accessing SRH related services. The response from Participant 3 shows that they feel that the doctrine is 'unfair and limiting' to those that do not want to get married as it prohibits the engagements in sexual activities before marriage. This has also been supported by Gondwe (2024) and Tohit and Haque (2024) who claim that this doctrine can limit young women from accessing SRH related education and information. Participant 11 highlights that the doctrine protects individuals from unsafe sexual activity. However, this particular quotation also shows that the doctrine has shaped their willingness to seek SRH. Farahani (2020) also supports that the abstinence before marriage doctrine can aid in promoting positive SRH outcomes for young people. It can reduce the risk of contracting STIs and encourage prioritising commitment in sexual relationships. Despite this argument, Eriksson et al. (2013) note that one cannot ignore the fact that the doctrine fails to address the reality and challenges that young Black religious women could be facing, thus leaving them vulnerable to STIs, unwanted pregnancies and other SRH risks. It therefore becomes important to initiate dialogues that help to educate church leaders on the importance of SRH discussions in the church and to bridge the gap between religion and SRH related needs.

4.5.2. THE CHURCH ENVIRONMENT

4.5.2.1. STIGMA RELATED TO ACCESSING CONTRACEPTION.

The responses below show that there is a conflict between religious teaching and practical healthcare needs. Most participants felt that the church often frowns on young Christian women using contraception especially if they are unmarried.

Participant 13: *"I do know that they say in our religion...if you do go on contraceptives, it's a sin to your religion, because you don't know where the blood goes…If I have to go on my healthcare journey, it's going to benefit me at the end of the day. But it'll fix me in the long run. because church wise, they don't motivate you to do that..."*

Participant 12: *"…Because it's like once you take it, then you're sexually active. Nobody is going to take a pill if they're not sexually active. There's no sperm going into you, you know? If it's a married person, they would definitely encourage it… I feel like once you're married, all of the ladies of the church are going to flock to you and tell you all of the information...So I think in that sense, if you're married, it will be very much encouraged but for some of us if you're married, it will be very much suffocatingly encouraged."*

Participant 15: *"...you'll find that this woman is giving birth to six children or seven kids, because, hey… there are certain people who do believe even in, in the Christian community, that family planning is a no-no. Why are you using contraceptives? God says, God said, be fruitful and multiply…So in that space, even for their married people. Contraceptives might be looked down upon, so they do not have access to such, and they are not going to use such…"*

4.5.2.2. DISCUSSION

The responses above highlight that the church does not motivate young single Black women to feel that they can access contraception. Holtman et al. (2024) also found similar results in their study, as most of their participants confirmed that SRH related topics were mainly posed for married individuals. Research studies by Hall et al. (2018) and Gondwe (2024) also found that the church creates significant barriers to SRH access for young Black women. It often forces them to choose between their religious beliefs and their healthcare needs (Hall et al., 2018; Gondwe, 2024). More so, through the lens of Amartya Sen's Capabilities Approach, these religious influences not only limit an individual's freedom to make choices about their own bodies and health, but it also undermines their ability to achieve their functionings and wellbeing (Sen 2000). According to Lorimer, Greco, and Lorgelly (2023) the Capabilities

Approach directs its focus on how resources are made available to individuals and how they actually use these resources to achieve their goals. Lorimer et al. (2023) allude that the Capabilities Approach concentrates on empowering individuals to achieve their full potential. In the quotations presented in this section, Participants 12, 13 and 15 highlight that Christian religious norms stigmatise the use of contraceptive methods which indirectly then dictates how young Black women can take charge of their SRH needs. The lack of the support from the church in relation to contraception could lead young women to delay healthcare seeking, and experience distress in attempting to maintain both their religious identity and their healthcare needs. On the other hand, the Capabilities Approach emphasises the importance of creating an environment in which individuals have the capability to make decisions about their SRH (Sprague, 2009). Ultimately, the responses from young Black women provided in this section show that young Black women's capabilities are impacted which limits the way they function or take charge of their own growth, needs and development.

4.5.2.3. LACK OF SRH DISCUSSIONS IN CHURCH

The responses below indicate that the majority of participants felt there is a lack of space for SRH discussions within the church environment. The church is not perceived as a system where young Black women can access SRH information or support.

> **Participant 10:** *"...It's like the last place you want to talk about sexual and reproductive health care because it's a church, you know, everything has to be pure and it's against the norm. Yeah… And, you know, we don't talk about such things. Those, those conversations are only for behind closed doors, even behind closed doors. We don't engage in that… if you go to your pastor now, your priest, and you have a problem, let's say a sexual and reproductive problem, you can't go to your pastor and be like, I need help, you know. You'll be scared because it's your pastor, they don't really make it easy for us to talk about it or to ask for assistance, you know, cause it's Christians, we're pure, even engaging in sex, you have to wait up until you're married to engage in stuff like that."*

> **Participant 7:** *"I don't think they talk about it. I've never really been in a space, at church where they talk about sexual and reproductive healthcare. Like it's not something that they teach us, especially in Sunday school…* "

> **Participant 15:** "*...But also then the boundary comes on saying we are a church, and we only preach abstinence. So, anything beyond that barrier. You're not going to get that much of help or information because at the end of the day we're in a church setting…"*

4.5.2.4. DISCUSSION

The quotations from Participants 7 and 11 convey that the church is not regarded as an environment for discussing SRH related issues. Participant 15 also highlights that church discussions about SRH only include teachings related to abstinence. SRH discussions in church are therefore mostly focused on the adherence to the customs and traditions of the church even when it restricts open dialogue about female healthcare. A study by Gondwe (2024) similarly found that discussions that are considered to be impure are avoided in church settings. This could cause young Black women to feel stigmatised who want to explore the topic or silence young Black women who are socialised in the church (Erasmus et al., 2020). More so, a research study by Powell et al. (2017) found that church leaders fear that addressing SRH related topics in church might be opposed by church members. The findings suggest a need for interventions that can help churches develop more supportive environments while maintaining their religious principles. This will assist in developing spaces where the diversity of human choices is recognised when it comes to SRH related needs whilst also respecting religious beliefs and values (Tohit and Haque, 2024). For example, government bodies like the NDoH could offer SRH programmes and interventions that provide skills, information, and approaches to religious institutions (NDoH, 2024). This will thus promote human development by allowing young Black women to achieve their functionings and capabilities (Kuhumba, 2018).

4.5.3. JUDGEMENT

4.5.3.1. JUDGMENT FROM THE CHURCH COMMUNITY

Most participants reported that young woman could expect to be judged by the church community for their SRH needs and decisions.

> **Participant 12:** *"You know, as a female, if I have had...a yeast infection. At the time, yes, I was sexually active, but as I've learned from my research, yeast infections happen because of a pH imbalance, not because it's an STI. However, I feel like people who are misinformed and judgmental in the church would say, oh, you slept with a guy, you let a penis inside of you, and this is your punishment..."*

> **Participant 4:** *"...You are not allowed to explore your sexuality because religion doesn't allow you. And of which, what does religion have to do with a person? I'm going to church only because I believe that God is there, and I need to talk about those things of God. Now that you're judging me as a person, if the Bible actually says that, if you have not sinned*

throw the first stone, why is it that religion is depriving those young Black women to express themselves… Because going back to the word of judgmental, those old women in church, they'll still come for you when it comes to talking about the sex. You can't go to church and be like, oh, today we're going to talk about sex. And they'll look at you be like, what? Why are we talking about this? And things like that. And I feel like church is not a safe space to talk about these things…"

Participant 8: *"…because it's something that is considered to be immoral in the religious or Christianity, let me say. Um. So, you really don't wanna, feel judged if this is something that you want to speak about or like you ask questions related to sexual reproductive, um, health care. So, they tend… young religious people, they tend not to then ask for any help…"*

Participant 5: *"…being a woman, being woman and Black, then being young, Black and a woman there. There's so many limitations, there's so many judgments that come along with the decisions you make, and I think the Church is very discouraging…"*

Participant 13: "…*it says in the Bible that we can't have intercourse before marriage. So, um, for us, it does affect us. It's a sin yes. Okay. So, for us, it's a sin firstly secondly, we also as young, as young Black females, we face judgment in the church when we normally come on pregnant, if we had no contraceptives, and we come pregnant, we face judgment. So then at the time, at a time when you hear people say, you know, I don't want to go to church anymore. So, you're not going to want to come to youth, you're not going to want to do anything in the church…"*

4.5.3.2. DISCUSSION

The statements above show that young Black women feel that church members will judge them if they openly explore or express their SRH interests and needs. These findings are reflective of results from a research study by Clucas (2017). Those results show that participants perceive the church as an unsafe space to discuss SRH related issues as they felt judged or condemned for seeking SRH support from the church (Clucas, 2017). A study by Gondwe (2024) similarly found that the church stands in the way of young Black women's personal autonomy on matters relating to SRH. The responses from participants in this research study show that judgement from the church community can silence, discourage, and shame young Black women for their SRH decisions and needs. Similarly, findings from a study by Narker (2022) found that women avoided seeking SRH related services as they felt ashamed and feared being judged, rejected, and labelled by the church community. This undermines the goals of the NISRHR policy

(NDoH, 2020b) which tries to support the autonomy of every individual in relation to their SRH choices. Thus, it becomes important to promote inclusive and supportive spaces in the church by educating the church community about the importance of SRH so as to eliminate young women experiencing stigma and judgement for their SRH needs.

4.6. ACCESSING SRH SERVICES AND INFORMATION

Research question 3: What are the challenges and experiences that affect young Black women when accessing sexual and reproductive healthcare services and information?

4.6.1. BARRIERS TO ACCESSING SRH.

4.6.1.1. POOR TREATMENT FROM HEALTHCARE PROFESSIONALS

The narratives below reveal that poor treatment from healthcare providers represent a significant barrier to accessing SRH support. Most participants described experiences of judgment and insensitivity from healthcare providers.

> **Participant 10:** *"...So, for contraceptives, ... they're going to ask you, why do you want contraceptives instead of like, helping you, like, these are the best contraceptives that we have, or this one might help you. Instead, they'll just judge you because you use contraceptives, it's like you're engaging in sex. If you're on contraceptives and you're engaging in sex, then why are you engaging in sex? You know, and if you want treatment, like HIV treatment, even people like now, they end up relapsing because they're scared to go to the clinic and get HIV treatment or TB treatment or treatment for STIs because, you know, they will get judged for that and instead they just end up not doing anything about it and the sickness becomes worse and, you know, they put their lives in danger. So that's the challenge that we have, that we're scared to access. I mean, the healthcare is there, but we're scared to go and access it ..."*

> **Participant 11:** *"It mainly depends on the type of hospital or clinic you're going to and the doctor that you are speaking to. Because some doctors have a bad attitude towards younger females...Whereas if it's someone out of their teens or someone 18 and older, then they have a more positive response...I was in the hospital for some health issues. And the first thing that the doctor asked me was, are you pregnant? And then he was like, okay, I'm going to test you anyway. We're going to take a test anyway...he didn't really care what I was telling him..."*

> **Participant 9:** *"... definitely think that the attitudes need to be changed. Um, they definitely need to separate personal feelings and agendas. It's a professional space and, uh, clients*

are there to be in a safe space as well. So, I think it's important for that because the dialogue can change really quickly from someone that's coming to seek contraceptives, and then at the end of the day, it might be a rape victim. So, I think it's very important and, um, a lot of our healthcare workers need to separate themselves from seeing themselves as elders to the clients. And not everyone needs that at that time. Yeah."

Participant 15: *"… Their attitude also comes from how they were raised. Like, they're also drawing the line between what is my belief and what is my profession…Cause some of them would probably be Christian and the only thing they know is that there is no need for sex before marriage. And in the end, they bring that mindset and be like, okay, I'm not going to give a, any young person a contraceptive because they're not even supposed to be having sex in the first place. So, the first thing they do is like. Why are you having sex? Why? You're a young person…like I might have been raped or something like that and I'm not ready to go report it, but then I come to you and be like, can I please get an emergency pill? Because I'm trying to prevent me getting pregnant. …"*

Participant 2: *"...If you have to answer 10,000 questions before you get a morning after pill, I would rather just fall pregnant and deal with it then..."*

4.6.1.2. DISCUSSION

The statements above show that judgement and the lack of sensitivity of healthcare professionals towards young Black women are significant concerns for most participants. The quotations from Participant 10 and Participant 2 explicitly show that young Black women feel scared to receive SRH treatment due to the poor treatments from healthcare providers. Studies by Lewis et al. (2016) and Pillay et al. (2020) also found that women felt that they were not valued by healthcare providers which made them shy away from getting further assistance. Mnisi (2021) also suggests that young Black women could risk unintended pregnancies rather than endure the scrutiny and humiliation from healthcare providers. The responses in this study also show that healthcare professionals tend to moralise the concept of SRH which then affects young women seeking SRH assistance. This is supported by Müller et al. (2016), who highlight that some healthcare providers can use their personal values and personal considerations to inform their practice. Müller et al. (2016:74) highlight that nurses often diminish their basic nursing responsibilities by moralising and trying to rescue patients. This can cause women to feel stigmatised and judged when trying to access SRH services (Müller et al., 2016). Ivanova, Rai and Kemigisha (2018) and Heron and Eisma (2021) highlight that poor treatment and

judgement experienced by young women when accessing SRH related services can lead them to refrain from reporting abuse. The increased susceptibility of adolescent girls and young women to sexual abuse highlights the importance of creating supportive environments which can encourage them to seek related SRH services (Holtman et al. 2024; Delany-Moretlwe et al., 2015).

4.6.1.3. VARIED TREATMENT BETWEEN PUBLIC AND PRIVATE HEALTHCARE INSTITUTIONS

The responses below provided by the majority of participants reveal that the treatment from healthcare providers in public healthcare institutions is perceived to be different than treatment in private healthcare settings.

> **Participant 8:** *"… Um, going back to the story of public health clinics where the nurses are not as open about these things or like, they just act very strange towards you when you're seeking that kind of help especially as a young person when you go seek that kind of help or like they act some type of way towards you… there's this thing with accessing public healthcare facilities, there's this stigma that, um, the people working there are not nice or not professional…"*

> **Participant 7:** *"I do not really have so much trouble with this because I have the medical aid although this year, I only had three times to go get assisted by a private doctor, so I ended up going to the public hospital. Of which if you go to a public hospital, you spend the whole day being there. And it also constraints with my time… I can't be spending the whole day in the line. So that is why, some people may end up not actually going there… Because the treatment is different. But for me, when I go to my private doctor, you know, it's like, you just have a headache, they will treat you the same. But if it's a public… they are kind of harsh, and you know, they will like to diagnose you, your treatment, they will not view you in like, you have a headache. Like, oh, this girl, you just see the facial expression..."*

> **Participant 3:** *"…, I've been fortunate enough to have a doctor that's quite supportive and doesn't have to shame people for their choices or anything… it seems from the conversations I've had with friends, that is not always the case for everyone. And the experience also differs from the private sector to the public sector. So, I only have experience with the private sector, which is quite good. I haven't had much experience with the public sector…"*

4.6.1.4. DISCUSSION

The findings indicate that negative treatment from healthcare professionals in public healthcare institutions could affect younger women more than women using private healthcare providers. Participant 7 highlights that the 'facial expressions' of public healthcare professionals can make young Black women uncomfortable when seeking SRH. Negative treatment and attitudes that are held by healthcare professionals can have significant consequences on younger women's SRH outcomes (Jonas et al. 2017). This could raise the prevalence of STIs, maternal mortality and reliance on unsafe methods of abortion as well as increase the risk of unwanted pregnancies (Jonas et al. 2017). This is a result of young women losing confidence and trust in the healthcare system due to the negative behaviours from healthcare professionals (Maeko, 2024). More so, this can lead to feelings of embarrassment and shame as highlighted by Participant 3 and 8, which can cause women to delay taking immediate action to address their SRH concerns (Jonas et al., 2018; Maeko, 2024). The above quotation from Participant 7 also highlights the impact of long waiting times when accessing SRH. Long waiting times to receive help and the insensitive treatment of patients by healthcare workers in public health centres, can be a result of a lack of adequate resources and healthcare staff (Aikman, 2019; Mbarushimana et al., 2022). According to Aikman (2019) and Mbarushimana et al. (2022) these factors can impact the healthcare services that are rendered to individuals. There is thus a need for interventions that are focused on improving healthcare provider attitudes and sensitivity, particularly in public healthcare settings. According to Aikman (2019) and Maeko (2016) there is also a need to increase funding to public healthcare institutions in order to improve the services that they provide. This will help to ensure that healthcare facilities are sufficiently staffed and resourced (Aikman, 2019). Tohit and Haque (2024) also suggest that there is a need to mainstream healthcare centres so that they can offer standardised services with well trained professionals.

4.6.1.5. PRIVACY AND CONFIDENTIALITY CONCERNS

The narratives below voiced by the majority of participants show that young Black women experience a lack of privacy and confidentiality when seeking SRH services. Their experiences highlight a lack of trust in healthcare providers stemming from concerns about confidentiality breaches.

> **Participant 13**: "*... it affects us big time if I have to put it in that way. It's something else because, because even if you walk into the hospital…, um, for example, we're going now for*

a test, pregnancy test, whatever it is. We sit in there, but we know people are watching us and they're obviously speaking, which is mos now judgment, but it does affect us big time...."

Participant 10: "*Especially like your local clinic, since the nurses know your parents, they know your family. So, if you go there and you say you want contraceptives, it's like they'll tell your parents... I don't have to think twice and be like, Yoh, so and so's mother works there. She's a nurse there. Oh, if I go there, she's going to tell my mom. And, you know, there's no confidentiality. There's no privacy. You know, I mean, I don't want to go somewhere, and I know that my parents will know about it. You know, it should be private. It should be, like. It should be very easy for me to access that…"*

Participant 6: *"There's no privacy anymore. There's no, patient, doctor confidentiality…If I go there, she's going to tell my mom and ask her why I came for a service like that, and then there's no confidentiality. There's no privacy."*

4.6.1.6. DISCUSSION

The above responses show that young Black women are concerned about a lack of privacy and confidentiality in healthcare centres. Young Black women also feel scrutinised and judged by healthcare providers as well as other patients, which can lead to feelings of discomfort (Chilinda et al., 2014; Omollo et al. 2022). In addition, confidentiality breaches in community-based healthcare facilities may even be more pronounced than in private healthcare organisations. Thus, there is a real fear from young Black women in this study, which was particularly highlighted by Participant 10 and Participant 6, that healthcare providers may disclose sensitive information to their parents and other family members. These findings are supported by the research study outcomes of Maeko (2024) and Holtman (2024) which highlight that young Black women lack trust in healthcare providers because of their weak management of privacy and confidentiality. A study by Omollo et al. (2022) also found that a lack of trust between the patient and the healthcare provider can cause the patient to feel too uncomfortable to fully disclose their health challenges. This can impact their ability to make informed decisions about their own health (Omollo et al., 2022). It therefore becomes important to address the limited privacy and confidentiality in healthcare settings, particularly in public facilities as this can lead to increased vulnerability and poor health outcomes amongst young Black women.

4.6.2. SOURCES OF SRH INFORMATION

4.6.2.1. SCHOOL-BASED EDUCATION

The majority of participants believed that schools play a major role in providing sexual health education.

> **Participant 6:** *" …I think that should start in school already. Uh, that should be part of, I'm not even sure if they do, they like inform girls about that in school. Cause I didn't go to like a public school, so we had a different curriculum. They had the whole, um, sex talk to us and they educated us on like the whole, like using contraception and all that. But I don't know, like other schools…"*

> **Participant 3:** *"…And then school plays a pivotal role because that's where a child spends most of their time of their day. Um, if it's introduced into life skills, life orientation type of subjects, um, it's a place where it's a healthy environment to learn about it and just different broader definitions as well..."*

> **Participant 11:** *"…It's good if schools also has stuff like that available. It's good if every university or college has something like that available. So that females always have a place to go to. So that, again, they don't have to sit in a two-hour line at the clinic to speak to someone at family planning…"*

4.6.2.2. DISCUSSION

The statements above emphasise the role played by school in the development and growth of human beings (Batra, 2013; Riley, 2019). The responses from Participant 6 and Participant 3 highlight that schools can be an appropriate source of gaining age appropriate SRH related information. Thus, areas like self-esteem, exploration of close relationships and age-appropriate SRH information to develop healthy attitudes and behaviours are essential in promoting SRH in schools (Njenga, 2019; Aibangbee et al., 2024). However, Obach et al. (2022) found that there is limited SRH provision in schools due to notions that the exposure to such information could promote sexual activity. Moreso, Robeyns (2003) highlights that a lack of information can impact the functionings of an individual and suggests that school based SRH related education is essential as it promotes SRH related freedoms, opportunities, as well as civil rights (Sprague, 2009). More so, the Department of Social Development (DSD) can also make professionals like social workers available to provide SRH related information in school in order to raise awareness around the topic. SRH information and knowledge should however be present and strengthened in both primary and secondary schools as it plays a critical

role in providing young Black women with accurate and comprehensive information (Njenga, 2019; WHO, 2009).

4.6.2.3. SRH INFORMATION FROM PEERS

The responses below reveal that peers serve as a primary source of information about SRH to young Black women. Most participants described information from their peers as unique and valuable as it is grounded in shared experiences and social contexts.

> **Participant 12:** *"...My peers? Yoh, actually I've learned more from them and their experiences than from like Google. Or a doctor or something because, you know, you go to the doctor, you get your prescription...but for my friends, they will tell me, oh, the pill made me gain weight or lose weight...*"

> **Participant 8:** *"It kind of made me confident in my sexual and reproductive health because then I know I'm not alone...I could talk to them about it, whereas I couldn't like speak to my parents about it..."*

> **Participant 9:** *"…if I look at my own experience, I had my friends, we made it an open dialogue, and your friends are your first people that you listen to first when you're growing up. You feel very encouraged by them and influenced by them as well. So definitely dialogues that start in your smaller groups…"*

> **Participant 15:** *"…Cause, well, simply because, there are certain spaces where you do have one on one with women. If it's going to be with the older generation, ehhh. But when we are in youth settings, and we discuss the things that we face, because as young people, which I can say, that becomes a peer-to-peer situation, then it is easier to talk about such things…"*

4.6.2.4. DISCUSSION

These narratives highlight that peer networks can provide a sense of community and connection in navigating the complexities of SRH. A study by Hall et al. (2018) also found that sharing SRH related experiences, advice, and support with peers helps to mitigate feelings of shame and judgement. Moreover, Govender et al. (2019) and Mbarushimana et al. (2022) support that peers facilitate young women to make informed decisions about their health and wellbeing. From the responses in this study, it is evident that peers play a critical role in fostering a sense of community, connection, and empowerment among young women navigating the complexities of SRH. However, Tohit and Haque (2024) suggest that information from peers can also perpetuate misinformation and myths. It may therefore be valuable for organisations

promoting and supporting positive SRH outcomes, public health or social development to collaborate and develop interventions like community workshops that can leverage existing information networks while improving the quality and reliability of information shared through these channels (Zhou et al., 2018; WHO, 2009b).

4.6.2.5. DIGITAL INFORMATION SOURCES

Most participants agreed that the internet and social media are significant sources of SRH information for young Black women.

> **Participant 13:** *"...Normally, I just go to Google and if I want to like know something, like for example, I had this issue now recently when um, I pee, and then it starts to burn...I went to go search..."*

> **Participant 10:** *"...they are helpful. Like they're very helpful. I mean, every time I have a problem I go straight to Google, and I Google the symptoms and what I can take and how I can like prevent something or how I can help to mitigate something. So yeah, like they've been very helpful…"*

> **Participant 14***: "… So I access YouTube… there are lots of doctors online who give advice. I listen to some podcasts…there's some podcasts on like Spotify and on YouTube as well where people have like doctors that specialise in sexual reproductive health care for women, for Black women in particular…"*

4.6.2.6. DISCUSSION

The narratives above suggest that the internet has become a major source of SRH information to young Black women. The internet offers women anonymity and convenience of online searches over traditional sources of information like family members and healthcare providers. Participants in a study by Ochieng (2023) also indicated the use of social media platforms like TikTok and YouTube, to obtain SRH related information. However, while findings indicate that these digital sources provide valuable knowledge, there are concerns about information accuracy and completeness (Martin, 2017). Farahani (2020) also supports that the exposure to media can influence young people's choices of role models in sexual health and behaviour that are inappropriate. This can lead young people into making risky SRH behaviours and decisions (Farahani, 2020). Therefore, it is important that the options like user reporting and online community guidelines on these online platforms receive ongoing monitoring in order to ensure that information on these platforms is clear and accurate (Martin, 2017). More so, the NDoH

can also launch digital initiatives to provide access to online information that is accurate and up to date.

4.7. CONCLUSION

This chapter presented the research findings and discussions of the outcomes. The findings highlight that there are various factors that challenge young Black women's access to SRH. These barriers are present on the family, religious and community level. The participants revealed that they experienced a lack of open communication about SRH with older family members, as well as judgement within their communities and church for their SRH needs and decisions. Young Black Christian women are therefore likely to feel ashamed when trying to access SRH. In addition, the study highlighted disparities in treatment between public and private healthcare facilities. On the other hand, peer networks, schools and the internet play significant roles in providing young women with access to SRH knowledge, awareness and support. The findings show that women's SRH rights must be supported and respected in various spheres for them to have comprehensive access to SRH services and information.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5. INTRODUCTION

This chapter presents conclusions drawn from the findings of the study. The chapter provides recommendations for families, the church, healthcare providers and policymakers to address the identified SRH barriers from the previous chapter and to improve the sexual and reproductive outcomes of young Black women.

5.1. MAIN CONCLUSIONS BASED ON THE RESEARCH OBJECTIVES.

5.1.1. TO EXPLORE AND DESCRIBE THE SOCIAL BARRIERS THAT AFFECT YOUNG BLACK WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE.

Various social barriers have been noted by participants in this study that contribute to restricting young Black women's access to SRH. The majority of participants agreed that limited family communication about SRH hinders young women's ability to seek SRH information and support. Zuma et al. (2020) also highlight that inadequate SRH information can hinder young women from making informed SRH decisions. This lack of communication and support can expose young women to difficult situations, including unwanted pregnancies, unsafe abortion practices, and uninformed use of sexual and reproductive health-related medication (Godia et al., 2014; Levandowski et al., 2012). On the other hand, positive family support can play a crucial role in facilitating better access to SRH for young Black women (Holtman et al., 2024).

In addition, the fear of judgment from family members and the community, as well as cultural taboos have been presented by participants as barriers to open communication and access to SRH. Young women face feelings of shame, guilt, and anxiety from being judged, punished, or ostracised by their families and communities (Jonas et al., 2018; Erasmus et al., 2020). With regards to taboos, most participants in this research study also explained that it is difficult to initiate SRH discussions in Black families and with older generations as talking about this topic is not the norm. The responses show that women could experience judgement and stigma from older generations. They can be made to feel that they are doing something wrong for wanting to speak about or wanting to access SRH. They can subsequently be discouraged from seeking SRH related services.

The research study's findings contribute to the existing literature on the social determinants of health, and place emphasis on the complex interplay between family, community, and cultural factors that shape young Black women's access, discussions and feelings of SRH (Gondwe, 2024). Ultimately, addressing these social barriers is critical to promoting positive health outcomes, reducing health disparities, and empowering young Black women to make informed decisions about their SRH.

5.1.2. TO EXPLORE AND DESCRIBE THE RELIGIOUS BARRIERS THAT AFFECT YOUNG BLACK WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE.

The findings of this research study highlight the role of the church and religion in shaping young Black Christian women's access to SRH. The "no sex before marriage" doctrine emerged as a dominant religious restriction, influencing how young women think about and approach SRH. This is a contradiction to what is actual happening as young religious people have been found to be engaging in premarital sex (Nayebare and Omona, 2021; Eriksson et al. 2014). Religious norms and values further create conflict between the religious beliefs and healthcare needs of young Black women. The findings show that young Black Christian women can feel that accessing SRH is unnecessary when Christian churches strongly support and promote sexual abstinence before marriage. The findings reveal that religious acceptance of SRH is often contingent on marital status, which shapes the freedom, thoughts and choices of young unmarried women (Tohit and Haque, 2024; Gondwe, 2024). These restrictions can lead to delayed healthcare seeking, distress, and suppression of young Black women's rights to access SRH (Mbotho et al., 2013). Eriksson et al. (2014) and Tohit and Haque (2024) emphasise that there is a need to address religious influences and promote inclusive and sensitive SRH services. This research findings also highlight the need for Christian churches to support young Christian women to have the freedom to make their own decisions about SRH and ultimately promote positive health outcomes and human rights as stipulated in Constitution of South Africa, 1996 (Republic of South Africa, 1996).

Additionally, the findings reveal that the church environment often present significant SRH challenges for young Black women. Church settings are characterised by unwelcomed SRH discussions, judgment, and limited information on SRH topics. The findings show that young Black Christian women can feel ashamed and experience judgment from the church when seeking reproductive healthcare, support or information. According to Narker (2022), Christian

women who express feeling criticised, labelled and stigmatised by the church because of their SRH needs and decisions often refrain from taking care of their own health necessities.

5.1.3. TO EXPLORE AND DESCRIBE THE CHALLENGES AND EXPERIENCES THAT AFFECT YOUNG BLACK WOMEN WHEN ACCESSING SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES AND INFORMATION.

The research study highlights that school-based education, peer information networks, and digital sources play significant roles in providing SRH information. The research study found that despite the limited SRH information that is available in Black families and church environments, YouTube, Google and advise from friends function as reliable sources of SRH information amongst young Black women. In relation to the use of digital sources, Martin (2017) suggests that information accuracy and completeness are significant factors to consider. Thus, there is need to ensure that information obtained through these sources is monitored and then leveraged to enhance personal development (Martin, 2017; Zhou et al., 2018; WHO, 2009b).

The participants in this research study described treatment from healthcare professionals as negative, for example they have been characterised as being insensitive and judgemental. A study by Pillay et al. (2020) likewise found that healthcare provider attitudes can be marked by judgment and insensitivity and that it can deter young women from seeking necessary SRH. More so, the results from this research study revealed that such behaviours are particularly characteristic of healthcare workers in public healthcare institutions. Negative treatment from healthcare professionals, including disregard for patient autonomy and inadequate information provision, undermine young women's human rights and create significant obstacles to SRH access (Ivanova et al., 2018; Pillay et al., 2020). Furthermore, this study also yielded results that show that privacy and confidentiality breaches in healthcare institutions are concerns that can lead young Black women to delayed healthcare seeking behaviour. Ivanova et al. (2018) support the fact that such situations can increase vulnerabilities and poor health outcomes of young people. Addressing these challenges is critical to promoting positive SRH outcomes, and empowering young Black women to feel safe, confident and comfortable to access SRH services.

5.2. RECOMMENDATIONS

Research objective 4: TO EXPLORE AND DESCRIBE RECOMMENDATIONS BY YOUNG WOMEN TO STRENGTHEN ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE?

As highlighted by the objectives of this study, this research also aimed at exploring and describing recommendations that can facilitate strengthening access to sexual and reproductive healthcare. This section will thus focus on the recommendations that were suggested by the participants, as well as recommendations that were identified by the researchers that are aligned with the SRH barriers that emerged during the data collection process.

5.2.1. RECOMMENDATIONS FOR FAMILIES

- Families, particularly parents, have to be encouraged to engage in discussions about SRH with their children (Participant 7, 8 and 12). The development of family communication programmes may therefore be required to create opportunities for families to learn how to conduct open communication about SRH (Holtman et al., 2024). It is also important to create parent education initiatives or parenting groups where parents can learn strategies to support their children's SRH needs and where parents can voice their concerns about talking to their children about SRH.
- Furthermore, it is vital to develop reliable information sources, particularly in the community, for both families and young people in order to raise SRH awareness and to empower young Black women to make better SRH choices.

5.2.2. RECOMMENDATIONS FOR COMMUNITIES

- The community needs to be less judgmental to allow young Black women to seek SRH related services freely (Participant 10). This can be done by organising sensitisation campaigns to raise awareness, transform attitudes and views, and promote understanding about SRH topics.
- It is important to also encourage community-based stakeholders to collaborate in order to promote sustainable interventions that can be used to foster positive SRH outcomes (Lamaro Haintz et al., 2023).
- There is a need to prioritise community initiatives, like community workshops and information sessions that focus on SRH (Participant 15). Workshops and training sessions can be conducted with community members and community leaders. These

can focus on various SRH topics, such as human rights, policies and personal autonomy in relation to healthcare. It could also include peer educative programmes that educate and train the community or groups about SRH related topics. The community or specific groups in the community could then use this knowledge to inform and educate others about SRH. This could help to raise awareness of SRH issues at the community level and also shape community norms and perspectives about SRH (Isokpan and Durojaye, 2018).

5.2.3. RECOMMENDATIONS FOR THE EDUCATION SECTOR

- It could be helpful to provide SRH related information at school level (Holtman et al., 2024). Holtman et al. (2024) emphasise the importance of ensuring that the school curriculum provides comprehensive SRH information that is relevant and age appropriate. These recommendations could assist in counteracting misinformation or biased information that have been obtained through sources like peers or social media.
- Social workers could also be deployed in schools by the DSD to provide educational sessions about SRH in order to increase awareness around the topic.

5.2.4. RECOMMENDATIONS FOR THE RELIGIOUS SECTOR

- Churches can organise programmes that allow young people to discuss SRH related topics (Participant 3 and Participant 6). Church leaders can also initiate programmes and discussions that promote acceptance, and respect for the diversity of human choices regarding SRH-related needs. According to Powell et al. (2017) involving older adults and parents in such programmes can increase the likelihood of broader acceptance of SRH topics and discussions in the church environment.
- Church leaders should also work with young people to get diverse views that inform the development of approaches that facilitate discussions of SRH related topics in church (Powell et al., 2017).
- Church leaders should establish positive relationships with younger church members to help them feel comfortable to share and learn information regarding SRH from their church leaders (Powell et al. 2017). Church leaders should thus also foster a welcoming, safe, and inclusive environment where young people can discuss their needs and SRH rights.
- The NDoH (2024) could take the lead to offer SRH training and information sessions to skill leaders within Christian churches to be able to discuss and support the SRH

needs of young women in the church. For example, church leaders could be trained to discuss issues related to contraception, SRH rights and biases held within the church and the church community.

5.2.5. RECOMMENDATIONS FOR POLICYMAKERS

- There is a need for policy goals to be prioritised, such as promoting and strengthening SRH rights and education in the family, community, healthcare sector, religious organisations and educational contexts.
- Attention should be given to increase funding for SRH-related services. This can improve SRH service delivery and outcomes (Lince-Deroche et al., 2015). Funding should therefore be prioritised for organisations, like the NDoH, the DSD, and NGO's that work in the field of SRH.
- The Government should include religious leaders in their discussions in order to strengthen SRH rights and advocacy in church, and the broader church community (Sonke Gender Justice, 2024).

5.2.6. RECOMMENDATIONS FOR HEALTHCARE PROVIDERS

- Healthcare professionals should allow young Black women to express their needs fully without the fear of being judged and stigmatised (Participant 7 and 9).
- Programmes should be conducted with healthcare professionals that encourage them to be more sensitive to the needs of young women's when rendering SRH services. This can assist to encourage young women to seek SRH related services (Participant 8 and 10). Healthcare workers should therefore be provided with training in order to ensure on-going professional development in the area of SRH (Holt et al., 2012).
- Healthcare providers should be skilled to uphold the privacy and confidentiality of their patients, especially young Black women (Müller et al., 2016). Beltran-Aroca et al. (2016) suggest that it is necessary to already start skilling medical professionals in this area while they are at university.
- Medical health professionals should also be trained to handle sensitive information in ways that do not negatively impact their patients (Beltran-Aroca., 2016).

5.2.7. RECOMMENDATIONS FOR FUTURE RESEARCH

- Further research could examine how SRH is prioritised and supported in Christian churches and how religious norms, values and messages impact young Black women in relation to their SRH decisions and views.
- Future research could also investigate how social media platforms and online health information influence young women's perceptions of SRH.
- Future research could additionally explore the perceptions and experiences of healthcare providers towards providing SRH services to young people since past research studies have generally focussed on the services users.
- Future research could also examine the influence that the family and the community have on Black women's SRH decisions and rights.
- Research studies exploring SRH concerns could further be conducted with a larger sample that includes Black women of various ages including adolescents, young adults, and older adults to gain a more comprehensive understanding of barriers and strengths that affect women's access to SRH.

5.3. CONCLUSION

The evidence presented in this research study reveals that multiple social and religious factors act as barriers that significantly limit access to SRH for young Black women following Christian norms and values. Success in improving access to SRH will require coordinated interventions at multiple levels, from healthcare system reform to community engagement and the involvement of religious institutions and family systems. The mission as stated in NISRHR policy (NDoH, 2020b:4) must be to "accelerate the equitable delivery of a comprehensive range of quality, integrated, and rights-based SRHR services that are available, accessible, acceptable, effective, and safe to individuals, couples, and communities in South Africa.

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LIST OF APPENDICES

APPENDIX I: CONSENT FORM

Consent to Participate in a Masters Research Study

I hereby agree to volunteer to participate in the Masters research study conducted by Nonhlanhla S Mlangeni from the University of Cape Town. By signing this consent form, I understand that I will participate in a research study enquiring into social and religious barriers affecting the access of young Black women to sexual and reproductive healthcare in Cape Town.

I fully understand the following points:

1. My participation is voluntary and that I may decide to end my participation at any time without any consequences from the researcher, any other parties or organisations.

2. I have the right to decline to answer any question(s) without any consequences from the researcher, any other parties or organisations.

3. The research study will require me to be interviewed by the researcher for approximately 45 minutes and that the session will be audio recorded.

4. The researcher will keep my identity anonymous by using pseudonyms when my information is converted into a written format for the Master's dissertation.

5. The researcher will have exclusive access to my information and will ensure that all data collected are kept in a safe and secure location.

I (Full names) ……. agree that I have read the document, and I fully understand the details provided. All the possible questions I have about the study have been answered.

Participant's signature **Date**

APPENDIX II: WRITTEN CONSENT: CHURCH A

KINGDOM GOODNEWS INTERNATIONAL MINISTRIES

Cell: 073 183 4096

0643 983 835

13 October 2024

To whom it may concern

It is with pleasure that I write this email to confirm that I have agreed for Nonhlanhla to conduct the research study presented to me at Kingdom Good News Church.We are pleased to support your academic endeavours and contribute to the advancement of knowledge in your field.

As discussed, the research study will take place between the month of October and November starting from the 16th of October depending on the availability of the congregants that match the requirements.

We have also agreed that we shall provide you with one of the prayer room to use for conducting your interviews.
Please note that we expect you to adhere to the following conditions:

- Conduct the research study within the agreed-upon time frame and location.
- To obtain signed consent from all participants before the research interviews.

If you have any further questions or concerns, please do not hesitate to contact me on 073 183 4096. We look forward to supporting your research study.

Yours in Christ

Apostle Tigere

Cell: 073 183 4096

KGN Senior Pastor

APPENDIX III: WRITTEN CONSENT: CHURCH B

GOD'S GRACE MINISTRIES

N8 Hampton Place
Gie Road Parklands 7441
Cell: 062 421 2645

06 October 2024

To whom it may concern

Re: Permission to Conduct Research Study

I Sylvester Gumbo is pleased to grant Nonhlanhla S Mlangeni permission to conduct her research study at God's Grace Ministries in Cape Town South Africa

Below are the agreed details:

Date: Between October till November 2024
Location: Beit Hall Dorchester Complex Parklands

Please feel free to contact us if you need any further assistance.

Kind Regards

S . Gumbo

GGM Senior Pastor

APPENDIX IV: INFORMATION SHEET

Department of Social Development

Information Sheet for participation in a Master's Research Study

Dear Participant

My name is Nonhlanhla S Mlangeni. I am conducting a qualitative study on barriers affecting the access of young Black women to sexual and reproduction healthcare in Cape Town. I am conducting this study as a requirement towards completing my Master's degree at the University of Cape Town.

Title of study

A phenomenological inquiry of social and religious barriers affecting access of young Black women to sexual and reproductive healthcare in Cape Town.

Study purpose and overview:

The study aims to enquire how social and religious norms and values affecting access of young Black women to sexual and reproductive healthcare in Cape Town. This includes exploring barriers to sexual and reproduction healthcare such as stigmatisation and lack of relevant information on the topic. You are therefore invited to voluntarily participate in this study as your experiences and perceptions can contribute to the fulfilment of the study's goals.

Data Collection procedure:

The researcher will conduct an in-person interview with each participant which will be approximately 45 minutes in duration.

Possible risks of participating in the study.

The research topic could be considered of a sensitive nature, as it relates to sexual and reproductive healthcare. The research holds a small potential to lead to psychological harm. A debriefing session will be provided after the interview in order to reduce the impact of psychological harm if it occurs. Moreso, names of relevant organisations and phone numbers of where adequate support can be received will be given if psychological harm is experienced.

Voluntary Participation

Participating in this research study is completely your voluntary decision. You therefore do not have a responsibility or duty to be part of the research study. Moreover, your decision to

participate or discontinue your participation in this research study will not lead to any consequences from the researcher, any organisations, or other persons.

Protecting your identity

Your identity will be kept anonymous to ensure that your responses cannot be recognised as coming from you. This will be done by using pseudonyms (alternative names/titles rather than your own) to conceal your actual identity and name. Moreover, the researcher will have exclusive access to your information. In protecting your identity, the researcher will also ensure that all personal information is safely handled, processed and stored. Notes will therefore be kept in a locked cupboard and any electronic devices that will be used will be password protected to ensure that only the researcher has access to the information obtained from the participant.

Audio recording

The researcher will use a recorder or cell phone to record the session. The audio recording will be used to create a transcript which will be analysed for research purposes. However, the access to both the transcript and audio recording are limited to the researcher and the supervisor. After the information has been analysed and presented in the final document, the recording will be deleted.

Possible Benefits of participating in the study.

The researcher cannot guarantee that you will benefit from this research.

Questions and Contacts:

You can contact the researcher for any enquiries related to the research study on the details below.

Name of researcher: Nonhlanhla S Mlangeni
Email: mlnnon021@myuct.ac.za

You can also contact my University of Cape Town's research supervisor, Mr Silas Loubser, via email, silasucthumanities@gmail.com if you require any further information related to this study.

Thank you for taking the time to consider participating in this study.

APPENDIX V: SHORT FORM

Department of Social Development

Permission to be contacted for research purposes.

Dear Participant

My name is Nonhlanhla S Mlangeni. I am conducting a qualitative study on barriers affecting the access of young Black women to sexual and reproduction healthcare in Cape Town. I am conducting this study as a requirement towards completing my Master's degree at the University of Cape Town.

Title of study: A phenomenological inquiry of social and religious barriers affecting access of young Black women to sexual and reproductive healthcare in Cape Town

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SECTION A

Please tick one of the boxes below to indicate if you want to be contacted to be part of this study. ***Please Note:*** *If you* ***do not want*** *to be contacted to participate in this study,* ***DO NOT*** *complete Section B.*

I agree to be contacted for participation in this research study.	YES	NO

SECTION B ***(****Only complete details below if you* ***agree*** *to be contacted to participate in this study)*

Name and Surname: _____

_____

Age: _____ **Cell-phone Number:** _____

Email Address: _____

_____

Thank you for taking the time to consider participating in this study.

APPENDIX VI: INTERVIEW GUIDE

INTERVIEW GUIDE FOR PARTICIPANTS

Exploring the Socio-Religious Barriers Affecting Access of Young Black Women to Sexual and Reproductive Healthcare in Cape Town

Good morning / Good afternoon. My name is Nonhlanhla Mlangeni, and I am from the University of Cape Town. Thank you for agreeing to be part of this research study. This interview session will take about 45 minutes. All the information that you will give in this interview will be treated with utmost confidence. Your personal information will not be revealed in my final Master's thesis. The information that you share will be used only for research purposes. You are not obliged to answer any questions that make you feel uncomfortable. Feel free to stop this interview at any given time if you do not wish to continue participating in this study.

Section A: Participant's biographical data

a. Please share with me your age.
b. What is your current marital status?
c. Are you currently employed? If not, then how do you provide for your own needs?
d. Which religion do you follow?

Section B: Accessing sexual and reproductive healthcare.

1. Please share your understanding of the term sexual and reproductive healthcare.
2. What is it like for you when accessing sexual and reproductive healthcare services.
3. Briefly describe how the sexual and reproductive health perceptions of your family have shaped the way you access sexual and reproductive healthcare.
4. Do you feel that your family has shaped your perceptions in a positive or negative way?
5. Describe the information that your church shares regarding sexual and reproductive healthcare.

   Follow up: How is this information useful to young Black women attending the church?
6. What information about sexual and reproductive healthcare was shared with you by your peers?
7. How did this influence you in accessing sexual and reproductive healthcare?

8. What sources of information do you use when looking for information about sexual and reproductive healthcare?
9. Do you feel that the information and education that you receive on sexual and reproductive health through these sources are helpful?

Section C. <u>Questions related to social barriers.</u>

1. In your opinion, how do families of young Black women respond to them seeking information about sexual and reproductive healthcare?
2. How open is your family about speaking about issues related to sexual and reproductive healthcare?

   Follow up: How does this make you feel?
3. What can you say about the way that South African communities respond to young Black women seeking information about sexual and reproductive healthcare.
4. What can you say about the attitudes of medical personnel towards the needs of young Black women seeking sexual and reproductive healthcare.
5. Do you feel that doctors and nurses are sensitive to the needs of young black women seeking sexual and reproductive healthcare?

   Follow up: How would the sensitivity of doctors and nurses make you feel if you need to access sexual and reproductive healthcare?
6. In your opinion, what other challenges could young black women face when going to medical professionals to access sexual and reproductive healthcare such as contraception, testing, treatment, or counselling?
7. Do you feel that these challenges can affect the mind-set and behaviour of young black women towards accessing sexual and reproductive healthcare?

<u>D. Questions related to religious barriers.</u>

1. In your opinion how does religion impact the way that young Black women access sexual and reproductive healthcare?

2. Do Christian values and norms limit or encourage women to be well-informed about sexual and reproductive healthcare?

Follow up: Please give a reason for your response.

3. What are some religious perspectives and norms that have shaped your ideas about sexual and reproductive healthcare?

Follow up: Briefly share if those perspectives and norms on sexual and reproductive healthcare is beneficial to young black women?

4. Would you say that the church is a space where young Black women feel comfortable about speaking about their sexual and reproductive healthcare needs or views?

Follow up: Please provide a reason for your answer.

5. Please share with me any conflicts that you may have between your religious beliefs and your sexual and reproductive healthcare views.

E. Recommendations and conclusion

a. What suggestions can you provide for families to better support young black women to access sexual and reproductive healthcare.
b. In your opinion, how can communities better support young Black women to access sexual and reproductive healthcare.
c. How can young black women be better informed about their sexual and reproductive rights?
d. What suggestions can you provide for the church to better support young Black women to access sexual and reproductive healthcare.
e. What suggestions can you provide for the doctors and nurses to better support young Black women to access sexual and reproductive healthcare.
f. What other recommendations can you provide that could strengthen young Black women's access to sexual and reproductive healthcare?

APPENDIX VII: ETHICAL CLEARANCE FORM

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF SOCIAL WORK AND SOCIAL DEVELOPMENT
FACULTY OF HUMANITIES

Taryn Powell
Administrative Assistant

University of Cape Town
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31 August 2024

Student: **Nonhlanhla Stephanie Mlangeni (MLNNON021)**

Supervisor: **Silas Loubser**

Outcome: **ACCEPTED**

I am pleased to inform you that ethical clearance was given by an Ethics Review Committee of the Faculty of Humanities for your study, ***A Phenomenological Inquiry of Social and Religious Barriers Affecting Access of Young Black Women to Sexual and Reproductive Healthcare in Cape Town.*** The reference number is SWK-REC-2024-SR014.

I wish you all the best for your study.

Yours sincerely

Dr Emma Campbell

Lecturer

Chair: Ethics Review Committee