Adolescent Girls’ Experiences of Sexual and Reproductive Health Services in Public Clinics in the Western Cape

By

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Declaration

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Abstract

This study explored the experiences that adolescent girls had when attending public clinics in the Western Cape for sexual and reproductive health (SRH) services, as well as explored the opinions and beliefs of healthcare workers (HCWs) who provided these SRH services. Participants were adolescent girls between the ages of 13-17 years, and the HCWs at the clinics who provided these adolescents with SRH services. Participants were recruited through purposive sampling. Data were collected through semi-structured interviews with 15 participants (adolescents (n=11); HCWs (n=4)), and through observations of the clinic environment with the use of an observation schedule. The interviews were audio-recorded and transcribed verbatim for reflexive thematic analysis. Findings of this study reveal that adolescent girls had positive experiences at the clinic and with HCWs, which were unlike their initial expectations. Adolescents reported being comfortable, happy, and even enjoyed being in the clinic during their SRH consultations. The HCWs created an adolescent-friendly environment that allowed adolescents to ask questions, and speak about sex and SRH openly and comfortably. Adolescents reported the main influences that encouraged them to seek SRH services were from their mothers and peers. HCWs had differing personal views as to when they believe adolescents were ready to engage in sexual activity. However, there was an overall agreement that their personal beliefs were not to affect the way they treated adolescents who approached them seeking SRH services. The HCWs reported numerous barriers that may hinder adolescents' access to SRH services, which included: clinic operating hours that did not accommodate high school times; understaffed clinics; lack of resources; and governing body of schools who did not allow HCWs to provide SRH education and services at high schools. The findings from this study demonstrate that it is possible for adolescents to have positive experiences when seeking SRH services, even in contexts or cultures that may be more conservative. There have been numerous reports from

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adolescents, in various areas of rural and sub-Saharan Africa, where HCWs were reported to humiliate, scold, and even refuse to provide SRH services to adolescents who approached them for these services. As such, the clinic environment and behaviour of HCWs are two of the determining factors to whether adolescents will continue to seek SRH services and care. This study recommends targeting the needs of adolescents to make the clinic environment adolescent-friendly in order to promote adolescents' adherence to utilising SRH services, thus promoting better long-term adolescent SRH outcomes.

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Opsomming

Hierdie studie het die ondervindings van adolessente meisies tydens hulle besoeke aan openbare gesondheidsorgklinieke in die Wes-Kaap vir seksuele en reproduktiewe gesondheidsdienste (SRG-dienste), asook die menings en oortuigings van die gesondheidswerkers (GW’s) wat hierdie SRG’s voorsien, ondersoek. Deelnemers was adolessente meisies tussen die ouderdom van 13-17 jaar en die GW’s by die klinieke wat hierdie adolessente van SRG-dienste voorsien het. Deelnemers is gewerf deur middel van ’n steekproef. Data is versamel deur semi-gestruktureerde onderhoude met 15 deelnemers (adolessente (n=11); GW's (n=4)), en deur waarnemings van die kliniek-omgewing deur van 'n waarnemingskedule gebruik te maak. Die onderhoude is deur middel van stemopnames verbatim getranskribeer ten einde reflektiewe tematiese analise moontlik te maak. Die bevindinge van hierdie studie toon aan dat adolessente, anders as hul aanvanklike verwagtings, positiewe ondervindings by die kliniek en die GW’s gehad het. Adolessente het gemeld dat hulle op hulle gemak en gelukkig was en dat hulle dit selfs geniet het om in die kliniek te wees tydens hulle SRG-konsultasies. Die GW’s het 'n adolessent-vriendelike omgewing geskep waarin adolessente toegelaat is om vrae te vra en openhartig en gemaklik oor seks en SRG te gesels. Adolessente het aangetoon dat die belangrikste invloede wat hulle aangemoedig het om SRG-dienste te besoek, die van moeders en hul portuurgroep was. GW's het verskillende persoonlike opinies oor wanneer hulle glo adolessente gereed is om seksueel aktief te raak. Daar was egter 'n algehele konsensus dat hul persoonlike oortuigings nie die manier moet beïnvloed waarop hulle adolessente behandel wat hulle nader vir SRG-dienste nie. Gesondheidswerkers het verskeie struikelblokke uitgelig wat adolessente se toegang tot SRG-dienste mag belemmer. Openingstye van klinieke wat nie hoërskoolure in ag neem nie, personeeltekorte in klinieke, gebrek aan hulpbronne en beheerliggame van skole wat nie GW’s toelaat om SRG-voorligting en –dienste by skole aan te bied nie, is daarby ingesluit.

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Die bevindings van hierdie studie bewys dat dit moontlik is vir adolessente om positiewe ervarings te hê wanneer SRG-dienste verlang word, selfs in kontekste en kulture wat meer konserwatief van aard is. Talle mededelings van adolessente in verskeie landelike gebiede in sub-Sahara Afrika is ontvang wat rapporteer dat GW's adolessente sou verneder, met hulle raas en selfs SRG-dienste aan adolessente weier wat hulle daarvoor nader. As sulks is die kliniekomgewing en gedrag van GW's die twee faktore wat sal bepaal of adolessente sal voortgaan om SRG-dienste en –sorg op te soek. Hierdie studie beveel aan dat dat die behoeftes van adolessente aangespreek moet word om die kliniekomgewing 'n meer adolessent-vriendelike ruimte te maak om sodoende die volgehoue gebruik van SRG-dienste onder adolessente te bevorder en gevolglik beter langtermyn adolessente SRG-uitkomste te bewerkstellig.

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List of Abbreviations

HCW	Healthcare worker
HIV	Human Immunodeficiency Virus
SA	South Africa
SRH	Sexual and reproductive health services
STI	Sexually Transmitted Infection
TOP	Termination of pregnancy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organisation

Glossary of Key Terms

Term	Definition
Barriers	An obstacle to communication, understanding or progress.
Healthcare worker	Someone who works in a hospital or health centre.
Influence	The capacity to have an effect on the character or behaviour of someone, something, or the effect itself.

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Sexual and reproductive health services	Providing high quality services for family planning, including: fertility services; eliminating unsafe abortion; combating STIs including HIV; reproductive tract infections; cervical and other gynaecological morbidities.
Termination of pregnancy/Abortion	Removal of pregnancy tissue, products of conception, or the fetus and placenta in the uterus.

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Chapter 1

Introduction

1.1. Background

Adolescence is a complex stage in life characterised by conflicts among independence, experimentation, responsibilities, as well as potential social and health problems. According to the World Health Organisation (WHO), the main health issues among adolescents include HIV/AIDS, early pregnancy, childbirth, violence, depression, malnutrition, intentional injuries, tobacco, drug and alcohol use, and obesity (World Health Organisation, 2018). Adolescents live in a world that has become increasingly mobile and urban. In 2007, the global population become more urban than rural for the first time (Liang et al., 2019). Urbanisation has levelled off in more developed countries and continues to increase rapidly throughout the developing world, Sub-Saharan (Eastern, Southern, Western, and Middle Africa) has one of the fastest rates of urban growth, with its urban population increasing from 29% in 1994 to 41% in 2019 (Liang et al., 2019). Social changes have accompanied this rapid urbanisation. An increase in the age of marriage is seen in South Africa, which has been accompanied by a rise in premarital sexual activity and premarital births among adolescents (Mfono, 1998, Clarke et al., 2017).

A significant number of adolescents around the globe are sexually active with this proportion increasing steadily from mid-to-late adolescence (Salam et al., 2016). 80% of the 1.2 billion adolescents worldwide live in developing countries where access to the sexual and reproductive health services, that are meant to support them, are fragmented and inadequate (Beksinska et al., 2014). Access to SRH in the Asia Pacific Region is dependent on age and the regulation of marital status (Govender et al., 2019). Religious and customary laws require persons under the age of 18 years to seek consent from spouses or parents to access SRH

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(Govender et al., 2019). HCWs may also be prohibited from delivering contraceptive services to unmarried persons (Godwin et al., 2014). In South Africa, adolescents' have the legal right to access SRH services from the age of 12 years, without parental consent (CA; Act 38, 2005). However, adolescents in South Africa still experience high rates of unintended pregnancy, and sexually transmitted infections (STIs), such as HIV (UNAIDS, 2019; Stats SA, 2019; Holt et al., 2012).

Adolescence is a life stage that is associated with increased risk-taking behaviour (Crone & van Duijvenvoorde, 2021; Bjork & Pardini, 2015). Risky sexual behaviour may lead to detrimental health consequences (Willoughby et al., 2014). Examples of risky sexual behaviour include early sexual debut, engaging in unsafe sex (sex without the use of a condom), and engaging in sexual activities with multiple partners (Toska et al., 2017; Salam et al., 2016). Accessible reliable SRH education and services are necessary for decreasing the rate of risky sexual behaviour among adolescents (Guiella & Madise, 2007). Sexual and reproductive health (SRH) programs are often not prioritised due to a lack of funding and the emphasis that is placed on community-based HIV prevention programs (Govender et al., 2019). Clinic services and education are essential in promoting positive adolescent sexual development and decreasing adverse health and economic outcomes associated with sexual behaviour (Govender et al., 2019). Teachers, parents, and HCWs are the gatekeepers of adolescent SRH because they are responsible sources of SRH information and services for adolescents (Kumi-Kyereme et al., 2014). In sub-Saharan Africa, Adolescent girls are vulnerable to being harmed by sexually transmitted infections (STIs) due to both social and biological factors (Asha et al., 2020). Furthermore, adolescent girls tend to have poorer access to health services, and tend to receive less education about sexuality and reproduction (Asha et al., 2020). Adolescent girls are also at higher risk of unsafe sex compounded by sexual violence and intimate partner violence (Asha et al., 2020). Finally, adolescent girls are

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less likely to complete secondary school, or have secure employment as they transition into adulthood, and have less decision making autonomy and restricted mobility compared with their male peers (Asha, et al., 2020). It is critical to tackle the gendered dynamics that shape adolescent health, especial the sexual and reproductive rights of adolescent girls, in order to realise sustainable development goals (Asha et al., 2020).

Adolescent birth rates in sub-Saharan Africa, Latin America, and the Caribbean remain the highest worldwide (Liang et al., 2019). In sub-Saharan Africa, adolescent birth rates exceed 100 births per 1000 women aged 15-19 years (Liang et al., 2019). Furthermore, Africa accounts for the highest prevalence rates of gonorrhoea and genital herpes (Liang et al., 2019). These persistently high levels of adolescent STI rates and unwanted pregnancy have been attributed to numerous factors. These factors include adolescents' lack of education and awareness about sex and SRH, peer influence, lack of adolescent-friendly SRH services, negative attitudes of HCWs, poverty, and stigma from the community and HCWs (Beksinska et al., 2014). Studies have suggested that behaviour and attitudes of HCWs in public clinics have discouraged many adolescents from attending clinics for SRH services, resulting in the spread of sexual diseases, as well as unwanted pregnancies (Warenius et al., 2006; Holt et al., 2012; Beksinska et al., 2014). HCWs, in rural and sub-Saharan areas of Africa, were reported to have insulted, humiliated, and even turn away adolescents who sought SRH services (Warenius et al., 2006; Holt et al., 2012; Beksinska et al., 2014). There is limited research on the experiences of adolescents seeking SRH from clinics in urban areas of Africa. Research has focused primarily on HCWs' experiences with adolescents, their opinions on adolescent SRH, and the barriers to facilitating adolescent-friendly SRH services.

This was a qualitative study that aimed to explore the experiences of adolescent girls who attended public clinics for SRH services through the use of narrative research methods. Additionally, the opinions of HCWs were explored. Participants were recruited from two

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public clinics in Cape Town, South Africa. Data were gathered and analysed through interviews and reflexive thematic analysis, respectively.

1.2. Rationale of study

This study aims to explore the experiences of adolescent girls when attending clinics in Cape Town, as well as explore the beliefs and opinions of the HCWs who provide them with SRH services. Previous literary studies have focused on investigating the experiences of adolescent girls when seeking SRH services in rural and sub-Saharan parts of Africa. There is a lack of study on the experiences that adolescents have in clinics based in urban areas of Africa. Furthermore, research conducted in South Africa has mainly focused on HCWs' experiences and opinions on adolescent SRH, rather than adolescents' experiences themselves. Therefore, this study may provide insight into the experiences adolescent girls have when seeking SRH services in clinics in the Western Cape, as well as the influences that encourage these adolescent girls to seek these services. This study could also provide insight into the beliefs and opinions of HCWs, and the environment of the clinics, to understand if these factors may play a role in how adolescent girls experience SRH services at these clinics.

1.3. Research questions

The following research questions guided this study:

- What are adolescent girls' experiences when seeking sexual and reproductive health services in public clinics in SA?
- What are the sexual and reproductive healthcare workers' opinions of adolescents' engagement in sexual activity?
- What are the influences on adolescent girls' decisions to utilise sexual and reproductive health services from clinics?

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- What are the barriers that may prevent adolescent girls from obtaining sexual and reproductive health services?

1.4. Aims

The aim of this study was to explore the experiences that adolescent girls have when attending clinics for SRH services, as well as the influences that affected their decision to utilise these services. This study also explored the opinions of the HCWs who provide SRH services to adolescents, and the barriers that prevent adolescents from obtaining these services.

1.5. Objectives

The objectives of this study were:

- to explore the experiences of adolescent girls when seeking SRH services.
- to identify the influences on adolescents' decisions to utilise SRH services.
- to explore the opinions of HCWs who provide adolescents with SRH services.
- to identify barriers that prevent adolescents' from receiving these services.

1.6. Overview of chapters

Chapter 2 provides an overview of the current literature on the developmental phase of adolescence, the laws, guidelines, and regulations of SA's policy about SRH for adolescents, the experiences adolescent girls have had when they sought SRH services, the influences on adolescent behaviour and risky sexual behaviour, as well as the views, beliefs, and opinions of HCWs who provide adolescents with SRH services. Chapter 2 also provides the theoretical framework of this study, which was Bronfenbrenner's ecological systems theory.

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Chapter 3 provides the methodology this study followed. It provides a detailed description of the steps followed to recruit participants and collect data, as well as the instruments used during the data collection process. This chapter also provides an explanation of the steps followed during data analysis.

Chapter 4 provides the results of this study. This chapter presents the demographic characteristics of the participants, the themes found during reflexive thematic data analysis, and the observational data collected on the clinic environment. This chapter includes a report of the three main themes and four sub-themes identified during data analysis, as well as illustrative quotations.

Chapter 5 provides the discussion and conclusion of this study. The results of this study are discussed in further detail and compared to the existing literature on the relating topic. This chapter also provides the limitations of this study, as well as considerations for future study.

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Chapter 2

Literature Review

2.1. Introduction

In this chapter, I provide a review of the literature pertaining to adolescent girls' experiences when utilising sexual and reproductive (SRH) services in South Africa. To begin with, I discuss the developmental stage of adolescence. I will then discuss the topic of risky sexual behaviour during adolescence and the consequences of risky sexual behaviour. Thereafter I will discuss the different aspects of adolescent SRH, which include SA laws with guidelines that support adolescent girls' rights to obtain SRH services, adolescents' opinions and experiences of SRH facilities, and health care workers' (HCWs) opinions on adolescents receiving SRH services. I will also discuss the stigma that adolescent girls experience relating to sex and how it affects their utilisation of SRH services. Finally, I will provide a theoretical framework for this study where I will discuss Bronfenbrenner's (1979) ecological systems theory.

2.2. Adolescence

Adolescence is defined as the developmental stage where individuals transition from children, with high dependency on parents, to adults who are independent members of society (Crone & van Duijvenvoorde, 2021). There are various biological, physical, psychological, and emotional changes that are associated with this stage of development. The beginning of adolescence is marked by puberty (Crone & van Duijvenvoorde, 2021). Puberty refers to the developmental transition from a non-reproductive state into a reproductive state and is a prolonged developmental process (Holder et al., 2013). However, the end of adolescent development is less clearly defined. In South Africa, the Children's Act clarifies that any person over the age of 18 is an adult (Faber & Van Vuren, 2009). Adolescence can be divided into three phases.

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The first phase of adolescence is puberty, between the ages of 10 to 16, and is characterised by cognitive, physical, and social-emotional changes. Several physiological and physical changes accompany pubertal development, including the development of secondary sexual characteristics (e.g. growth of pubic hair, breast budding in girls, and testicular enlargement in boys) and the onset of reproductive competence (e.g. menstrual cycles in girls and spermarche in boys) (Marshall & Tanner, 1970). Typically, girls begin pubertal development around the ages of 10-11 and complete the process by the ages of 15-16 (Marshall & Tanner, 1970). Boys begin their pubertal development around the ages of 11-12 and complete it by the ages of 16-17 (Marshall & Tanner, 1970). These changes are associated with the rapid increase in gonadal hormones (Shirtcliff et al., 2009; Crone & van Duijvenvoorde, 2021).

The second phase of adolescence, between the ages of 16 to 24, is strongly culturally dependant and accompanied by changing social goals (Sawyer et al., 2018; Crone & van Duijvenvoorde, 2021). During this period, adolescents develop a sense of social maturity where relationships with peers become important and parents are a source of emotional support (Oris et al., 2015). Adolescents begin to separate from their parents and strive for independence (Kail et al., 2019). This period is also associated with sensation-seeking behaviour, risk-taking, intense emotions, and the desire to be liked by peers (Crocetti, 2017).

The third phase, between the ages of 18 to 29, is the transition from adolescence to adulthood (Crone & van Duijvenvoorde, 2021). Historically, the end of adolescence was defined by social role transitions, especially those around marriage and parenting (Sawyer et al., 2018). In this phase, adolescents may be recognised as adults by law, but are still developing in terms of self-focus, and identity exploration (Arnett et al., 2014; Crone & van Duijvenvoorde, 2021).

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2.3. Adolescent risky sexual behaviour

Risk-taking behaviour increases during adolescence (Strang et al., 2013; Crone, & van Duijvenvoorde, 2021; Bjork & Pardini, 2015). Risk-taking behaviour is described as behaviours that may lead to detrimental health consequences (Willoughby et al., 2014). Examples of risky behaviours include high levels of substance abuse, sex with multiple partners, and unprotected sex (Toska et al., 2017). Adolescents may be aware that some of their behaviours may involve several risks. However, the anticipated pleasure and rewards associated with risky behaviour may overtake their ability to suppress their desire to engage in risky activities (Sturman & Moghaddam, 2012). The inability to suppress risky behaviour can be attributed to their rewards-and-pleasure-seeking brain systems maturing faster than the systems that control behaviour (Goddings et al., 2019).

A significant number of adolescents around the globe are sexually active with this proportion increasing steadily from mid-to-late adolescence (Salam et al., 2016). The sexual activity of adolescents varies by region and gender. In low- and middle-income countries, more girls are sexually active compared to boys (Salam et al., 2016). By age 19, 70% of adolescents have become sexually experienced (Govender et al., 2019). The median age for sexual debut was found to be 16 years for females and 15 years for males, with South African females predominantly having their first sexual intercourse experience outside marriage (Govender et al., 2019).

Sexuality plays a role in human development but in adolescence sexual activity may be particularly risky. Risky sexual behaviours include early sexual debut (i.e. before age 15), a high number of sexual partners, and lack of contraceptive use (Bowling et al., 2021). Sexual risk-taking behaviours have been linked to increased susceptibility to reproductive risks, such

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as unintended pregnancy and early childbearing, abortions, and STIs, including HIV (Salam et al., 2016).

2.4.1. Consequences of adolescent girls' risky sexual behaviour

Unwanted pregnancy and adolescent maternal mortality

Adolescent pregnancy is a worldwide public health problem. 16 million adolescents, aged 15-19, give birth annually (Govender et al., 2019). The World Health Organisation (WHO) estimates that 3 million adolescents undertake unsafe abortions annually. In South Africa, 13.4% of around 1.1 million births occurred to mothers aged 15-19 (Govender et al., 2019). The adolescent birth rate in LMICs is more than double that of high-income countries (HICs) (Salam et al., 2016). Pregnancy-related death among females aged 15-19 is the second leading cause of death after self-harm (Salam et al., 2016). Adolescents younger than 19 years have a 50% increased risk of neonatal deaths and stillbirths, and adolescent mothers are at an increased risk of anaemia, postpartum haemorrhage and puerperal endometritis (Salam et al., 2016). Africa has the highest maternal mortality ratio among adolescent girls, followed by the Eastern Mediterranean, and Southeast Asia (Liang et al., 2019). Adolescent mothers in sub-Saharan Africa account for 20% of all maternal deaths, due to complications such as unsafe abortion, hypertensive disorders, and pre-eclampsia (Liang et al., 2019).

Data collected from the Demographic and Health Survey (2003), indicated that one-third of 15 to 19 years olds had been pregnant and that two-thirds of the pregnancies were reported to be unwanted. In addition to adolescent health consequences, early childbearing prevents adolescents from attending school and perpetuates the cycle of poverty (Salam et al., 2016). Beksinska et al. (2017) examined the prevalence of contraceptive use among female adolescents (aged 15-19 years), and the association between effective contraceptive use and adolescent pregnancy. They found that 35% of their participants reported having an

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unintended adolescent pregnancy. They also found that 52% of participants (who had never been pregnant) were at a high risk of becoming pregnant because they had initiated sexual activity without using a contraceptive. In LMICs, adolescent pregnancy leads to numerous challenges including school dropout, abandonment by partners, and lost productivity, which ultimately limits their future economic and social opportunities leading to the intergenerational transmission of poverty (Salam et al., 2016). Panday et al. (2009) highlight the need for adolescents to access comprehensive SRH services by stating that the national rate of youth pregnancy was high- with 35% of women pregnant before the age of 20, and by recognising that HIV prevalence among adolescents (aged 11-15 years) was at 11.4%.

STIs and HIV

Several studies report adolescents to be at a higher risk of contracting sexually transmitted diseases compared to older persons (Amoateng et al., 2014; Imaledo et al., 2012; Ugoji, 2014; Biney et al., 2020). The global prevalence of all STIs, excluding chlamydia, has increased among adolescents since 1994 (Liang et al., 2019). The prevalence of all STIs is higher among female adolescents than males (Liang et al., 2019). Genital herpes is the most common STI that affects adolescents, affecting 4.3% of adolescents globally in 2017 (Liang et al., 2019). Genital herpes has its highest prevalence in Africa, followed by America, for both younger adolescents (10-14 years) and older adolescents (15-19 years) (Liang et al., 2019). Prevalence rates of gonorrhoea among adolescents are also highest in Africa (Liang et al., 2019).

Of all STIs, the HIV/AIDS epidemic has led to the greatest devastation, increasing globally by 64.8% among adolescents (aged 15-19 years) between 1994 -2017 (Liang et al., 2019). The number of 10-19 year olds living with HIV increased from 920 000 to 1.6 million between 1994-2018 (Liang et al., 2019). South Africa accounts for the largest share of the

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HIV/AIDS epidemic in any single country in the world (UNAIDS, 2019). In sub-Saharan Africa, deaths attributed to AIDS among adolescents aged 10-19 started declining, partly due to the increasing availability of antiretroviral treatment (Liang et al., 2019). Adolescent girls and young women aged 15-24 years are at a particularly greater risk of HIV infections than any other age cohort (Stats SA, 2019). In sub-Saharan Africa, adolescent girls account for the majority of adolescents living with HIV. In 2018, an estimated 880 000 adolescent girls were living with HIV compared to the estimated 580 000 HIV-infected boys (Liang et al., 2019). Unsafe sexual practices hamper the efforts towards the eradication of the burden of AIDS (World Health Organisation, 2005).

Adolescents in sub-Saharan Africa account for a majority of new HIV infections (Agaba et al., 2016). In a community sample of women (aged 15-24), in KwaZulu-Natal over 7% were found to be living with HIV in 2012 (Bekinska et al., 2014). Reported condom use by young females between the ages of 15-24 years dropped from sixty-five percent to under fifty percent, in SA, between 2008 and 2012 (Bekinska et al., 2014). This is a large drop in condom use over a short period of time. In a study done by Beskinska et al. (2017), adolescents indicated they mainly learned about contraception through a nurse, counsellor, or doctor. Only 9% of their participants reported learning about contraception in school, which highlights the potential lack of comprehensive sexual education that adolescents in SA are receiving. There are numerous factors that may contribute to adolescents' increased engagement in risky sexual behaviour including peer influence, adolescents’ experiences when seeking SRH services, as well as lack of parent-adolescent communication about sex and SRH.

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2.5. Factors that influence adolescent girls' engagement in risky sexual behaviour

An array of social and demographic factors affects adolescent sexual risk-taking behaviours. Research has found that individuals who become sexually active at younger ages (before 14 years) are more likely to have poor access to SRH information and consequently are more prone to HIV-related sexual risk behaviours, such as poor contraceptive use (Yarinbab et al., 2018; Etrawati et al., 2017). Education and wealth have also been found to affect the sexual behaviours of adolescents. Education is seen to have a protective effect on sexual behaviour because education improves adolescents' knowledge of and access to SRH services (Guiella & Madise, 2007). Research has shown a positive association between the level of education and the use of condoms, with the odds of condom use increasing with years of schooling among adolescents (Guiella & Madise, 2007).

Many factors can influence adolescent girls' engagement in risky sexual behaviour. These factors include peer interactions, quality of parent-adolescent relationships, adolescents' experiences when seeking SRH services from clinics, and concern for confidentiality when seeking these services (Panday et al., 2009; Lince-Deroche et al., 2015).

2.5.1. Peer interactions

Adolescence is a time when the developing child strive for autonomy from their parents and family while investing more in their peer groups. During adolescence, there is a shift from self-orientated behaviour to other-orientated (pro-social) behaviour (de Boer et al., 2017). Adolescents are more involved in risk-taking behaviour than at any other age (de Boer et al., 2017). One reason risk-taking behaviour peaks during adolescence is that adolescents are more susceptible to the influence of their peers (Steinberg & Monahan, 2007; de Boer et al., 2017). Peer relations and social status become more important during adolescence. Peer pressure, concerns about social rejection, and the desire to be popular all has a large influence

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on adolescents' behaviour (Forbes & Dahl, 2010; de Boer et al., 2017). Risk-taking behaviour might be encouraged by motivations such as receiving peer approval and higher social status. Adolescents have increased motivation to attract peers and pay more attention to peer contexts (Forbes & Dahl, 2010; de Boer et al., 2017). In an experimental study conducted by de Boer et al. (2017), the authors examined the extent to which peers influenced risk-taking behaviour in adolescents aged 12-15. The adolescents in their study completed a Balloon Analogue Risk Task (BART) as a measure of risk-taking behaviour. The BART was completed both individually and in the presence of peers. Their results showed that adolescents took significantly more risk when they completed the BART with peers than when they completed the task individually. Their study demonstrates that adolescents may be more inclined to engage in risk-taking behaviour in the presence of peers.

Adolescents feel compelled to conform to the perceived expectations and norms of their peer group (Baumeister, 1990; de Boer et al., 2017). Research has shown that more frequent communication with peers about sexuality-related topics was associated with a higher likelihood of subsequent sexual intercourse initiation (Busse et al., 2010; Silva et al., 2019). In a study done by Silva et al. (2019), the authors assessed the association between sexual communication with peers and changes in adolescents' experiences with different sexual behaviours ranging from naked touching to intercourse. Their study found that adolescents who had more frequent communication with peers reported significant increases in their experiences with sexual behaviour. An explanation for this association may be that, during sexual conversations, peers exchange information about their sexual behaviour that contributes to increasing adolescents' awareness of their peers' sexual activity. The increased awareness of peers' behaviours could stimulate adolescents to engage in similar behaviours through a process called role-modelling (Bandura, 1971; Silva et al., 2019).

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Literature has distinguished between three types of sexual peer norms, namely; descriptive norms, injunctive norms, and peer pressure (de Boer et al., 2017, Silva et al, 2019). Descriptive norms are the adolescent's perceptions of their peers' sexual behaviours (i.e. what peers do). For example, an adolescent has their perceptions of how many of their peers have ever had sexual intercourse, and as a result, the adolescent may feel motivated to behave in a similar way (Silva et al., 2019). Injunctive norms are adolescents' perceptions of their peers' approval or disproval towards sex (i.e. what peers think) (Silva et al., 2019). Studies have shown that adolescents who perceived their peers to be more permissive toward sex were more likely to engage in sexual behaviours themselves (O'Sullivan & Brooksgunn, 2005; Silva et al., 2019; Santelli et al., 2004). Descriptive and injunctive norms work indirectly to influence adolescents. However, the final sexual peer norm is more direct, which is peer pressure. Peer pressure is the explicit social pressure that adolescents perceive from their peers to engage in sexual behaviours, regardless of the adolescents' wishes (Silva et al., 2019).

Adolescents are particularly susceptible to socially prescribed norms and negative peer pressure among adolescents may promote high-risk sexual behaviour (Selikow et al., 2009). Selikow et al. (2009) conducted a study where they investigated the mechanisms through which negative normative peer pressure function in adolescents in Cape Town, South Africa. The authors found that adolescents' strong need to belong to a social group facilitates peer pressure, as adolescents who do not conform to dominant norms may be excluded from friendship circles. Negative pressure was experienced by both adolescent girls and boys in their study. Peers reported that girls put pressure on female and male peers to be sexually active, noting that it was "fashionable" to be sexually active (pg. 109, Selikow et al., 2009). Furthermore, girls reported that they risked being excluded from friendship circles if they were perceived to be abstaining from sex. A female adolescent participant stated, "I now you

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say your friend tells you, "*if you don't do it, then I am not going to be your friend anymore, they tell you and then you must [have sex].*'' (pg. 109, Selikow et al., 2009). Furthermore, adolescents have reported to view their peers as untrustworthy sources of information. Adolescents from a study, done in Cape Town, explained that, despite the misleading information, they still preferred to speak to their peers about sex because it was "*easier*" and they were able to "*speak more openly*" (pg. 110, Selikow et al., 2009). However, adolescents reported believing that adults provided more accurate information about friends but, unfortunately, reported that adults were often reluctant to discuss sex because they were considered "*too young*" (pg. 110, Selikow et al., 2009).

2.5.2. Lack of parent-adolescent communication about sexual and reproductive health

Parents can be critical partners in bringing sexual education closer to adolescents in their everyday lives (Panday et al., 2009; Modise, 2019). They are seen as a key protective factor for adolescents' health and an important source of SRH information for their adolescents (Silva et al., 2016; Silva et al., 2019). Parents greatly influence their adolescent's behaviours and attitudes towards their SRH through communication (Bhatt, et al., 2021; Silva et al., 2019).

Whitaker and Miller (2000) explore how parent-adolescent communication about sex could reduce the extent to which peer norms influence adolescents' sexual behaviour. There are a few ways in which this could happen. Firstly, parents are able to communicate information that peers may not. Adolescents may act on accurate information that they receive from their parents, rather than the potentially inaccurate information provided by their peers. Secondly, parent-adolescent communications about sex and SRH may reinforce parental values about sex, and adolescents might be more likely to behave in a manner that is consistent with those values (Whitaker & Miller, 2000). Finally, parent-adolescent

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communication provides adolescents with practical information, such as sexual decision-making skills, that may enhance adolescents' ability to handle peer pressure. If adolescents had the abilities and skills to decide on their own to abstain from sex or use a condom, they should be less likely to respond to peer pressure to have unprotected sex (Whitaker & Miller, 2000). Parent-adolescent communication has been associated with a greater ability to negotiate condom use and is associated with later sex initiation (Bhatt et al., 2021). Additionally, parent-adolescent communication is associated with increased SRH service utilisation among sexually active adolescents in Ethiopia (Feleke et al., 2013). However, the association of parent-adolescent communication with the utilisation of SRH services is less known globally (Bhatt et al., 2021). Several South African studies have found that the majority of parents fail to communicate, educate and inform their adolescents on sex and SRH matters (Maneli, 2011; Modise, 2019). Factors that play a role in the lack of parent-adolescent communication include a lack of parent's knowledge on SRH, parent's own sexual conflicts, and cultural norms (Modise, 2019; Govender et al., 2020)

Cultural barriers may inhibit open communication about SRH between parents and adolescents. In most African communities, parents may hold the belief that talking about sex with their children is inappropriate and taboo (Shrage & Stewart, 2015; Modise, 2019; Govender et al., 2020). This lack of parent-adolescent communication poses a problem because parent involvement in sex education has the potential to promote positive adolescent SRH behaviours and beliefs (Modise, 2019; Bhatt et al., 2021; Feleke et al., 2013). Parents in rural African communities tend to hold stronger taboos regarding SRH talk than parents in urban areas (Modise, 2019). Modise (2019) conducted a study aimed to explore rural South African parents' beliefs about appropriate SRH education for their children. This study found that parents believed that talking about sex with adolescents was for other people to do, such as teachers at schools. A female participant (mother, aged 63 years) stated, *"I cannot talk [to*

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my child] about sex, I am not comfortable and at the same time [I cannot] even use a condom." (pg. 85 Modise, 2019). Another participant in this study (aged 64) explained that she did not feel free to talk about sex with her adolescent because she stated that she was not educated to do so. Other parents in this study felt comfortable speaking about sex with their adolescents and found no issues. Despite the mixed results of this study, rural parents should find culturally appropriate ways to educate their adolescents about sex and SRH (Gill, 2013; Modise, 2019).

Another study investigated parent-adolescent SRH communication in rural Kenya. This study found that some parents never talked with their adolescent children about sexual and romantic relationships (Maina et al., 2020). The parent's main role was to delay sexual or romantic relationships among adolescents. When SRH communication was initiated by parents, it was more likely to be with their daughters than sons and was often initiated because something "bad" had happened in the community (such as a young girl falling pregnant). When such discussions occurred then it was mainly the parents talking and making decisions regarding their adolescents' SRH behaviours (Maina et al., 2020). This study emphasised the need for improved communication strategies for parent-adolescent dialogues on SRH issues, and parents need to be empowered with factual, up-to-date SRH information to ensure the discussions between adolescents and parents are helpful.

Mkhwanazi (2010) conducted a study in Nyanga East, Cape Town. It was found that was that discussing topics of sex was to be avoided between adolescents and parents. Adolescents received little information regarding puberty and contraceptive usage from their parents (Mkhwanazi, 2010). In matters relating to sex, adolescents were simply told 'not to sleep with boys', by an older female relative or their mothers (p.351, Mkhwanazi, 2010). On the other hand, young men did not receive any formal instruction on how to conduct themselves, from their parents (Mkhwanazi, 2010). Most of the mothers were aware that their

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daughters were sexually active but could not talk to their daughters about sex. This lack of parent-adolescent communication is due to the idea that it is respectful and appropriate conduct to avoid discussion regarding sexual matters. Adolescents felt uneasy to talk to adults about contraceptive usage and in turn, adolescent girls felt uncomfortable approaching HCWs for guidance. As a result, these girls turned to their friends for advice and were often given incorrect information about sex and contraceptive usage. An adolescent participant explained that she fell pregnant because her peers told her that, "*it is good to take breaks between [contraceptive] injections to give the body a rest*" (p.350. Mkhwanazi, 2010).

2.6. Adolescent girls and their sexual and reproductive health

2.6.1. Sexual and reproductive health laws in South Africa

South Africa's Constitution guarantees all individuals the right to access SRH services (Constitution of the Republic of South Africa, 1996). South Africa's legal framework also includes laws that protect adolescents' rights to make decisions regarding reproduction and their SRH. The Constitution of South Africa (1996) allows adolescents to receive contraception from the age of 12 years old (Müller et al., 2015). The Children's Act (CA; Act 38, 2005) states that children, from the age of 12, may not be refused condoms nor contraceptives, and that such provision must be kept confidential. More so, girls of any age have the right to terminate pregnancy up to 12 weeks (Müller et al., 2015). The 2005 South African Children's Act allows children, from the age of 12, to access health care services without parental consent (Holt et al., 2012).

These guidelines establish the importance of addressing women's needs- at all ages, and give adolescents the freedom to access SRH services, as well as choose the contraceptive method they want to receive (Lince-Deroche et al., 2016). According to the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012),

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contraceptive clients should have access to unbiased, accurate information about all available methods in order to make an informed choice (Lince-Deroche et al., 2016). Despite these adolescent-friendly SRH laws and guidelines, various other factors influence adolescents' utilisation of SRH services from public health clinics in South Africa.

2.6.2. Adolescents' views on sex, sexual and reproductive health, and sexual and reproductive health services

Westernisation and urbanisation influence adolescents' views on sex, premarital sex, and SRH. These views play an important role in adolescents' decision to abstain or engage in sexual activity. A study done in Kwazulu-Natal in South Africa assessed the knowledge of and attitudes towards sex among adolescents (Govender et al., 2019). This study found that 24.2% of adolescent participants agreed that it was acceptable to have sex before marriage. Furthermore, they found that 23.9% of the adolescents admitted to being too embarrassed to buy or procure condoms. The majority (86.8%) of participants agreed that SRH services can help prevent unwanted pregnancy, but more interestingly- 66.3% of adolescent participants believed that females are responsible for protection during sexual intercourse (Govender et al., 2019). However, when it comes to receiving contraception and SRH services adolescents seem to be wary, despite understanding the importance of these services.

Benzaken et al. (2011) conducted a study that determined adolescent students' exposure to sex education, their perceptions of accessibility to SRH advice, as well as their preferences in implementing SRH education in Mumbai, India. Their study found that the majority of the adolescents desired formal school-based SRH education, and that majority of adolescents' knowledge about sex and SRH comes from the school environment. The majority of the adolescents also preferred doctors, lecturers, and trained professionals to deliver SRH education. Their study also found that female adolescents were more limited to accessing contraceptive and SRH advice than males. Female adolescents were almost twice

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as likely to associate the lack of access to advice with embarrassment compared to males. Female adolescents are twice as susceptible to contracting an STI compared to boys and are more dependent on school for SRH information (Benzaken et al., 2011). Their study also found that a significantly higher proportion of female adolescents obtained their information from parents and other family members compared to males. These results demonstrate female adolescents' reliance on schools and parents as key sources of their SRH information and advice, as well as adolescent preference for trained professionals to be the main source of their SRH education. Furthermore, their study demonstrates the societal norm of gender differences and the impact it has on female adolescent SRH service utilisation. Adolescents' preferences for SRH service delivery should be noted when wanting to improve their utilisation of these services.

Onukwugha et al. (2019) conducted a systematic review of literature pertaining to adolescents' and HCWs' views on access and use of SRH services and information in both LMIC and HIC. They found that many studies linked adolescents' non-use of SRH services to structural, economic, psychological, and social factors. A cross-sectional study compared the views of adolescents with that of HCWs and found that more than half of HCWs often view confidentiality, cost of treatment, lack of awareness of SRH services, hours of services, and geographical location as the hindrance to adolescents' access to SRH care. However, adolescents placed a greater importance on the personal attributes of HCWs as the determent to them accessing SRH services (Johnston et al., 2015). Another study investigated how HCWs and adolescents viewed each other. Adolescents reported that HCWs had no respect for the concerns of adolescents and lacked understating of issues of confidentiality (Jacobson et al., 2001). A study conducted in South Africa, exploring young women's SRH experiences and needs, found that HCWs' unsupportive attitude was the main reason young women did not want to access family planning and abortion services (Lince-Deroche et al., 2015).

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Similarly, in a study in Uganda, Malawi, Burkina-Faso, and Ghana, sexually active adolescents reported that they did not know where to receive STI and contraceptive treatment due to embarrassment and fear of HCWs (Biddlecom et al., 2007). Adolescents, from a qualitative study in the Republic of Vanuatu, stated that HCWs' judgemental and unfriendly attitude was their major concern when accessing services. These adolescents reported that they feared HCWs would rebuke and make them feel embarrassed. This study suggests that providing adolescents with confidential and free SRH would improve their access to these services (Kennedy et al., 2013). Other studies in Australia and Africa echoed that HCWs characteristics, confidentiality, and accurate SRH information were adolescents' most valued markers of quality in SRH services (Donovan et al., 1997; Muntean et al., 2015; Both & Samuel, 2014; Amuyunzu-Nyamongo et al., 2015). Interestingly, HCWs do not think that their attitude interferes with adolescents' use of services. In a study, in Ethiopia, HCWs reported that the factors that impeded service utilisation were limited SRH knowledge, low status of women, lack of open discussion of sexual matters, cultural and logistical barriers, and limited resources for health facilities (Muntean et al., 2015). A study, in Kerala, India, also found HCWs to report similar barriers to adolescent use of SRH services, including stigma to utilise services, lack of awareness of parents, and economic factors (Nair et al., 2013). Comparison of these studies shows that what HCWs consider hindrances to adolescents' access to SRH differs from what adolescents feel themselves. HCWs from these studies did not recognise their attitude to be interfering with adolescents' access to SRH services (Onukwugha et al., 2019).

A study conducted in Kenya and Zimbabwe assessed which characteristics of SRH services were most important to adolescents (Erulkar et al., 2015). These adolescents rated confidentiality, low cost, short waiting time, and friendly staff as the key enablers of service use. Interestingly, this study showed that adolescents did not prioritise stand-alone youth

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services. A quantitative study, that examined adolescents' use of SRH, found that proximity to specialist clinics was found to be associated with greater use of SRH services, while high parental monitoring and low spending money were associated with less use (Parkers, Wight, Henderson, & Parkes, 2004). Studies in Kenya, Zimbabwe, and Australia all noted that adolescents view friendly service as an essential feature to them accessing SRH services (Kennedy et al., 2013; Matich, Harvey, Larkins, & Page, 2015). These adolescents preferred SRH services where HCWs were friendly, confidential, non-judgemental, and good listeners. Studies, conducted in Nigeria, Burkina, Faso, Ghana, Malawi, and Uganda, found that adolescents preferred seeking SRH from hospitals, or public clinics (Omobuwa et al., 2012; Biddlecom et al., 2007). Adolescents also preferred HCWs who were specialised in providing SRH services (Agampodi & Agampodi, 2008; Buseh et al., 2002). A study in the United Kingdom (UK), revealed that adolescents wanted clinics to run more frequently and that these adolescents did not mind if they shared a waiting room with adults (Nwokolo et al., 2002). Adolescent girls preferred to attend clinics with a friend and confidential walk-in service. Accommodating adolescents' preferences for SRH service delivery may improve their experiences when seeking SRH services from public clinics.

2.6.3. Adolescent's experiences when seeking sexual and reproductive health services

Numerous studies focus on HCWs opinions, beliefs, and experiences when delivering SRH services to adolescents. However, there is limited study on adolescents' personal experiences when seeking SRH from clinics. Most of the literature focuses on the accessibility, acceptability, and availability of SRH services for adolescents, while is limited study on adolescents' personal experiences in SRH clinics.

A study, conducted in Nepal, explored the factors impacting access and acceptance of SRH services (Pandey et al., 2019). Adolescent participants partook in focus group

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discussions where they shared their experiences and concerns with HCWs. Adolescents expressed that they felt HCWs, who were much older, treated them like children and were unable to understand their SRH issues. Adolescents also had heated discussions about HCWs attitudes, as they mentioned the "*condescending attitudes*" of HCWs often prevented them from seeking SRH services (pg. 8, Pandey et al., 2019). HCWs were reported to show attitude, anger, and speak to adolescents harshly when they requested condoms. Adolescents who reported these negative experiences were all unmarried, suggesting that HCWs' attitudes of reluctance are rooted in socio-cultural norms and beliefs around adolescent sexuality and premarital sex (Pandey et al., 2019).

Patel et al. (2012) examined the sexual vulnerabilities of Acholi adolescent girls living in displacement camps in Northern Uganda. Adolescents reported receiving SRH information from parents, siblings, teachers, peers, churches, sexual partners, and various sources of media, such as magazines, newspaper articles, FM radio stations, and online videos. An adolescent from this study explained that they did not often receive SRH from HCWs. She stated, *"When they (family planning services) are teaching about condoms, they usually restrict it to people of 18 years and above. They are the ones who are advised to use it. The use of family planning is for married women (those with husbands) not for girls… young girls in the ages of 12-14 years don't have any knowledge about condoms"* (pg. 8, Patel et al., 2012).

Mkhwanazi's (2010) paper discusses the circumstances that surround adolescent pregnancy and reactions to adolescent pregnancy in the township of Nyanga East, in the Western Cape. This paper highlights several issues that hinder adolescents' access to contraception or contraception information. A few of these issues were centred around HCWs' behaviour toward adolescents who sought SRH services. Adolescents reported that HCWs were rude to them, by insulting adolescents who sought contraceptive methods and

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ridiculing pregnant adolescents (Mkhwanazi, 2010). HCWs were also reported to have withheld information on the correct use of contraception. A young female participant stated, "*When I went to get contraceptive, the nurses told me that I am a loose woman and I will become pregnant. But I was not. I was just innocent. They did not tell me straight what I must do or what I must not do…*" (p.352, Mkhwanazi, 2010). Furthermore, participants reported that adolescents did not trust HCWs to provide them with detailed information on how to use contraceptives. There were two reasons for adolescents' distrust in HCWs. Firstly, HCWs were often part of the same community as adolescents, therefore adolescents' feared at their utilisation of SRH would become public knowledge (Mkhwanazi, 2010). Secondly, the community held an ideal of not adults not discussing sex and SRH with adolescents. Thus, made adolescents hesitant to willingly approach HCWs, who were adults in the position to provide information and guidance on contraception use (Mkhwanazi, 2010). These incidents suggest that HCWs might be allowing their beliefs, personal values, and opinions influence the way they behave towards adolescents who approach them for SRH services.

2.7. Opinions of sexual and reproductive healthcare workers

Unfavourable behaviours and attitudes of HCWs contribute to the poor utilisation of SRH services by adolescents (Wood et al., 2006; Geary et al., 2014; Tilahun et al., 2012; Jonas et al., 2018). HCWs seem to conduct themselves in manners that are informed by their personal beliefs and values (Atuyambe et al., 2015; Jonas et al., 2015). In South Africa, HCWs form the largest number of health care providers and are the most common category of health personnel that adolescents meet for their SRH needs (Warenius et al., 2006). HCWs' attitudes and behaviour towards adolescents have a significant impact as to whether these adolescents will return to the clinic to utilise the SRH services or not. Studies from Kenya and Zambia have shown that staff behaviour discourages young people from attending the clinics or for follow-up visits (Warenius et al., 2006).

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Holt et al. (2012) conducted a study where they explore HCWs opinions on adolescent SRH services in clinics in Soweto, South Africa. In this study, most HCWs said that adolescents should not be having sex, either for religious reasons, concerns for young women's futures, or due to a belief that adolescents are incapable of making decisions regarding sex. The phrase, "*indulging in sex*" was used, implying judgment and the idea that adolescents are irresponsibly or excessively engaging in sex (pg. 4, Holt et al., 2012). Despite personal beliefs against premarital sex, HCWs described how important it was to use condoms if adolescents decided to have sex, suggesting that they might be able to put aside their personal beliefs when counselling adolescents about prevention. A few HCWs made comments about sex being natural for adolescents to experience, regardless of whether they are married or not. When expressing their views on the causes of adolescents' high HIV and pregnancy rates, HCWs felt that adolescents were not taking advantage of the SRH information that they receive (Holt et al., 2012). Reasons for the poor use of SRH information by young women included that adolescents are "*ignorant*", in the sense that they ignore the SRH information they receive, or that adolescents want to get pregnant "*because they see their peers doing it*" because their family wants them to get pregnant, or because they want to child support grant (money paid by South African government) (pg. 5, Holt et al., 2012). These HCWs also pointed out that substance use, such as drugs and alcohol, as well as unemployment and a lack of activities to keep adolescents busy, lead to them engaging in unprotected sex. Peer pressure and poor parent-adolescent communication were mentioned as contributing factors to unprotected sex in communities (Holt et al., 2012). HCWs explained that mothers would send their adolescent for SRH, but will still not discuss sex or why the adolescent might need SRH services. This poor communication may result in adolescents receiving incorrect information from other sources (Holt, et al., 2012).

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In Kenya and Zambia, HCWs' attitudes were found to be similar to those in Soweto. The HCWs disapproved of adolescent premarital sex, abortion, and contraceptive use (Warenius et al., 2006). This support for “proper” sexual behaviour and sexual abstinence before marriage has its roots in religion and culture (Warenius et al., 2006). In addition to this, Warenius (2006) found that the HCWs who had more youth-friendly attitudes were the ones who had greater education and who received continuing education about adolescent sexuality and reproduction. For this reason, it is suggested that critical thinking around the moral and cultural dimensions should be included when educating HCWs about adolescent sexuality, and this critical thinking should be emphasised in undergraduate training. Warenius (2006) suggests that such training helped HCWs come to terms with the reality of adolescent sexuality.

HCWs are commonly confronted with ethical dilemmas. In Zambia and Kenya, there has been little focus in education that produces professionals who are skilled at ethical problem-solving (Warenius et al., 2006). Counselling adolescents with sexual health problems caused ethical dilemmas for respondents in Warenius (2006). The lack of focus on educating HCWs to deal with ethical problem-solving suggests that they were not properly prepared to deal with adolescent sexuality, especially considering that the HCW-midwives who had undergone continuing education related to adolescent SRH were the ones who had more youth-friendly attitudes (Warenius et al., 2006).

Jonas et al. (2018) explored HCWs' beliefs and views of adolescents’ SRH services. Their study was conducted among HCWs at public clinics that were situated in the urban centres of Cape Town. They found that HCWs felt that the SRH services for adolescents they are expected to provide were sometimes in conflict with their values and beliefs. An example used by HCW participants was the provision of condoms. They felt it was inappropriate to provide a 12-year-old with a condom because they thought that is encouraging the adolescent

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to start having sex. HCWs, in this study, also expressed the need to have abstinence recommended to adolescents as a prevention strategy for STI and HIV management. A degree-qualified nurse stated, *"Like we don't speak about abstinence anymore, you don't even see it on posters, it's not even spoken of now and it's just condoms and condoms"* (pg. 17, Jonas et al., 2018). The provision of termination of pregnancy (TOP) was another factor that HCWs mentioned to be against their morals and values. Several HCWs had strong feelings against this basic, yet necessary component for SRH for adolescents. However, they still felt that it was their duty to provide these services, irrespective of their own beliefs (Jonas et al., 2018).

Despite HCWs personal disagreements with certain elements of adolescent SRH services, they had positive responses in support of better quality SRH for adolescents. HCWs expressed time pressure and lack of resources as challenges that hindered the adequate provision of SRH services to adolescents, as well as a shortage of staff in the clinics. HCWs also stated that the healthcare system does not prioritize the SRH needs of adolescents (Jonas, et al., 2018). HCWs reported external factors that impacted the provision of adequate SRH services to adolescents, such as limited access to schools in the areas surrounding the clinic. HCWs suggested that a separate space or room should be provided for adolescents' SRH services, as well as an adolescent-friendly environment that improves the utilisation and access to services (Jonas et al., 2018). Lastly, HCWs reported that the operating clinic hours were not suitable for adolescents and needed to be extended by at least 30 minutes to an hour to accommodate the adolescents that finish school at 3 p.m. and have to travel to the clinic (Jonas et al., 2018). These infrastructural barriers, along with socio-cultural barriers, contribute to adolescents' poor utilisation of SRH services.

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2.8. Stigma and socio-cultural gender norms experienced by adolescent girls

Adolescents are still under scrutiny for exercising their right to engage in sexual activity. Adolescents cannot exercise their sexual agency without being constrained by an ethos of sexual shame (Bhana & Mcambi, 2013). Adolescent sexuality is scorned and punished. Specifically, the agency of adolescents is limited by the adults' dominating view of teenage pregnancy being unacceptable (Bhana & Mcambi, 2013). This is seen in media reports about the rates of teenage pregnancy increasing. These reports included headlines such as; '*Bored teens bonk- MEC'*, '*Just Kids Having Kids*' (Sunday Tribune, 20 March 2011); and '*Pregnant pupils, please bring your own midwives to school'* (Sunday Times, 28 November 2010) (Bhana & Mcambi, 2013). These headlines can be shaming, degrading, and humiliating adolescents who fall pregnant while still in school. Furthermore, sexually active adolescent girls fall victim to the stigma of being impure and loose.

Stigma is described to be a complex process that marks an individual for an attribute that violates social expectations and is devalued culturally (Hall et al., 2018). Stigma has also been defined as *"labelling, stereotyping, discrimination, separation, and loss of social status, social networks, and self-esteem, that co-occur in a context in which power is exercised, and which can result in negative health and social outcomes"* (pg.2, Hall et al., 2018). Hall et al.' (2018) study explored the experiences and stigma that young Ghanaian women, aged 15-24, faced when dealing with SRH issues. Their study found that adolescent SRH stigma was grounded in fears of contagion, of becoming *"tainted and spoiled"* (pg.11, Hall et al., 2018). The most vivid description of community norms around adolescent SRH was referred to through stories of "*bad girl*", which was a term that labelled adolescents with pregnancy, sex, abortion, childbearing, and family planning (FP) experiences as "*bad*" (pg. 6, Hall et al., 2018). The "*bad girl*" stigma extended to communities and families, and lead to "tarnished" homes and schools (pg. 6, Hall et al., 2018). A 15-year-old participant stated, "*Teachers and*

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religious leaders are also not doing their part. That's why she is giving birth at the wrong age. Also, she's a bad girl" (pg. 6, Hall et al., 2018). "Bad girls" were seen to be a result of failed leaders, parents, and teachers. This stigma fuelled adolescent social marginalisation and discrimination, where sexually active and pregnant adolescents were rejected by loved ones, expelled from homes, schools, and churches. This social marginalisation resulted in adolescents suffering from various mental health issues, such as loneliness, sadness, and depression (Hall et al., 2018). Furthermore, adolescents suffered physical, psychological, and verbal abuse from elders in the community. Adolescents would be shouted, screamed at, and even beaten, which contributed to further disgrace and public humiliation (Hall et al., 2018).

Adolescents may find it difficult to make choices regarding their sexual behaviour due to the contradictory messages from various sources. Adults may not provide adolescents with adequate information and guidance regarding responsible sexual behaviour and attitudes due to cultural and religious views against premarital sex (Maina et al., 2020 Modise, 2019;). Therefore, adolescents turn to other sources of information, such as their peers and media (Mkwanazi, 2010; Selikow, 2009). Adolescents turning to these sources poses a problem since the information is not always accurate (Selikow, 2009).

Gender roles are related to behaviours and attitudes that are considered acceptable for an individual based on their gender (Mulu et al., 2021). The social category of gender has the ability to confer different societal, peer, family and even personal norms and expectations upon women and men (Varga, 2003). Gender ideals and norms are a mediating factor in how adolescent girls may conduct themselves, thus it is important to consider gender roles, norms, and ideals when researching adolescent SRH experiences.

A study done by Varga (2001) illustrated the link between gender roles and the social impact of childbearing in the lives of Zulu adolescents in rural and urban KwaZulu-Natal, as

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well as demonstrated the influence of gender norms on the sexual dynamics that lead to adolescent pregnancy. The author found that a girl's respectability was gained by her being sexually available to her partner through allowing him sexual decision-making authority, being sexually faithful and avoiding pregnancy. Furthermore, it was found that a woman's sexual fidelity is highly-valued, and having multiple sex partners compromises this respectability. Avoiding pregnancy was another integral part of female attractiveness and sexual respectability, and was considered solely female responsibility (Varga, 2001). However, girls who suggest or who attempt to use male condoms were considered, by both male and female participants, to be conducting themselves highly inappropriately and reflecting their loose morals. This places adolescent girls in a no-win situation concerning the use of protection, as well as pregnancy avoidance. Contrasting these beliefs, men were believed to have a biological need for sex which made it acceptable for them to have multiple partners and expect sexual acquiesce in relationships (Varga, 2001). Boys had a greater social latitude when it came to acceptable sexual behaviour and are expected, or even encouraged, to engage in practises considered inappropriate for girls (Varga, 2011).

2.9. Theoretical framework

In this chapter, I use Bronfenbrenner's ecological systems theory to understand, conceptualise, and organise my research findings. I chose this theory because adolescent behaviours do not operate in isolation, rather adolescents interact simultaneously in several social spheres that can serve to restrain or promote their behaviours (Pilgrim & Blum, 2021). In order to understand both environmental and individual factors that influence adolescents' decisions to seek SRH services, a multisystem perspective is necessary. Bronfenbrenner's ecological systems theory (1979) provides a multilevel perspective that shows that an individual's development is dependent on the context of their environment. Bronfenbrenner

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mentions five types of nested environmental systems that interact with each other to affect a young individual's development.

2.9.1. Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner (1979) defined the ecological theory as the study of human development in context. He viewed an individual's development as taking place within a series of social systems. The individual is positioned in the centre of these interrelating systems. Five systems make up this framework. These systems are the microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

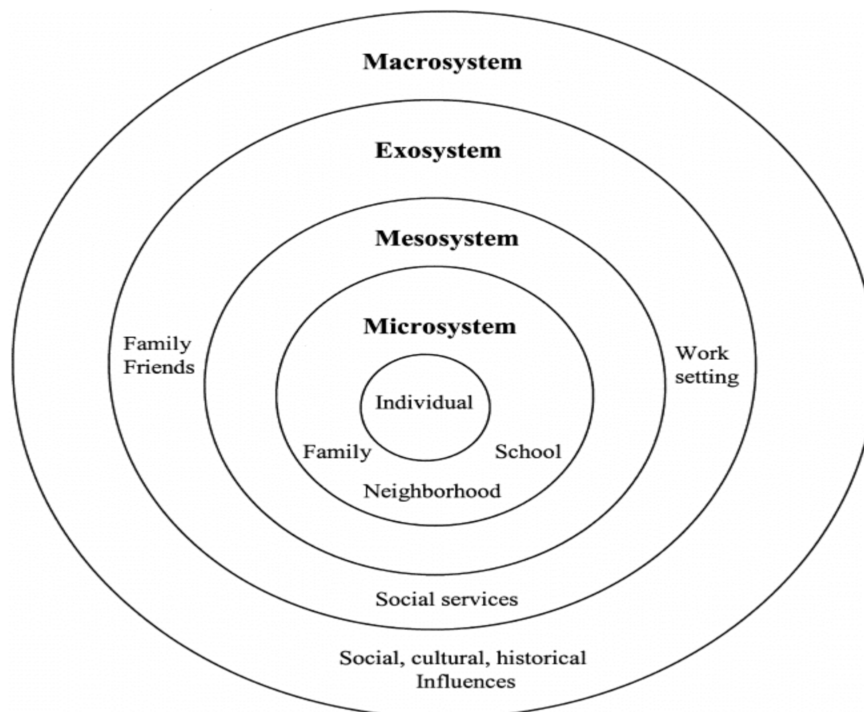

Figure 2.8.1.1 Bronfenbrenner's Ecological Systems Theory (excluding outermost chronosystem layer)

The ecological system theory focuses on the context of the individual's environment. In terms of this study, I will be focusing on the environment of the adolescent. According to

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Bronfenbrenner (1979), different environments interact with the adolescent throughout their lifetime, and these environments influence the behaviour of the adolescent.

The microsystem is the primary system and consists of the adolescent's immediate environment. The adolescent has direct interactions with immediate people in this system, such as parents, caregivers, teachers, peers, and HCWs. Structures in the microsystem include the school, family home, neighbourhood, and healthcare clinics (Bronfenbrenner, 1979, Pilgrim & Blum, 2021). The mesosystem is the interrelations among major settings containing the adolescent, such as parent-teacher interactions that may foster positive behaviours in the adolescents (Bronfenbrenner, 1979; Pilgrim & Blum, 2021). The exosystem is the third system from the adolescent. This system includes social structures that affect the immediate setting in which the adolescent develops. These social settings interact with each other, where at least one setting does not include the adolescent directly (Bronfenbrenner, 1979). An example of this is pressures at the adolescent parents' workplace that may affect the among of time the parent can spend with the adolescent (Pilgrim & Blum, 2021). The macrosystem is the fourth system that refers to the overarching culture of which the aforementioned systems are concrete manifestations (Bronfenbrenner, 1979). For example, overall cultural beliefs about how to rear female and male adolescents may affect the behaviour of the adolescents (Pilgrim & Blum, 2021). The chronosystem is the fifth system that encompasses change or consistency over time in the characteristics of the adolescent, as well as the environment in which the adolescent lives (Bronfenbrenner, 1979). An example of this system is be the psychological effects of parental divorce that may manifest in the adolescent long after the actual event (Pilgrim & Blum, 2021).

Each system influences the adolescent either directly or indirectly (Bronfenbrenner, 1986). For example, the physical, psychological, emotional, and genetic factors in the microsystem can influence the adolescent's decision to consistently utilise SRH services at

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the clinic. Peers, parents, and especially HCWs can either positively or negatively influence the experiences that the adolescent has when seeking SRH services. Broader, societal factors such as poverty, accessibility to the clinic, and cultures and beliefs in the community influence the adolescent's experience of SRH services. Bronfenbrenner's ecological systems theory provides a holistic approach to identifying factors that may encourage or discourage the adolescent when seeking SRH services. These factors can be identified across multiple levels.

2.10. Chapter summary

In this chapter, I reviewed literature pertaining to adolescence, adolescent risky sexual behaviour, influences on adolescents' decisions to engage in risky sexual behaviours, adolescent experiences of SRH services, as well as opinions and beliefs of HCWs providing these services to adolescents. Furthermore, I discussed the socio-cultural barriers that inhibit adolescents from receiving SRH advice due to cultural taboos, as well as provided Bronfenbrenner's ecological systems theory as the theoretical framework for this study. Research has reported incidences in SRH facilities where adolescents were turned away or scolded by HCWs for seeking SRH services. However, most of this research was from studies conducted in rural areas of Africa. I also reviewed a recent study, by Jones et al., (2018), that was conducted in a setting similar to this study, as it took place in public clinics in the Western Cape. These HCWs highlighted barriers that hindered adolescent-friendly SRH from clinics. Furthermore, Bronfenbrenner's (1979) ecological systems theory allows for the identification of various influences that affect an adolescent's SRH behaviour. These influences can be seen to impact the adolescent in all of the systems, from microsystem to macrosystem. Each structure in these systems may either positively or negatively affect the adolescents' experiences of SRH services.

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Chapter 3

Methodology

3.1. Research design

In this study, I aimed to gain insight into the experiences that adolescents have of SRH services in the Western Cape, and I explored HCWs' opinions of adolescent engagement in sexual activity, as well as their experiences when consulting adolescents for SRH services. In this chapter, I gave a detailed explanation of the different components of my research study such as the study setting, participants, and the procedures that I followed in order to collect and analyse my data.

Narrative research was implemented in this study. Narrative research is a type of research design that has a specific focus on the stories that individuals tell, which give account of an event (Creswell et al., 2007). The procedures for implementing narrative research consists of studying one or more individuals, gathering data through collecting their stories, reporting their individual experiences, and chronologically ordering the meaning of those experiences (Creswell et al., 2007). This design was suited for this study as the primary aim was to explore the experiences that adolescents have when seeking SRH services. The adolescent participants shared their experiences with me through interviews, allowing them to share their narratives. My second aim was to explore the experiences and opinions of HCWs, which allowed HCWs to share their narratives that were related to working with adolescents who sought SRH services.

Qualitative research usually focuses on and understanding the lived experiences of individuals, groups, and communities that are being studied (Leech & Onwuegbuzie, 2007; Bless et al., 2013). This form of research is extremely useful for obtaining meaning attached to experiences of selected individuals and groups (Nastasi & Schensul, 2005; Leech & Onwuegbuzie, 2007). Qualitative methods were used as it was most suited for this study. My

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study explores the experiences and opinions of adolescents and HCWs. Gathering data through qualitative methods, specifically semi-structured interviews, was appropriate since it allowed the participants to narrate their lived, personal experiences. Furthermore, I was able to develop a better understanding of participants' opinions, and experiences at the clinics.

3.2. Research setting

This study was conducted at two public clinics (henceforth referred to as Clinic A and Clinic B) in the Western Cape of South Africa. Both clinics offer SRH services that include counselling about contraceptive choices as well as obtaining oral, intravenous, and latex contraception. Adolescents and adults attend these clinics for SRH. Both of these clinics provide ongoing care to persons seeking services that include pregnancy/family planning, and STI, and HIV testing, as well as treatment.

Clinic A offered SRH to adolescents specifically on Tuesdays and Thursdays. As such, these were the days that I attended the clinic to in order to collect data. There was a small window for data collection at Clinic A as the adolescents attended their SRH consultations after school, usually from 14h00-16h00. Often I spent time waiting at the clinic for the adolescents, thus added an observational phase to my study. My first round of data collection at Clinic A was on 1 July to 11 October, 2019. The second round of data collection was on 11 February to 21 February, 2020. During the second round of data collection, I was only able to interview adolescents on Thursdays, because this was the only day that there was an available office in the clinic for me to conduct interviews Thereafter, the first COVID19 lockdown regulations were instated, and my data collection was halted. After lockdown regulations were lifted and my ethics application was re-approved, I attempted to continue collecting data at Clinic A on the 14 September to 18 September, 2020. I was able to interview one HCW during this time period. However, the clinic was not following strict COVID19 protocols, which made data collection unsafe for me and the participants in this

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study. There was little social distancing, no temperature checks or sign ins, nor was there an individual at the door providing sanitiser. My supervisors and I decided that data collection at Clinic A would be too risky. My first round of data collection at Clinic B was from 4 November to 29 November, 2019. There were no adolescents who attended clinic B during my initial data collection period at this clinic. I sat in the waiting room, in Clinic B, on Mondays, Wednesdays, and Thursdays, from the 2 November to 28 November, 2019. The clinic closed early on a Tuesday and HCWs informed me that adolescents were less likely to attend on Fridays. I made my observations in the time that I waited at Clinic B. During my second phase of data collection, 21 September to 16 October, 2020, and I was able to interview the HCWs at Clinic B.

3.2.1. Clinic A

Clinic A was an outpatient clinic located in a township in the Western Cape. This clinic mainly serviced individuals in the area and provided services to patients of all ages- ranging from infants to adults. The SRH section of this clinic was in a separate, partially concealed section of the clinic. This section of the clinic had its own waiting space that allowed for privacy for individuals waiting for their consultations. The SRH section had a long corridor with benches outside the consultation offices, where adolescents could sit and wait. The SRH section was not visible from the main waiting room for all other consultations. SRH consultations took place in numerous waiting rooms along the corridor. Adolescent SRH consultations took place on Tuesday and Thursday afternoons between 14h00-16h00. My interviews with adolescents took place on Thursday afternoons in the available consultation room in the SRH area. Clinic A was busy and HCWs rotated schedules, therefore the head HCW allocated an office to me when I arrived each day.

Clinic A also offered an additional educational service to adolescents seeking SRH services. A volunteer organisation, named LoveLife (https://lovelife.org.za/en/), had two young

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women who attended the clinic on Tuesdays and Thursdays and spoke to the adolescents before they consulted with the HCWs. LoveLife is a project that specifically addressed HIV/AIDS and life skills education for adolescents and young adults (https://lovelife.org.za/en/). The LoveLife staff educated the adolescents on various SRH matters, such as correct contraception use, the importance of regular SRH consultations, and provided information about STIs. The LoveLife staff were available to answer any questions adolescents had about SRH. The LoveLife staff generously and voluntarily assisted me with recruiting adolescents for interviews at Clinic A. The staff spoke to those adolescents who attended their sessions about my study and asked that those adolescents who were interested in seeking further information about the study go to my allocated office after they consulted with the HCWs.

My observations at Clinic A showed that all adolescents reported their arrived to the administrative (admin) staff before being seated in the waiting room area of the SRH section of the clinic, where they waited for their appointments with the HCWs. The admin staff were responsible for scheduling adolescents' appointments and follow-up consultations.

3.2.2. Clinic B

Clinic B was an outpatient clinic located in suburb in the Western Cape. This clinic was located opposite a high school and serviced individuals of all ages, from infants to adults. Clinic B was notably smaller than Clinic A. There was only one waiting room for all patients, and not a separate waiting area for SRH services as was the case at Clinic A. Adolescents were seen every day, at any time for SRH consultations. Only one HCW was allocated to the SRH section of the clinic.

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3.3. Participants

Participants in this study were female adolescents, aged 13-17 years, who attended these clinics seeking SRH services. Participants were also adult HCWs who provided adolescents with SRH at these clinics. All adolescents were recruited at clinic A pre-COVID, while HCWs were interviewed at both clinics I attended. The following inclusion and exclusion criteria were used for the adolescent participants.

Inclusion criteria

- Female adolescents aged 13-17 years
- Attending the clinic for SRH services
- Willingness to give assent (further information in section 3.7)
- Competence in English or Afrikaans

Exclusion criteria

- Adolescents requiring urgent medical attention or have severe mental health problems, defined as a diagnosis of schizophrenia, bipolar mood disorder, or currently experiencing an episode of psychosis
- Adolescents with a significant learning disability (or deemed unable to complete the measures by the recruiting HCW).

I did not detect any conditions in my participants therefore none were excluded.

3.4. Recruitment procedures

Before recruitment commenced, my supervisors and I met with the clinic manager of each clinic in order to explain the purpose of the study and request gatekeeper permission to access staff and patients at the two clinics. During these meetings, I explained the nature of the study and requested the clinic manager to assist with the recruitment of participants. At Clinic A, the clinic manager, referred me to the LoveLife staff to elicit their assistance with

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recruitment of adolescents following their consultations with the HCWs. The LoveLife staff volunteered to assist with recruitment of my adolescent participants. Recruitment at Clinic A thus took place as follows:

- Following the adolescent patients' routine SRH consultation with HCWs, those eligible for the study were informed briefly about the research by the LoveLife staff.
- Adolescents who expressed an interest in learning more about the study were referred to me in a private office at the clinic.
- I explained the study to the adolescent, and those who agreed to participate were asked to complete and sign an assent form.
- Adolescents were provided with snacks (mini chocolate bar) and refreshments (juice box) as a token of appreciation for their time.

I invited young women (between 13 and 17 years old) to participate in individual semi-structured interviews. The interviews with adolescents were intended to be approximately one hour in length, however, in reality they were considerably short and lasted on average 12 minutes (ranged in length from 10 to 15 minutes). Interviews took place in a confidential room at each clinic and were conducted in English using a semi-structured interview schedule (Appendix J). I digitally recorded the interviews using a Dictaphone. I then transcribed the interviews verbatim for analysis purposes.

Health care workers were recruited in the following manner:

- The head nurse of each clinic referred HCWs to me if they were interested in being interviewed.
- The HCW proposed a time that was convenient for them to meet, and I made sure to be available and ready at the suggested time.

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- HCWs were provided a R150 Checkers voucher as a token of appreciation for their time.

I aimed to recruit the maximum number of HCWs that was possible under the conditions present at the clinic. Unfortunately, due to Clinic A being overwhelmed with patients and understaffed with HCWs, I was only able to interview 2 healthcare workers. Clinic B was a smaller clinic and only 1 HCW was allocated in the SRH department, there was another who occasionally helped with SRH services. I interviewed both- 2 HCWs- at Clinic B. Interviews took place in their private offices and were conducted in English. Interviews with the HCWs lasted on average 38 minutes (ranged between 30-45 minutes).

3.5. Instruments

3.5.1. Demographic questionnaires

- Adolescents: The demographic questionnaire obtained adolescents' age, self-reported racial identity, first language, gender, full names, and marital status (Appendix A).
- Health Care Workers: The demographic questionnaire obtained HCWs' self-reported racial identity, gender, and full names (Appendix A).

The demographic questionnaires were used to seek basic information from participants to help develop an understanding of the participant and their background.

3.5.2. Semi-structured interviews

Interviews with adolescents

Adolescents were asked a series of open-ended questions relating to their experiences with seeking SRH at the clinic (Appendix B). They were asked about their first experiences at the clinic (e.g. "how did you feel when you first attended the clinic?"), current experiences (e.g. "tell me about some of the experiences you've had when coming to the clinic for SRH

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services”), the reason they sought SRH (e.g. “what made you come to the clinic”) if their mothers knew they were attending the clinic (e.g. if not, “why are you hesitant to let your mother know you attend consultations). I also asked their personal opinions about sex (e.g. “when do you think girls are ready to have sex”), about the conservations they have with their peers about sex and SRH.

Interviews with healthcare workers

HCWs were asked general questions, such as their role in the clinic, the areas they serve, and how often they attend to adolescents seeking SRH services. They were then asked about their personal opinions about sex and adolescents (e.g. “when do you think young girls are ready to have sex?”), the reasons for why more adolescents are engaging in sexual activity (e.g. “why do you think that the statistics for adolescents STIs and pregnancies are higher?”), and how they would handle certain situations with adolescents (e.g. “how would you handle a situation where an adolescent comes to you asking about sex, but you feel she is not ready to be engaging in sexual activity?”). I also asked HCWs which adolescents they feel their clinic is not attending to/reaching, and how they feel they could make the clinic environment more adolescent-friendly.

2.5.3. Observation schedule

I observed the clinic environment at both clinics while waiting for participants. I arrived at Clinic A about 2 hours before adolescents arrived (13h00) and observed the clinic environment. Once the adolescents arrived, I observed the interactions between the adolescents and the different parties at the clinic (e.g. peers, HCWs, and the LoveLife staff). Most of my observations were on Tuesday afternoons, as there was no available office for me to conduct interviews in.

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At Clinic B, I took my observational notes while waiting for adolescents to arrive for their SRH consultations. I sat in the waiting room of Clinic B for three days a week (Mondays, Wednesdays, Thursdays) from 14h00-16h00 (the time adolescents leave school). I spent all those times observing as there was no adolescent attendance during my time there (Appendix C).

I made these observations to contextualise to my interviews and help me understand my participants' experiences in a better light. I made as many objective observations as possible (e.g. noting the structure of the clinic, how well-kept the clinic was, watching interactions between different individuals). However, certain observations were subjective to me and how I felt, as a young woman, sitting in the clinic (e.g. "whether or not I felt comfortable in the clinic and if would attend for SRH"). Furthermore, I was not in contact with the admin staff unlike the adolescents who reported to the admin desk before every appointment. It is important to note that the interaction between adolescents and the admin staff may play a significant role in shaping the experiences that adolescents have at the clinic. The first step to receiving SRH services is through interaction with the admin staff to schedule or query SRH appointments. If adolescents feel uncomfortable or are shamed during this interaction, it may result in adolescents no longer attending appointments and not receiving SRH services. My interaction with the admin staff was limited and contradictory to some of the experiences of the adolescent participants from this study. I felt comfortable communicating with the admin staff when necessary, however I was in my early 20s and not querying an appointment for SRH services, which explains why my experiences of the admin staff was unlike the experiences of some adolescents in this study. Although I am not an adolescent, I was close in age, 22-23 years old during the time of data collection. My subjective observation may have provided useful to how friendly the SRH environment of the clinic was to younger women.

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3.6. Data collection

Data collection followed the following steps:

1. Signing of assent form.
2. Completion of demographic form.
3. Semi-structured interviews.
4. Observations.

Initially, I planned to collect data until data saturation. Data saturation occurs when the information participants provide becomes redundant and repetitive. Unfortunately, due to the government COVID19 lockdown regulations, data collection had to be halted before saturation may have occurred.

3.6.1. Data saturation

Data saturation refers to the point in data collection where no new additional data are found (Francis et al., 2010). Data saturation is a difficult topic to define because there is no one-size-fits-all method to reach data saturation. Study designs are not universal and the amount of data required in qualitative studies in order to reach saturation for one study may not necessarily be enough for another study. O'Reilly and Parker (2013) argue that adopting saturation as a generic quality marker is inappropriate, as the meaning of data saturation is unclear. The concept is seen as poorly specified, and many authors who claim saturation are not always transparent about how it has been achieved (Malterud et al., 2015). Malterud et al. (2015) explain the concept of information power. They suggest that this model be used as the determining factor for termination of participant recruitment, instead of using data saturation. The information power of an interview sample is determined by the study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy (Malterud et

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al., 2015). They argue that the researcher should revisit these items along the research process and then terminate the recruitment of participants when the sample holds sufficient information power.

3.6.2. Sample size

Majority of articles and books recommend that the size of purposive samples be established inductively and that sampling should continue until saturation occurs (Guest et al., 2006). The problem with this approach is that guidelines for research protocols and proposals require the researcher to state upfront the number of participants to be involved in the study, and researchers are often stuck carrying out the number of interviews they prescribe in a proposal, for better or worse. Guest et al. (2006) argue that researchers need a general guideline for the amount of participants at which data saturation is likely to occur. In a study conducted by Guest et al. (2006), the authors systematically documented the degree of data variability and saturation over the course of their analysis of 60 in-depth interviews with women in two West African countries. During code development, they found a total of 109 content-driven codes, where 80 (73%) of the codes were identified within the first 6 transcripts. Thereafter, an additional 20 codes were identified in the following 6 transcripts. Within the first 12 transcripts, a cumulative total of 100 (92%) of the codes were discovered. The full range of thematic discovery occurred almost completely within the first 12 interviews.

Guest et al. (2006) also assessed whether the codes developed in the early stages turned out to be the most important. They defined the importance of a code as the proportion of individuals to which the code is applied. After analysis of all 60 interviews, a total of 36 codes were applied with a high frequency to the transcripts. Of those, 34 (94%) had already been identified within the first 6 interviews, and 35 (97%) were identified after 12 interviews.

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The authors concluded that data saturation, for the most part, occurred by the time they had analysed 12 interviews and that the extra 4 or 5 codes identified were not novel in substance but rather were variations on already existing themes (Guest et al., 2006). These authors made the following recommendations: if the goal is to describe a shared perception, belief, or behaviour among a relatively homogenous group, then a sample of 12 will likely be sufficient; and if your aim is to measure the degree of association between two or more variables using a nonparametric statistic, you would need a larger sample. It is important to note these authors cautioned against assuming 6 to 12 interviews will always be enough to achieve a desired research objective or using the findings to justify "*quick and dirty*" research (pg. 79, Guest et al., 2006). Purposive samples still need to be carefully selected, and 12 interviews may not be enough if the domain of inquiry is diffuse or vague, the selected group is heterogeneous, the data quality is poor, and if your goal is to assess variation between distinct groups or correlation among variables (Guest et al., 2006). However, for most research enterprises, in which the aim is to understand common experiences and perceptions among a group of relatively homogenous individuals, 12 interviews should suffice (Guest et al., 2006).

The group of adolescent participants in this study were relatively homogenous, where all participants were isiXhosa-speaking adolescent girls within the small age range of 15-17 years. When considering Guest et al. (2006) considerations for data saturation, saturation occurred within the data collected from my adolescent sample, despite the short interview lengths, no new themes were emerging. The data from the HCWs were not sufficient to reach saturation. However, the main aim and focus of this study was to explore the adolescents' experiences, and exploring the HCWs opinions was an additional focus that was added in order to help understand the adolescents' experiences. It is important to note that I believe this study would have benefitted from a larger adolescent sample from various clinics, but,

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unfortunately, due to the circumstances (COVID-19 and the constant change in lockdown regulations by the government) and the setting of this study (public clinics) it was not feasible to continue data collection. The conditions of the pandemic did not allow for numerous face-to-face interviews with adolescents and HCW, and the HCWs of the public clinics were overwhelmed. Therefore, data collection was halted.

Overall, there are contradicting opinions on when data collection can be terminated. An increasing opinion is that data saturation is too vague and that the quality of the data obtained is more important than the number of participants recruited.

3.7. Ethical considerations

Ethics approval was obtained from the Health Research Ethics Committee of Stellenbosch University and the Department of City Health. Special permission was obtained to allow minors to give consent without a parent or guardian, due to the nature of the study. Permission was obtained from the Head Nurses at each of the clinics (Clinic A and Clinic B) for data collection to take place at the clinic. The identity of participants was kept confidential through the use of pseudonyms, in transcriptions, to de-link participants from the data. All data were stored on a password-encrypted hard drive and notes were kept in a locked cabinet in my home, to which only I had access to. All information was kept confidential.

Assent was obtained from the adolescent participants and informed consent was obtained from the HCW participants. Participants signed the consent form (Appendix D) before the commencement of the interview. I explained the nature and regulations of the data collection process, such as the interview being recorded, how the information will be stored, and that their identities will remain anonymous. I read over the informed consent form, allowed them time to read through it, and keep a copy of the form. I informed them that their

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participation was voluntary, that they did not need to answer questions that they did not want to answer and that they were allowed to withdraw from the interview process at any stage. There was no health risk imposed by the study on participants.

All the interviews were conducted in private offices at both clinics. The interviews were digitally recorded and conducted in English. Permission was obtained for the digital recording of the interviews, and participants were made aware of when the recorder was switched on and off (e.g. “I’m turning the recorder on now.”, “I’m turning the recorder off.”).

3.7.1. Waiver of parental consent for adolescent participants

Parental informed consent is required for individuals under the age of 18, however, under certain circumstances, parental informed consent may be waivered. The World Health Organisation (2019) explained that it may not be feasible to solicit permission from a parent or guardian for a child to participate in research. For reasons of sensitivity, such as discussions about sexual activities, it may be ethically justifiable and desirable for minors (under the age of 18) to choose independently (without parental assistance) whether to participate in research (WHO, 2019).

Individuals who are not legally able to provide autonomous informed consent may possess the ability to assent or dissent. The United Nations Children’s Fund (UNICEF) defines assent as *“the willingness to participate in research, evaluations or data collection by persons who are by legal definition too young to give informed consent according to prevailing local law but who are old enough to understand the proposed research in general, its expected risks and possible benefits, and the activities expected of them as subjects”* (World Health Organization, 2018). Assent is central to conducting research with children (including minor adolescents- under the age of 21), as it gives them the opportunity to express their views freely in maters that affect them. In some instances, it may not be feasible

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to solicit permission from a parent or caregiver for an adolescent participate in research, due to reasons of sensitivity, such as discussions about sexual activities, substance abuse, sexual abuse, physical abuse or neglect – it may be desirable and ethically justifiable for minors to choose independently (without parental assistance) whether to participate in research (World Health Organization, 2018). In this regard, minors may be unwilling to participate in the proposed research if they are required to tell their parents or guardians about the nature of the research (World Health Organization, 2018). In these circumstances, the researcher may consider applying to the governing research ethics committee for a waiver of parental or guardian consent (World Health Organization, 2018). Application for the waiver is only allowed if: the waiver will not adversely affect the rights and welfare of the subjects; the research involves no more than minimal risk to the participants; the research could not practically be carried out without the waiver or alteration; the research ethics committee or institutional review board determines that a research protocol is designed to study conditions in minors or a subject population where parental permission is not a reasonable requirement to protect the participants, and an appropriate mechanism is in place to protect the subjects, and the waiver is not inconsistent with federal, state or local law (World Health Organization, 2018).

Due to the sensitive nature of this study, I was allowed to obtain assent from the adolescents through signed consent forms. Adolescents in this study were expected to share their experiences regarding sex and SRH. These topics are sensitive in nature and adolescents were likely to decline participation if they were expected to inform their parents about the research study. There was no more than minimal risk imposed on adolescents during this study. Therefore, parental consent was allowed to be waivered.

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3.8. Data analysis

Interviews were analysed thematically using ATLAS.ti v.7. ATLAS.ti is a computer-assisted qualitative data analysis tool that assists researchers with coding and collating qualitative data. Inductive thematic analysis was used to analyse the transcripts within ATLAS.ti. I used reflexive thematic analytic procedures (RTA), which is a demarcated technique of thematic analysis (Campbell et al., 2021). RTA is described as independent of epistemology and theory (Braun & Clarke, 2019). The independence from a specific theoretical epistemology and framework allows for the flexible and broad application of the analytic approach across a range of epistemologies (Braun & Clarke, 2019). The researcher is responsible for selecting epistemology and theory, and ensuring that the RTA fits within that selected philosophical approach (Braun & Clarke, 2019).

There are four key decisions in the RTA process. It is the researcher's duty to make these decisions related to what counts as a theme, as well as the approach, level, and type of analysis (Braun & Clarke, 2019). When deciding what counts as a theme (i), the researcher has to consider the keyness and prevalence of a theme, which is the ability of the theme to capture what is important considering the research question (Braun & Clarke, 2019). The researcher then has to apply the same criteria consistently throughout the data. The keyness of a theme is judged on whether it is essential to addressing the overall research question. The type of analysis (ii) may either be inductive or theoretical. Researchers have the option of providing an in-depth account about one particular aspect of the data, or a rich description of the entire data set (Braun & Clarke, 2019). In the inductive approach, the themes are derived directly from the data themselves, and may bear little resemblance to the questions asked of the participant or the researcher's theoretical interest in the topic (Braun & Clarke, 2019). Whereas a theoretical approach is driven by a priori theoretical understanding of the topic (Braun & Clarke, 2019). The theoretical approach tends to focus on a particular aspect of the

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data and may involve coding for a specific research question (Braun & Clarke, 2019). The researcher must then consider whether themes will be identified at the semantic or latent (iii) level. Sematic (descriptive) themes identify and summarise the content of the data and capture the surface level (Braun & Clarke, 2019). Latent (interpretive) themes go beyond what is explicitly said, revealing the underlying ideas, conceptualisations, and assumptions within the data (Braun & Clarke, 2019). The analytic process (iv) details the active process by which the researcher identifies themes and patterns in the data (Braun & Clarke, 2019). This process is a six-phased approach highlighted in the figure below. These phases do not necessarily have to follow a linear approach and the researcher may return to a previous phase as required and as the analysis develops (Braun & Clarke, 2019).

Table 3.8.1 Phases of Reflexive Thematic Analysis

Analytic Phase	**Description**	**Actions**
Data familiarisation	• Immersing myself in the data to understand the breadth and depth of the content. • Begin to search for patterns and meaning.	• Transcribing audio recording data. • Taking notes. • Reading and re-reading the data set.
Initial code generation	• Generating initial codes to organise the data.	• Organising and labelling data items into meaningful groups
Generating initial themes	• Sorting codes into initial themes. • Identifying relationship and meaning between initial codes.	• Mapping or diagramming. • Writing themes and their defining properties.

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Theme review	• Identifying patterns at the level of coded data. • Reviewing entire data set as a whole.	• Ensuring there is enough data to support a theme. • Collapsing overlapping themes. • Refining and re-working codes and themes.
Theme naming and defining	• Identifying the story of each of the identified themes. • Fitting the broader story of the data set to respond to the research questions.	• Cycling between the data and identified themes in order to organise the story.
Report production	• Presenting an interesting and concise account of the story told by the data, both within and across themes.	• Writing a compelling argument that address the research questions. • Writing beyond the simple description of the themes.

Note: The table above is adapted from Braun & Clarke (2006)

I followed a six-phased approach to data analysis, which provides me with a step-by-step approach to reflexive thematic analysis. (Braun & Clarke, 2019). Braun and Clarke's (2019) six-phases involve: data familiarisation; initial code generation; generating initial themes; reviewing themes; naming and defining themes; and producing a report. I triangulated my interviews and observational data for coherent justification of the themes (Christensen, Johnson, & Turner, 2011)

First, I transcribed my data. I listened to each of my interview recordings carefully and transcribed in verbatim. I ensured to be authentic in my transcription by not correcting

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any language errors that were made in the conversation. All the transcripts were imported into ATLAS.ti v.7 where I familiarised myself with my data through reading and re-reading the transcripts. I paid attention to any recurring codes that I saw at first glance. I highlighted my data and noted any initial ideas using the memo function.

In my second step, I started my first round of code production. I produced my initial codes that were present throughout my data set. My entire data set was coded systematically. All relevant quotations were coded. This process involved continuous editing, where I changed, removed, and added codes where they were applicable. During this phase, I paid close attention to similar codes that may result in possible themes, to lead me into my next phase of analysis.

In my third step, I began searching for themes. I collated my codes into possible themes and gathered the data relevant to each theme. ATLAS.ti v.7's group manager function helped me organise my codes into three broad themes that related to the experience of adolescent girls when seeking SRH services. Codes were merged in this phase and redundant codes were removed.

My fourth step consisted of me comparing my themes to the codes that I have created in phases one and two, as well as generating a thematic map of my analysis. I reviewed and selected my themes.

In my fifth step, I continued with my analysis. In this phase, I gave my themes detailed descriptions, as well as named each theme and subthemes.

My sixth step was the final phase was where I produced a scholarly report of my analysis. It consisted of the final analysis of selected extracts which was related to the analysis of my research question and literature review.

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3.9. Establishing rigour and trustworthiness in data

According to Shenton (2004), the trustworthiness of qualitative research is often questioned because the concepts of validity and reliability are difficult to address. Qualitative researchers must incorporate measures to ensure trustworthiness in their research (Silverman, 2001). Guba (1981) suggests four constructs that he believes should be considered by qualitative researchers in pursuit of a trustworthy study, namely: credibility; transferability; dependability; confirmability. I will discuss these constructs in relation to the data analysis of my present study.

Credibility refers to whether the researcher's study measures or tests what it is intended to. Provisions can be made to promote confidence that they have accurately recorded the phenomena being investigated. To ensure credibility, my research methods had to be well-established., I sampled my participants randomly from the group of individuals who met my research criteria (i.e. adolescent and female).

Triangulation is the use of multiple data sources to help understand phenomena more thoroughly from multiple vantage points (Leesch & Onwuegbuzie, 2007). Triangulation is important as it improves the rigor of analysis and strengthens the trustworthiness of the findings (Lincoln & Guba, 1985; Leesch & Onwuegbuzie, 2007). Triangulating my interview data with the observations I made of the clinic environment helped me contextualise my findings. The supporting data provided a background to help explain the attitudes and behaviour of the adolescents and HCWs under scrutiny. The use of triangulation, with other methods, compensates for the researcher's individual limitations, and helps to ensure credibility in the study (Guba, 1981). I encouraged participants to be frank, before the interview started, and ensured that their identity will remain anonymous to allow them to be as honest as possible without the worry of scrutiny or judgement to their reputation from outside eyes, such as the colleagues from the clinic or peers at school. When a participant

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responded to a question in a vague manner, I was sure to ask them to elaborate so I could fully understand what they wanted to say, instead of drawing my own conclusions from their response.

Transferability refers to the extent to which the findings of one study can be applied to other situations (Merriam, 1998). Since my study was of a qualitative nature, it was specific to a small number of particular individuals and environments. The findings cannot be generalised to other situations and populations. The findings of this study was rather suited to provide a rich explanation of the phenomena at hand (Guba, 1981). I was able to gather rich descriptive data by gathering demographic information on my sample of participants, and collecting observational data at the clinics.

Dependability is the extent to which the findings of a study is replicable- if the work were repeated with the same methods, in the same context, and with the same participants then similar results would be obtained (Shenton, 2004). Qualitative research often deals with phenomena that is constantly changing. The observations I have made are specific to the situation of my study and the descriptions are frozen and static in the 'ethnographic present' (Florio-Ruane, 1991). However, I addressed the dependability directly through reporting my study processes in detail. My research design enables a future researcher to repeat the work, if not necessarily to obtain the same results. My detailed report also allows readers to develop a thorough understanding of my methods and their effectiveness.

Confirmability of a study is achieved through the researcher having met the criteria of credibility, transferability, and dependability (Lincoln & Guba, 1985). It is key for the researcher to admit to their own predispositions, and to have 'reflective' commentary (Shenton, 2004). Reflective commentary is a detailed methodological description that the researcher provides the reader in order to help the reader understand why the researcher favoured certain approaches and methods, as well as admitting to any weaknesses in

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techniques (Shenton, 2004). Additionally, information regarding the researcher's training and preparation should be provided (Shenton, 2004).

3.10. Reflexivity

Reflexivity is one of the defining features of qualitative research, where the researcher's subjectivity is viewed as a source of contamination or bias (Gough, 2017). Questions about reflectivity are part of a broader debate about epistemological, ontological, and axiological components of the self, inter-subjectivity, and the colonisation of knowledge (Berger, 2015). Researchers need to increasingly focus on self-knowledge and sensitivity; carefully monitor the impact of their beliefs, personal experiences and biases; and maintain the balance between the universal and the personal (Berger 2015). Reflexivity is viewed as the process of a continual internal dialogue and critical self-evaluation of the researcher's positionality, as well as the acknowledgment that this position may affect the research process and outcome (Berger, 2017).

Relevant researcher's positioning includes personal characteristics, such as gender, race, affiliation, age, sexual orientation, personal experiences, linguistic tradition, beliefs, biases, preferences, theoretical, political and ideological stances, and emotional responses to participant (Berger, 2015).

These positions of the research may impact the research in three major ways.

- They can affect access to the 'field' because respondents may be more willing to share their experiences with a researcher whom they perceive as sympathetic to their situation (Berger, 2017). The similarity in age and sex, between the me and participants, played an important role in the willingness of adolescents to share their personal experiences. All the participants in my study were female. Participants were able to perceive a relatability between me, the researcher, and themselves. Adolescents, particularly, could view me as someone who could

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understand their situation since I, too, was an adolescent not too long ago. Adolescents who perceived these similarities might have shared more information with me than they may have if someone much different, in age and sex, had interviewed them.

- They may shape the nature of the researcher-researched relationship, which, in turn, affects the information the participants are willing to share. I approached them as a young, female woman which is what allowed them to feel comfortable sharing their experiences with me. The information my participants shared during the interviews could have likely been extremely different if it were a middle-aged man conducting the research.
- The worldview and background of the researcher affects the way in which they construct the world, use language, pose questions, and choose the lens for filtering the information gathered and making meaning of it, thus may shape the findings and conclusions of the study. Ontology relates to the nature of being, where the researcher uncovers how their perceptions of human nature impacts the approach they consciously adopt to reveal social truths (Bracken, 2009). I was sure to speak to the adolescents in a semi-formal manner. I was aware that English might not have been their first language, thus had to be sure they understood what I was asking. Furthermore, I wanted the adolescents to feel comfortable having those sensitive conversations with me. Approaching them formally might have created a ‘power dynamic’ in the interview, where the adolescents may have seen me as an authority figure and may have been hesitant to share information out of fear of judgement.

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Prior to this study, I had experience with conducting interviews and doing qualitative research. However, the research was fairly small in nature as it was for my Honours Psychology degree. I only had one tool of data collection, which were interviews that I conducted with university students. I did not have any experience in conducting interviews with individuals who were in different age groups and social settings, such as in high schools in rural communities as opposed to on the university campus. Many of the interview methods and skills I learned were through theory in my previous degree. In order to prepare for my interviews in this study, I consulted my supervisors who equipped me with tools and interview techniques to use during data collection. Furthermore, I did extensive research on previous adolescent experiences with HCWs when seeking SRH services. Before the interviews, I ensured that I was comfortable and familiar with my study protocol and interview schedule. After data collection, I made notes to reflect on the interviews and what I could have done better. I was also sure to note any questions I had regarding any struggles I faced, so that I was able to consult my supervisors in attempt to mitigate the issue in future. One of these struggles was the interview time being only 10 minutes on average.

There were numerous reasons for this short interview time. Firstly, there was a small window of opportunity each day for me to interview these adolescents. Adolescents attended the clinic after school and arrived between 14h00-15h00, and the clinic closed at 16h00. This window of data collection came to one and a half hours per day, and unfortunately I was only able to interview the adolescents on a Thursday which gave me one and a half hours a week. Often adolescents attended the clinic for SRH services without their parents knowing. For this reason, many were in a hurry to get home before their parents questioned why they were taking long to get home from school. One interview I conducted was halted because the adolescent's friend came into the room and told her that her mother was looking for her and she had to leave. Adolescents being in a rush to get home shortened the interview times.

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Lastly, my second round of data collection was during the time they were writing their year-end examinations. Adolescents who agreed to be interviewed told me that they cannot take too much time as they had to go home and study.

I was aware that I, a complete stranger, was questioning adolescents on an extremely sensitive topic (sex and SRH). Not only was I asking them about SRH, I was also recording the conversation and it is understandable that there was hesitancy from the participants. Nonetheless, I made sure to consult my supervisors and do the most that I could to conduct the interviews to the best of my ability. I did so to ensure that I was not the main reason that the interviews were short in nature. My interviews with the adolescents was at Clinic B located in a rural area within Cape Town. With that knowledge, I went to my interviews dressed casually (jeans and plain t-shirt) because I did not want there to be a 'power dynamic' at play during the interviews. It could have been easy for the adolescents to stigmatise me if I was dressed professionally and approaching them as a researcher, asking imposing questions. I wanted to allow the participants to feel comfortable around me to express their stories openly and honestly. My interview schedule was reworked multiple times because I did not want language barriers to affect participant's answers. Many of my adolescent participants were isiXhosa, and English was not their Home Language. As a result, I used language that was more suited to their understanding, for example I interchanged the term "SRH" with the term "family planning" since that was the term they used for the services provided by the clinic. I did not want to be viewed as an authority figure as it may have made participants hesitant to disclose personal experiences, nor did I want the interview process to be difficult and daunting for my adolescent participants by using language that they were unfamiliar with.

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3.11. Chapter summary

In this chapter, I presented the methodology that I followed during data collection. I collected through demographic questionnaires, semi-structured interviews, and observations. I analysed my data through reflexive thematic analysis. The next chapter contains the results of my study, with four main themes that have been found during analysis.

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Chapter 4

Results

4.1. Introduction to chapter

In this chapter, I present the findings from my analysis of the qualitative data collected for my study. I begin with a description of the characteristics of my participants. Thereafter, I present the themes that I have identified from the data, where I use pseudonyms to protect participants' identities. Finally, I present the results of my observations and field notes that were taken during my visits to the public clinics. Unfortunately, data saturation was not reachable due to the lockdown regulations imposed by the South African government during the COVID19 pandemic. The data were collected over a total period of 6 months. The data were collected over multiple time periods. At Clinic A data was collected between the 1 July to 11 October 2019, 11 February to 21 February 2020, and 14 September to 18 September 2020. At Clinic B data was collected between 4 November to 29 November 2019, and 21 September to 18 October, 2020. Thereafter, data collection was halted. Since the national lockdown and the various risk levels imposed, it was difficult to collect data at the clinics for this study. Further, since healthcare workers have been at the frontline of the pandemic and overwhelmed with the additional responsibilities they have to attend to. Constant, numerous face-to-face interviews at the clinic were risky once the pandemic started to occur.

4.2. Demographic characteristics of participants

The final sample consisted of 11 adolescent girls, between the ages of 15 and 17 years old, and 4 HCWs. As can be seen in Table 4.2.1, the average age of adolescent girl participants was 16 years, all of whom were attending high schools in and around the area (Mean Age= 16; Standard Deviation= 0.77; Mode= 17). The HCWs interviewed were nurses

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that were either responsible for the SRH unit of the clinic or assisted in SRH services by attending to the adolescents during their appointments. Refer to Table 4.2.2.

Participants were recruited from City Health Clinics in the Northern Suburb region of Cape Town. The clinics will be referred to as Clinic A and Clinic B, to protect the identity of the clinic staff members. 11 adolescent girls and 2 HCWs were recruited from Clinic A. Clinic A was the clinic with the highest number of adolescent attendance for SRH services. As such, most of the adolescents who took part in this study were recruited from Clinic A. Staff at Clinic A reported that on average 154 adolescents attended the clinic each month in the period July 2018- June 2019. At Clinic B, the number of adolescents attending per month was considerably lower and estimated to be roughly 38 adolescents per month during the same period. I attempted to recruit both adolescents and HCW from Clinic B, however, I was only successful in recruiting HCWs due to the low rates of adolescent attendance at the clinic in the time period that I was recruiting for this study. Thereafter, COVID19 government lockdown regulations were imposed and data collection had to be halted.

Table 4.2.1 Adolescent Demographic Data and Pseudonyms

Adolescent Code	**Pseudonym**	**Sex**	**Age (years)**	**Race**	**Marital Status**	**Home Language/s**
A01	**Anathi**	Female	16	Black	Single	isiXhosa
A02	**Fezeka**	Female	15	Black	Single	isiXhosa
A03	**Cebisa**	Female	17	Black	Single	isiXhosa
A04	**Zintle**	Female	15	Black	Single	isiXhosa

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A05	**Akhona**	Female	17	Black	Single	isiXhosa & English
A06	**Nomobi**	Female	17	Black	In a Relationship	isiXhosa
A07	**Noxolo**	Female	16	Black	Single	isiXhosa
A08	**Nceba**	Female	16	Black	In a Relationship	isiXhosa
A09	**Themba**	Female	15	Black	Single	isiXhosa
A10	**Khanyiswa**	Female	16	Black	Single	isiXhosa
A11	**Nocawe**	Female	16	Black	Single	isiXhosa

Table 4.2.2 Healthcare Workers' Demographic Data and Pseudonyms

HCW Code	**Pseudonym**	**Sex**	**Race**	**Employed at Clinic**
H01	Sister Thandiwe	Female	Black	A
H02	Sister Denise	Female	White	B
H03	Sister Samantha	Female	Coloured	B
H04	Sister Gugu	Female	Black	A

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Note: Participants classified themselves according to the race that they identified with. The South African law classifies the following race categories: Black, Indian, Coloured, White, and Other (Rubin, 1974). I am aware of the controversy that surrounds the categorisation of individuals according to race, especially within South African scholarship, and am sensitive to the significant social meanings such categories may contain (Swartz, Gibson, & Gelman, 2002).

4.3. Qualitative reflexive thematic analysis results

I identified three main themes and four sub-themes during reflexive thematic data analysis of the data collected from the adolescents. These themes were: (1) the expectation versus the lived experience of HCWs by adolescent girls; (2) influences on adolescents' decisions to seek SRH services. This second theme consisted of 2 sub-themes namely, maternal influence and peer influence. Theme 3 entailed; the opinions and views of HCW. This third theme also consisted of 2 subthemes namely, adolescents' readiness to have sex and the barriers to adolescents receiving SRH education and services.

4.3.1. Adolescents' expectations versus their lived experiences when seeking sexual and reproductive health services

Adolescents reported that they were nervous when they attended the clinic for the first time. They assumed the HCWs may be judgmental or strict towards them. Anathi, 16 years old, expressed her initial concern about the HCWs being strict with her when she went first sought SRH services. She had expected judgement and hostility from the HCWs. Instead, she found the HCWs to be very welcoming. Anathi stated:

"They were understanding. They were nice and all. Like, because I thought they would be strict now hey... Yeah but now yeah it was welcoming."

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Adolescents claimed that they felt comfortable around the HCW during their consultations at the clinic. All of the adolescents stated that they felt at ease asking the HCW questions about SRH if and when they felt they needed to. The HCWS were described as helpful, kind, and understanding. Several adolescents stated that they enjoyed attending the clinic and went on to say that they loved being around the HCWs. They said it felt easy to speak to the HCWs about sex, and even compared it to having a conversation with their peers. Fezeka, 15 years old, expressed her admiration towards the nurses:

> *"It was good. I loved the nurses because they're so easy to talk to. It's like your friends. They're just like talking to your friends so it was great."*

Themba, 15 years old, said that she felt comfortable speaking to the HCWs when I asked her how she felt the first time she attended the clinic for SRH:

> *"Very comfortable because… like when I arrived I just go for HIV and it was very nice talking to her. I was comfortable"*

These statements show how fond the adolescents became of their HCWs at the clinic. Many of the adolescents called the HCWs 'chommie' which is an Afrikaans slang term for "friend".

Adolescents explained that it was not the HCWs that they had difficulty with at the clinic, but rather the admin staff. Adolescents reported that the admin staff tended to become annoyed if they missed their appointments or if they did not report to reception before entering the SRH section of the clinic. Adolescents reported that the admin staff would shout at them if they did not report to reception before they attended their SRH consultation with HCWs or if they missed consultation appointments. Ncemba, who was 17 years old at the time of this interview, elaborated on the issues she had with an admin staff member:

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"Sometimes the nurses are rude. Some of them. Like the receptionists are sometimes rude… Like if you ask- like if you ask anything, man! Then they answer you like, 'why don't you go to the nurses?' or 'why didn't you come here first?'. Sometimes they do that. Then when you answer them then they raise their voices."

Nomobi started attending the clinic a year before our interview and she was 14 years old at the time of her first attendance at the clinic. She explained that the admin staff shouted at her and told her that she was "*too small to prevent*". Furthermore, she said that they were speaking to her so loudly that everybody in the waiting room could hear the commotion. She told me that she felt judged by the admin and seemed humiliated by the situation as she explained:

"When I first came here I gave them my- they said they wanted my birth certificate and I gave it to them. Then they asked me, 'why are you here?'. And I said, 'I'm here to prevent' then they look at each other and they said, 'no you too small to prevent' and I look at them. Then they did my appointment card."

Despite the admin staff telling Nomobi that she was "too small to prevent", they allocated her an appointment with the HCWs. Nomobi said that, unlike the admin staff's behaviour, the HCWs were "*nice*" and comforting to be around. She was not deterred from attending her consultations despite the admin's judgement and shaming. which highlights the importance of the HCWs' adolescent-friendly behaviour.

According to Sister Thandiwe (head nurse at Clinic A), Clinic A used to be overwhelmed with adolescents who attended the clinic for SRHS after school. As such, in order to minimise the stress on the HCWs, Sister Thandiwe, explained that they started sending HCWs to deliver the contraceptive injection at the nearby high school to lessen the number of adolescents attending the clinic in the afternoons. However, she said the adolescents enjoyed

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being in the clinic environment so much that they still attended the clinic for their injection instead of receiving it at the school. However, there is the possibility that the adolescents did not want their peers or teachers at school to see them receiving contraception, which is why they continued attending the clinic in the afternoons. Sister Thandiwe stated:

> *"They very happy, shame. They very happy cause some of them, we actually said- the ones that are here [at the high school], 'cause we send a nurse in the afternoon at 1 p.m.- I think or 11 or 12 o'clock- to go there to give them the injection. But you find there are some of them, they will come here. They don't go there at the school, they come here. Then I'm like, 'We sending a nurse to you but you come to us!'. They wanna be here. They want to be here. Then I say, 'Ok I'm not gonna inject you!'. They say, 'Nooo! Give me the injection!' *playful* [laughter]. They want to be here on this corridors."*

There seemed to be a playful, joyous relationship between HCWs at clinic A and adolescents who attended. This playfulness is reflected in adolescents calling the HCWs "*chommie*", as well as the playful and friendly behaviour that the HCWs had with adolescents. This playful relationship, between HCW and adolescents, gives the impression that consultations were kept light-hearted and friendly by HCWs, which is why adolescents enjoyed attending the clinic.

Overall, none of the adolescents who took part in this study reported feeling any judgement from the HCWs, nor did they feel unwelcome. The adolescents expected the HCWs to be hostile/stern towards them, however, their experience with the HCWs was of the opposite. The HCWs were kind and friendly towards adolescents, which resulted in them regularly attending the clinics for their consultations.

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4.3.2. Influences on adolescents' decisions and behaviour

I found two main influences on adolescents' decisions to utilise SRH services of the clinic. The first influence being maternal, where adolescents reported that their mothers insisted that they attend the clinic for contraception. The second influence on adolescents' attendance was the influence from their peers. Adolescents reported that they saw their peers attend the clinic for SRH and joined them, either out of curiosity or out of fear of missing out.

4.3.2.1. Maternal influence on adolescents' decisions to seek sexual and reproductive health services

A few adolescents reported that their mothers were influential figures in their lives when it came to matters of SRH. HCWs and adolescents reported that mothers were concerned that their adolescent daughters would become pregnant, thus urged them to collect contraceptive medicine from the clinic. Anathi, 16 years old, explained:

> *"My mother sent me because she said to prevent pregnancy…Cause since I've gotten into high school, she's gotten more stricter than before. So sometimes it's kind of hard to talk about sex with my mother…but she's the one who's always trying to get in that conversation with me. So somehow I try to get opening with her."*

Anathi's mother constantly tried to speak to Anathi about sex. However, Anathi explained that she felt uncomfortable because she saw her mother every day. She preferred speaking to HCWs about the topic, presumably because they were adults that she does not have any personal connections with- "like I don't' see every day"- and HCWs are not supposed to be "strict" towards her in the way that her mother is. Sister Thandiwe explained why mothers send their adolescent daughters for SRHS:

> *"Mmh, and most of them, as well, they not getting home early. That's why their mothers say, 'Listen here, they playing outside till late- I'm not sure if they playing or*

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what' [laughter] but they all say, the mother is worried that she is not getting home early so she must come for injection"

While most adolescents reported that their mothers influenced their decision to obtain contraception, others explained that they did not feel comfortable speaking to any of their mothers about sex. Akhona implied that she felt that it was disrespectful to speak to her mother about sex:

"She is not strict, but I respect her, about talking to her about sex [to not talk to her about sex]*"*

Fezeka, who was 15 years old, said that she did not feel comfortable speaking to her parents about sex or SRH because they were too strict. Her parents told her that she should not have sex before marriage and that having sex while she is young is dangerous as she might fall pregnant:

"When they told us what parents tell us. Don't do it before marriage. That's why they advise us. And it's not good to sleep while you are young."

Fezeka's statement alludes to the taboo that adults place on adolescents, where it is frowned upon for to have sex while young and it is frowned upon for them to have sex before marriage. Despite this taboo, some adolescents reported that their mothers were encouraging them to receive contraception, while other adolescents reported that they were hiding their contraception use. Participants reported that the injection was their chosen form of contraception as it was convenient for them to hide, as opposed to having to take the pill every day and risk their mothers finding the tray of pills. Fezeka stated:

"No, I came for the needle. So the pill thing is very tricky because, you know, my mom can see the pill and be like, 'what's the pills for?' you know".

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Several adolescents reported that they were not sexually active and explained that they obtained contraception from the clinic if they decided to start engaging in sexual activity. These adolescents had a clear sense of responsibility towards their SRH health. Their decision to use contraception displays a potential concern that adolescents have for falling pregnant at their age. It is possible that adolescents have a certain plan for their future and were aware of the impact pregnancy could have on their lives and plans for their future.

4.3.2.2. Peer influence on adolescents' decisions and behaviour

Adolescents admitted that their peers were the people they consulted the most about personal matters. Adolescents spoke to their peers about SRH, SRH services, their sexual knowledge, and encounters. They found it was easier to speak to their peers, as their peers were of similar ages, and will not reprimand or judge them in the way that their parents might. Akhona stated:

> *"We talk about it like… Not every time. But I told them things that I experienced, yes, and they also told me their things."*

Most adolescents were hesitant to disclose the details of the conversations they would have with their peers, regarding sex and sexual health. The hesitancy in the adolescents seemed to be due to nervousness, as they were asked about sex (which is a sensitive topic) by me, a stranger whom they had just met, which explains participants' short and abrupt answers. The majority of participants did not disclose much information regarding the details of their conversations with peers on sexual matters. Fezeka explained:

> *"*Nervous laughter* Okay we speak about… Well… It was my first time. I never- my friends had sex before I did so they would speak about their experience, their positions, everything. How awful it is to start, how bad it is to actually break your virginity and stuff. So yeah, that's what we talk about."*

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The conversations between adolescents and their peers were curious in nature. Adolescents had a lot of questions about sex, as it may be a new topic for many, and they discussed it with their peers. An adolescents told me that she "googled" questions with her peers and when she was alone, as she often wondered about sex and SRH. An example is provided, by Nomobi, who stated:

"We speak about… like what happens if you have sex without a condom, can you fall pregnant when having sex your first time? Yeah and a lot of other things."

Adolescents reported that peers encouraged their friends to attend the clinic for SRH, which showed that adolescents have a sense of responsibility towards themselves and their peers. Adolescents and their peers consulted HCW on issues and questions regarding SRH. Cebisa explained:

"They did before because I was… it was march and uh, I had discharge but it was bad- smelling bad. Then they advised me I must come to the clinic and tell the nurses about what I have. I also did that and then the nurse said I need an STI treatment. Then they did give me that and it was over. So they did advise me."

Furthermore, adolescents' reported that their peers advised them to only have sex when they felt comfortable. There was no judgement towards adolescents who were not sexually active. Peers were supportive. Adolescents said that their peers told them to wait until they were ready or until they had a partner who they could trust. Overall, my data showed that peers are supportive and responsible when it comes to SRH, as they encouraged the adolescents to use protection and take care of their sexual health. Anathi explained:

"I would talk about…Uhm… protection, since I am the youngest in my friends- not the youngest but- they, I think we, girls, should talk about that and help ourselves and advise

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each other that we should not do such things. Even though some of my friends are in a relationship they must use protection even though they trust their partners."

"They say to me, if you feel like you are ready to have sex then you can have but if you don't feel like you ready then don't force yourself to impress your boyfriend."

All of the adolescents had a common curiosity to experience sex. This curiosity was often sparked by conversations with their peers. Several adolescents explained that they heard their peers speak about sex and wanted to experience it for themselves. Furthermore, adolescents admitted that they wanted to have sex so that they could be able to contribute in conversations with their peers. Often, it was the main reason that the adolescents, in my study, became sexually active.

I asked my participants why they thought it was becoming more common for adolescents to engage in sexual activities. The overall response was "peer pressure", however, my participants clarified that it is more "curiosity to experience" than actual "peer pressure". Peers did not judge or bully their adolescent peers into having sex, which is what the term "peer pressure" implies in this scenario. Instead, adolescents spoke to their peers about sex and wanted to experience what their peers spoke about. For example, Akhona stated:

"Pressure from their peers. It's like when someone is talking about when she had sex and you like, 'Yoh, I want to experience'.

Sister Thandiwe substantiates this statement by saying:

"They want to speak about it because when they talking about this they have a conversation about this- you don't have anything to because you don't know what is it [sex]. So when you do it, you will say your experience as well."

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Sisters Thandiwe clarifies her perspective on the 'peer pressure' mentioned. It is not exactly peer 'pressure' as she explains it is more of a curiosity to experience, to feel included. Furthermore, adolescents spent time with their peers and if their peers attended the clinic, adolescents were with them and this sparked curiosity in adolescents. She said:

> *"Peer pressure like they come in groups. They got groups. So maybe there are two girls in a group that are having sex and you're the only one in the group who doesn't. then maybe they are speaking about it and then you also want to experience, you understand? So I think it's basically peer pressure."*

HCWs from both clinics agreed that adolescents were more likely to engage in sexual activity because of influence by their peers. Adolescents were found, by HCWs, to be curious and were interested in having similar experiences to that of their peers. Adolescents admitted to engaging in sexual activity so that they could contribute to the conversations that their peers were having.

4.3.3. Opinions and views of healthcare workers

4.3.1. Adolescents' readiness to have sex

Adolescents' readiness to have sex refers to HCWS' opinions on when they believe that adolescents are ready to engage in sexual activity. I asked HCWs when they felt was the right time for adolescents to have sex. Age was a common response as a factor in adolescents' readiness to have sex. HCWs, at clinic A, explained that the younger the adolescents are, the less educated they will be on the matter of sex and SRH. Thus, resulting in them being less likely to think about the possible consequences of having sex, such as STDs or pregnancy. They reported that awareness of SRH developed with age, and that schools and clinics played a significant role in creating this SRH awareness through education. Sister Gugu stated:

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"I think that starting from the age of 18 whereby you will be having enough education about sex. Like I think, okay, I think everyone have to be educated about sex, ne. Because you will find that most of the girls, they are having sex without even knowing, like, what are they expecting. Like peer pressure from their-from the friends. So they ending up having sex at the early ages. I think 18 years when they are mature enough to make their own decisions… That is my own opinion"

However, HCWs from Clinic B had a slightly different opinion. Sister Denise reported that sex was something to engage in after marriage. She stated that abstaining from sex for 'as long as they can' was better for their SRH:

"In my opinion, if they can stay and abstain as long as they can. It's, it's better for them. In their health and well with all these cancers and cervix cancers that's popping in and yeah it's difficult to say what's my opinion. For me, it will always be, uh, when you get married"

Sister Samantha, from Clinic B, stated:

**pause* … Yoh… Yoh that's… You know… *hesitancy*… That's a difficult one. It's a very difficult question. The young people are engaging in sex very early now. They are experimenting uhh with sex and with all kinds of sex and with ways of sex. It's… yeah, and then I picked up by the vaginal infections that's coming in. The STIs. The STDs that come in from the young kids. Then you realise, 'Oh my God, what are they doing'. And it's not a shame. It's almost like you are not in- you are not popular if you are not having sex. And it's not just- sommer by the second visit. It's not that they they- the young relationships- start to know each other and wait. You know the sooner you can get it the better. So I don't think there's a cut-off but they are very active from the age of 14.*

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HCWs from Clinic B showed some hesitancy in disclosing their opinions on when adolescents were ready to have sex, which gave an impression that these HCWs did not believe adolescents should be engaging in sexual activity unless they were married- as stated by Sister Denise. While HCWs from clinic A were more open to discussing their opinions during interviews. It is worthy to note that clinic A's HCWs did not mention the topic of marriage during interviews.

4.3.2. Barriers to adolescents receiving sexual and reproductive health education and services

HCWs reported that SRH education should be taught to adolescents from parents, teachers, and HCWs. However, due to discomfort and stigma, often parents are not able to speak to their adolescents about SRH. Sister Gugu explained that adolescents should have their first conversations about sex with their parents, then at the schools and clinics:

> *"I think it must be, it's supposed to start at home. Especially with our Africans, ne? Because I find most of the time we are scared to speak with our girls- like telling them about sex. Like when they are reaching a certain age whereby you will notice that they are having a boyfriend. I think you are supposed to educate them at home first. And then at school and then at the clinic. But it is supposed to be started at home."*

At Clinic A, HCWs reported to be aware that adolescents may be hesitant to seek SRH services if there were other adults, from the community, at the clinic. These HCWs decided to accommodate two days of the week to adolescents' consultations, during this time they would try to ensure that no adults had appointments for SRH services. This allocation of time to adolescents was reported to allow adolescents to feel more comfortable in the clinic and seeking SRH services.

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"When they come here… When they come here, they not open. That's why we actually plan to have afternoon sessions with them. We want to see them… As you can see with the clinic now, it's not actually full. There's no adults. There's not lots of people. At this time when they come here, it's only them. Yeah, we hoping that it's only them because of the stigma. Let's say if a girl comes here and see the neighbour, then that mother will think 'ok she was there to get the injection, meaning she's sexually active' and then that girl won't come here again because of that, she saw that neighbour. So our point… that's why we do them in the afternoon. We start them from half past 2, when they are coming from school they come here. And with my other people, like my other clients, I always tell them, "Tuesday and Thursday I don't give afternoon appointments" because I don't want them to be here. I want to do the school children. The teenagers."

A potential barrier to adolescents accessing Clinic A was that some adolescents attended schools 15-20 minutes away from the clinic. Sister Thandiwe explained that they attended to adolescents at 14h00 until 16h00, and some adolescents would not make it to the clinic in time after school. Another barrier mentioned by HCWs was stigma about contraception and lack of education. They explained that adolescents would receive misinformation about SRH and thus were unable to make informed choices. These adolescents would then avoid attending the clinic or seeking SRH services. Sister Gugu stated:

"They don't have information I think. I think it's stigma and that they don't have information. Cause some of them, they will think that, there's this myth that if you go for an injection then it'll make your body loose. So I think it's that stigma…. But the ones that are here, I don't see any problem. They are happy. They want to be here. So I think it's just stigma."

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HCWs explained that, despite their opinion about when adolescents' are ready to have sex, they were not allowed to tell adolescents whether or not to abstain from sexual activities. Sister Thandiwe explained that HCWs' main role was to educate the adolescents and provide them with the necessary knowledge to make informed decisions:

> *"I don't say that they mustn't start. No, no I don't say that. The other thing we do is to give health education; do you understand? We give health education; we tell them the consequences that they face when they want to have sex. And we tell them that if they want to have sex then they must do everything, protect, use a condom, prevent pregnancy. So we're actually teaching about dual protection. So we are not… We can't say that "they mustn't have sex", "they must have sex". Do you understand? Our job is just to give them health education."*

Sister Denise from Clinic B explained that she was aware not to have a stern towards the adolescents at the clinic seeking SRH services. She reported that she would try to make adolescents comfortable by making jokes and being friendly:

> *"You need to open up. You need to have a very uhm casual approach. I mean you can't have this old fashioned strict face, like "omg what are you doing here?! You're not supposed to be here for- uh- why you having sex?" That is not the way to approach kids nowadays. You actually must salute them for taking the step to take the responsibility and, so that is more our approach. Trying to make them comfortable, make jokes and laugh and so that they feel at ease to come again."*

HCWs from Clinic A reported no issues with attending high schools to provide adolescents with SRH services. However, HCWs from Clinic B mentioned having issues obtaining access to the nearby high schools to offer SRH services. HCWs from Clinic B also explained that they did not have the resources to consistently provide SRH services to

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adolescents outside of the clinic, since there were only 2 HCWs in the SRH section of Clinic B. Sister Denise stated:

> *"We were thinking of going to the schools as well but the governing bodies don't like it. They say that you are almost promoting sex. Yes. It's a lot of schools that it's not on with. They will say 'no, no, no, we will first have to send a letter to the department of education. Get their, uhm, uhh, you know the right way to do things. Then, you know, it just goes dead,"*

Sister Samantha, who was also from Clinic B stated:

> "*And then some schools also don't want the children to get family planning. Yes. Some of the principles. You can't go to a high school and offer family planning to the girls. They don't allow it"*

HCWs from Clinic B reported the governing body and principle at the nearby school to be barriers to some adolescents receiving SRH education and services.

4.4. Observations and the clinic environment

The HCWs at Clinic A seemed to be more accepting of adolescents engaging in sexual activity. They did not mention religion or morals during interviews and seemed to have very neutral opinions on adolescents engaging in sexual activity, with their main focus being on ensuring that the adolescents were well-educated and equipped with the necessary preventative measures. At Clinic B, however, I noted that HCWs used certain phrases that expressed their distaste for adolescents engaging in sexual activity, for example, the phrase "good girls" was used to describe adolescents who abstained. These HCWs also had strong personal beliefs against premarital sex.

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Clinic A's HCWs allocated dates specifically for adolescent appointments in the SRH unit of the clinic. The clinic did so to ensure that adolescents felt comfortable attending the clinic, and did not have to worry about older members in the community seeing them attend the clinic for SRH services. Interestingly, my research shows that adolescents often avoid seeking SRHS due to the fear of being recognised by members of the community. Clinic A took measures to avoid this situation being a concern for adolescents, and it is clear that these measures positively affected the clinic as it had the highest number of adolescent attendance compared to other clinics that I was permitted to collect data from (according to the statistics provided to me by the clinics). Furthermore, the SRH service section of Clinic A was in a discreet area, where adolescents cannot be seen from the main section of the clinic, providing privacy for adolescents while they wait for their appointment. Clinic A took extra measures to spread awareness and education about SRH by having an organisation (LoveLife) at the clinic to speak to the adolescents before their sessions. These measures, taken by Clinic A, may have contributed to their notably higher numbers than Clinic B (and other clinics). Clinic A took the time and effort to keep their SRH services as adolescent-friendly as possible.

4.5. Chapter summary

In this chapter, I presented the results of my study. I began by outlining the participant demographics, after which I presented my thematic analysis findings. Four main themes were found during analysis, namely the expectation versus the experience of HCW by adolescent girls, influences on adolescents' decisions- including the sub-themes of maternal influence and peer influence, the sexual curiosity of adolescents due to peer interactions, and adolescents' readiness to have sex. I also presented my observations made in the clinic settings of this study.

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Adolescent participants identified numerous influences on their decisions to utilise SRH services, as well as their personal experiences of the clinic. HCW participants shared their opinions and experiences while attending to adolescents seeking SRH, as well as identifying barriers that prevented them from providing services that were as adolescent-friendly as possible.

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Chapter 5

Discussion and Conclusion

5.1. Introduction to chapter

The objectives of this study were two-fold: firstly, to explore the experiences that adolescents have when seeking SRH services from clinics, and secondly, to determine the opinions of HCWs on factors relating to adolescents' engagement in sexual activity as well as barriers that they identify that prevent adolescents' access to SRH education and services. In terms of the first objective, adolescents reported that they mostly had positive experiences while seeking SRH services. In terms of the second objective, most HCWs reported to not have strong opinions against adolescents engaging in sexual activity and seeking SRH services. Some HCWs reported to they did not believe it was ideal for adolescents to engage in premarital sex, however these HCWs said that they still ensured provided adolescents with friendly and kind services to ensure that these adolescent girls are able to make informed decisions about their SRH. HCWs reported to be aware of their behaviour towards adolescents seeking SRH services, thus would act in kind and friendly manners towards these adolescents. Furthermore, the HCWs identified numerous barriers to adolescents receiving SRH education and services including: clinic operating hours; understaffed clinics; and the governing body at a nearby school not allowing them to reach out to adolescents to provide SRH education and services.

In this chapter, I will first discuss adolescents' expectations versus their experiences of HCWs at the clinic. Secondly, I will discuss the different influences on adolescents' decision to engage in sexual behaviour. Thirdly, I will discuss the views and opinions of HCWs on adolescent readiness to engage in sex, as well as barriers that prevent adolescents

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access to SRH services. Lastly, I will discuss the stigma that adolescents experience relating to sex and SRH.

5.2. Adolescents' expectations versus their lived experienced of healthcare workers at clinics

Adolescents in this study reported mostly positive experiences of attending the clinic for SRH services. These positive experiences were unexpected as adolescents reported that they were initially concerned about being judged by clinic staff when first attending the clinic. The concern about being judged by HCWs can be explained by several studies that have reported on adolescents' initial experiences at SRH facilities. For example, in a study done by Mkhwanazi (2010), the authors found that there were HCWs who insulted adolescents by calling them "loose" when they attended the clinic for SRH services. Numerous other studies, conducted in and around Southern Africa, stated that adolescents had negative experiences with HCWs, which resulted in them avoiding the clinics and not receiving proper SRH care and advice (Warenius et al., 2006; Holt et al., 2012; Patel, 2012).

Despite these concerns, adolescents reported finding the HCWs to be friendly and easy to speak to. The HCWs reported to make jokes with adolescents and created a relationship where the adolescents could see the HCWs as friends. Adolescents' peers are the people that they trust to speak to without judgement or fear of being scrutinized (Selikow et al., 2009). However, there is the question of how accurate peers' advice is on SRH and whether or not adolescents should be consulting them regarding these matters (Selikow et al., 2009). Furthermore, adolescents in this study reported to feel too awkward and uncomfortable to speak to their parents about sex. It seems as though adolescents have difficulty speaking to adults, that they know, about topics of sex and SRH (Maina et al., 2020; Mkhwanazi, 2010). I found that HCWs may fall into the role of the adult that adolescents can consult about SRH without feeling the same discomfort that they felt when speaking to a parent. If the

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adolescents considered the HCWs as friends, it could be likely that they would speak openly about sexual matters with the HCWs too, thus being able to receive proper guidance about SRH from a healthcare professional.

In this study, the adolescents mentioned feeling a sense of enjoyment when speaking to the HCWs, and these HCWs reported to make the adolescents feel comfortable during SRH consultations at the clinic. The HCWs' adolescent-friendly approach seemed to play a significant role in the adolescents' commitment to regularly attending the clinic. The adolescent-friendly service the HCWs provided can be linked to the clinic's high number of adolescent attendance each month. Regular attendance by adolescents can ensure they receive proper SRH advice from professionals, as well as the adolescents consistently receiving contraceptive services. All of the adolescents said that they attended the clinic to receive their contraceptive injection and went once every 3 months for their appointment. Various studies, conducted in rural and sub-Saharan Afirca, have shown that unfavourable attitudes and behaviours of HCWs have discouraged adolescents from attending clinics for SRH services, and from returning to the clinic for follow-up appointments (Lince-Deroche et al., 2015; Mkhwanazi, 2010; Pandey et al., 2019; Jonas et al., 2018). These studies reported that this behaviour resulted in adolescents avoiding the clinic and not receiving SRH education and advice. The HCWs, from these studies, were reported to have lacked respect for adolescents' privacy, as well as have conducted themselves in unfavourable ways (Jonas et al., 2018). However, adolescents in this study reported regularly returning to the clinic for their SRH consultations. Furthermore, these adolescents enjoyed attending their SRH consultations with the HCWs. These findings may highlight the significant influence that HCWs' behaviours have on adolescents' decisions to utilise clinics for SRH services.

In this study, the HCWs behaviours were reported to be adolescent-friendly. This adolescent-friendly behaviour created an environment in which adolescents may have felt

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comfortable attending SRH services, and in turn, could provide a reason for the clinic's high number of adolescent attendance. These finding are consistent with previous literature, such as that of Jonas et al. (2018) where the authors proposed that a youth-friendly service environment could improve the utilisation and access of SRH services. HCWs were required to demonstrate positive attitudes and engage in behaviours that are supportive, inviting, and caring.

5.3. Various influences on adolescents' decisions to seek sexual and reproductive health services

Adolescents' decisions to seek SRH services may be influenced by external factors. According to Bronfenbrenner (1979), the interactions in the microsystem (such as family and peers) are strongest influences that affect an adolescent's behaviour. This study found that the main influences on adolescents' decision to seek SRH were from mothers and peers, which both belong to the adolescent's microsystem.

5.3.1. Maternal influence

A number of adolescent participants reported that interactions with their mothers were the reason they started attending the clinic for SRH services. Some mothers were reported to have tried to speak to their adolescent about sex and SRH, while other mothers were reported to have simply told their adolescent to attend the clinic for contraception without much explanation. Literature provides multiple possible reasons for mothers encouraging their adolescents to attend the clinic. Firstly, adolescence is a time where children become more autonomous (Arnett et al., 2014; Crone & van Duijvenvoorde, 2021). Adolescents spend less time at home and more time with their peers. During this phase of development, mothers begin to have less control over their adolescent's decisions (de Boer, Peeters & Koning, 2017). This decrease in control can possibly provide an explanation for why mothers

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encouraged their adolescents to receive contraception. Since mothers are not able to control whether their adolescent decides to engage in sexual activity, mothers could ensure that their adolescent receives contraception and is protected from falling pregnant or contracting STIs. Secondly, studies have shown mothers to feel uncomfortable with speaking to their adolescents about SRH as these mothers feel that they do not have sufficient SRH knowledge (Gill, 2013; Modise, 2019). Furthermore, previous studies found parents to believe that talking about sex was for professionals to do, such as teachers or HCWs (Modise, 2019; Govender, Naidoo, & Taylor, 2020). Both the lack of sufficient SRH education and the belief that SRH conversations were for HCWs, provides a possible explanation as to why mothers sent their adolescents to the clinic without much explanation besides telling their adolescent that they should not get pregnant. A recommendation for clinics to provide classes for parents and teachers where HCWs to educate them on SRH and how to communicate with their adolescents on this topic. This may equip parents to answer SRH questions that adolescents have, as well as guide them in making safe decisions relating to sex and their SRH.

Numerous studies mention the importance of parents as critical partners that bring sexual education closer to adolescents in their everyday lives (Panday, Makiwane, Ranchod, & Letsoalo, 2009; Modise, 2019; Silva, van de Bongardt, van de Looijjansen, Witjtzes & Raat, 2016; Silva et al., 2019). These studies explain that parent-adolescent communication about sex and SRH have a significant influence on adolescents' behaviour to make responsible decisions regarding their SRH and attend clinics for these services. The adolescents in this study reported that their mothers attempted to speak to them about sex and SRH, however, the adolescents felt too uncomfortable to engage in conversation about these topics. There are few studies that have examined parent-adolescent communication from the adolescents’ perspective (Afifi, Joseph, & Aldeis, 2008; Jerman & Constantine, 2010; Holman & Kellas, 2018). In a study conducted by Holman and Kellas (2018), the authors

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investigated adolescents' perceptions on parent-adolescent communication on topics about sex. Interestingly, they found that adolescents wanted their parents to have frequent conversations with them about sex. Some adolescents even urged their parents to talk to them about detail on sexual health and safety, and encouraged parents to not be afraid of bringing up the conversation, despite how uncomfortable it may be (Holman & Kellas, 2018). Other adolescents wanted their parents to be more specific in talking to them about romantic relationships and the different kinds of contraception (Holman & Kellas, 2018). These findings are in contraction to the findings of my study, where adolescents reported not wanting to speak to their parents about sex. The discomfort in adolescents in this study may be attributed to the context of this study, such as background and culture. Holman and Kellas' (2018) study was conducted in the HIC of Nebraska, in USA, whereas this study was conducted in the LMIC of South Africa. When considering the different contexts that adolescents in each study grew up in, it is understandable that there may be contradictions in how adolescents prefer to communicate about topics of sex with their parents.

Various cultural barriers may also explain adolescents' discomfort with speaking to their mothers about SRH. Often, in African communities, it is considered inappropriate for adolescents to speak to adults about sex and SRH. These topics are seen as taboo and, thus, open communication about SRH is inhibited (Govender et al., 2020; Modise, 2019; Shrage & Stewart, 2015). All of the adolescents were isiXhosa speaking, and most were living in the same community. The context of the adolescents' social environment can explain adolescents' discomfort with speaking to their mothers about SRH and sex. For example, a study conducted by Simmonds et al. (2021) reported that caregivers in SA found cultural issues to be barriers to talking about sex, sexuality, and HIV/AIDS with their adolescent grandchildren. In their study, participants explained that communication about sex was not something they had experienced during their own adolescence, due to the belief that parents

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discussing sex with their children encouraged them to engage in sexual activity. Culturally, SRH communication in Africa is difficult, as many communities regard conversations around sex, puberty, and sexuality as taboo (Bastien, Kajula, & Muhwezi, 2011; Simmonds et al., 2021).

5.3.2. Peer influence

Adolescents from this study had a curiosity about sex that stemmed from conversations and interactions with their peers. Peers were reported to have conversations about their experiences engaging in sexual activity, which seemed to have impacted the adolescents in two major ways. Firstly, adolescents became curious about the experience of sex. This curiosity may not have been sparked if their peers were not engaging or speaking about sexual activities. Secondly, adolescents reported feeling excluded and have a desire to contribute to the conversation. These feelings of curiosity and exclusion could have been possible influences on adolescents' subsequent decisions to begin engaging in sexual activity.

Literature differentiates between the different types of peer influence (Garnder & Steinberg, 2005; Steinberg & Monahan, 2007; de Boer, Peeters & Koning, 2017; Forbes & Dahl, 2010). The phenomenon of indirect peer influence, seen in this study, is keeping with many previous studies that explain how adolescents tend to conform to the perceived norms and expectations of their peers (Baumeister, 1990; de Boer, Peeters & Koning, 2017). Furthermore, literature has shown that frequent communication with peers about sexuality-related topics was associated with a higher likelihood of an adolescent engaging in sexual activity (Busse, Fishbein, Silva et al., 2019). Furthermore, adolescents reported that their peers encouraged them to seek SRH services when adolescents had questions or concerns regarding SRH. In this regard, peers had a direct influence on adolescents' SRH behaviour and decisions. Unexpectedly, this direct peer influence was positive since peers were

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encouraging responsible SRH behaviour, such as attending the clinic, rather than risky sexual behaviour. Interestingly, literature often states the opposite, where peer influence is related to risky sexual behaviour, such as peers discouraging adolescents to use condoms or abstain from sex until marriage (Govender et al., 2019).

Adolescents in this study reported their peers to be understanding and supportive of their decisions to engage in sexual activity or not. Peers were reported to have told adolescents to wait till they feel comfortable and ready with a partner that the adolescent trusts. These findings are in contrast with previous literature that emphasizes the negative attitudes of peers towards adolescents. An example is seen in Selikow et al. (2006) study, where the authors found adolescents' peers to directly pressure them to engage in sexual activity. Adolescents from their study reported that their peers would marginalise them if they decided not to engage in sexual activity.

In this study, adolescents often accompanied their peers to the clinic, but did not initially seek SRH consultations themselves. However, after some time the adolescents themselves also requested SRH consultations despite not being sexually active. Numerous adolescents in this study explained that they were not yet sexually active but chose to take precautionary measures if they may begin engaging in sexual activity. Peer influence, specifically that of injunctive norms, could explain this behaviour of adolescents. Adolescents could think that their peers approve of individuals who seek SRH services and engage in sexual activity responsibly, and as a result they start seeking SRH services (Silva et al., 2019). In this scenario, peers are providing somewhat of a positive influence on adolescents as it is promoting and encouraging responsible behaviour. It also seems that having the support of peers at clinics allows adolescents to feel more comfortable seeking and utilising SRH services.

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5.4. Opinions and views of healthcare workers

When comparing the difference in adolescent attendance at these clinics, it is possible that HCWs personal beliefs may affect the number of adolescents that attend each particular clinic. However, it is important to mention that various factors play a role in adolescent attendance at clinics, such as location and community. Furthermore, HCWs' answers during the interviews and the way HCWs treat adolescents during consultations may be very different. HCWs could have given strong answers regarding personal beliefs and used specific terms because I had asked them their opinions, and the interviews were a safe space for them to share their thoughts. They were also encouraged to be honest. Despite them having strong personal beliefs against adolescents engaging in sexual activity, they explained that they still tried to make adolescents feel comfortable during consultations and that it was important not to shout at the adolescents. Previous literature stated that HCWs stigmatized adolescents and were unsupportive of their decisions to utilise SRH services (Mkhwanazi, 2010; Lince-Deroche et al., 2015; Warenius et al., 2006; Holt et al., 2012). However, HCW in this study were not reported to have treated adolescents in an untoward, ill manner. Some HCWs did have personal beliefs against adolescents engaging in sexual activity but explained that their beliefs did not stop them from attempting to provide SRH services that were as adolescent-friendly as they could manage.

HCW participants were of the opinion that adolescents should have their own clinic for SRH services, as adolescents were more likely utilise these services if they were located away from adults in the community. HCWs expressed their frustration about their clinics being understaffed to provide the SRH to adolescents, as well as having clinic times that do not suit adolescents who travelled further from school. HCWs at Clinic A explained that they had to encourage adolescents to attend clinics closer to their school since the travelling time did not allow some adolescents to reach the clinic before it closed at 4 p.m. The views, issues,

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and opinions that HCWs had in this study were similar to that of the HCWs in a study done by Jones et al. (2018), where they explored the motivations, beliefs, and behaviours of HCWs in public clinics in Cape Town, SA. The HCWs in their study were highly motivated to provide adequate SRH services to adolescents despite having certain personal beliefs that may go against certain aspects of this SRH provision, such as beliefs against TOP. Furthermore, HCWs in Jones et al. (2018) study also felt that clinic operating hours did not accommodate many adolescents who attended schools further away from their communities that the clinic was situated in. Lack of staff, sufficient resources, and access to schools were among the problems faced by HCWs (Jones et al., 2018). These HCWs felt that these healthcare-related challenges are a contributing factor to the under-utilisation of and poor access to SRH by adolescents. This reported non-prioritisation of SRH services for adolescents in the clinics is concerning as it substantially hinders the provision of services provided to adolescents. It was noted that the prioritisation of SRH services are not the responsibility of the HCWs, but that of the healthcare system itself (Jones et al., 2018).

5.5. Stigma and socio-cultural gender norms experiences by adolescent girls

Adults have imposed a taboo on adolescents having sex (Modise, 2019; Mkhwanazi, 2010). Adolescents are told that they should not have sex at a young age, nor before marriage (Mkhwanazi, 2010; Maina et al., 2020). Many parents avoid talking to their adolescents about sex and SRH as it is either: deemed inappropriate in their culture or parents feel that they do not have enough SRH knowledge to share with their adolescents (Shrage & Stewart, 2015; Govender, Naidoo, & Taylor, 2020; Maneli, 2011; Modise, 2019). This lack of parent-adolescent communication could make adolescents feel restricted about who they could turn to for SRH advice. This study found that adolescents tended to turn to their peers when seeking advice about SRH issues. However, these sources may be misleading and may not give adolescents accurate advice. (Govender et al., 2019). Highlighting the importance of the

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HCW's role in the adolescent's life as a source of information relating to sex and SRH. HCWs act as sources of education for adolescents on SRH topics. Research has shown education to have a protective effect on sexual behaviour as it improves the adolescent's knowledge of SRH and increases the likelihood of adolescents practising safe sexual behaviour, such as using condoms (Guiella & Madise, 2007).

This study also found that there were adults who were against educating adolescents on sex and SRH. Governing bodies of high schools in the area of certain clinics did not allow HCWs to address the adolescents on SRH services, as these governing bodies believed that it would be promoting sexual activity. HCWs, in a previous study, found this challenge to be extremely frustrating because, often, it is adolescents from these schools that are attending the clinic for TOP (Jonas et al., 2018). Adults from these schools are preventing HCWs from reaching out to adolescents for education on SRH services, and as a result, the adolescents from these schools seem to be falling pregnant (Jonas et al., 2018). The school governing body is a statutory body of educators and parents who seek to work together to promote the wellbeing and effectiveness of the school community and thereby enhance learning and teaching (https://www.westerncape.gov.za/general-publication/school-governing-bodies-sgbs). It is concerning that these bodies, which are supposed to educate adolescents and promote their wellbeing, are preventing these adolescents from receiving quality SRH education from professional HCWs. Some parents do not speak to their adolescents about SRH because they expected schools to educate their adolescents on these topics (Modise, 2019). However, some schools are hindering this education from occurring, which may result in adolescents not receiving enough SRH education. An important question may be raised as to how much adolescents are at fault for engaging in risky sexual behaviour, especially when their SRH education and guidance are inhibited by the adults in their lives.

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5.6. Limitations and considerations for future study

There were a few limitations to this study. Firstly, the interview length with the adolescent participants was short. There are numerous reasons for the short interview time which include the small window that was allowed for data collection at the clinic (1-1.5 hour interval) due to the clinic operating hours, adolescents were hesitant to disclose sensitive information to a stranger recording their answers, adolescents did not have much time to be interviewed as they either needed to study for their high school examinations or were in a rush to get home as their parents did not know they were seeking SRH services and English not being their first language. It is recommended that future research accounts for the small interview window by making appointments with adolescents for their time, as well as having a space for interviews that is not at the clinic so that the operating hours do not affect the interview times. Multiple interviews (2 or 3) with each adolescent could be ideal in allowing the adolescent to feel more comfortable around the interviewer and possibly be willing to share more information. A bilingual interviewer or an additional translator could also help facilitate the interview to run smoothly and possibly allow the adolescents to express themselves better in the language they feel most comfortable with.

Secondly, the small sample size provided another limitation. The adolescents were only recruited from one clinic. All the adolescents had similar experiences since they attended the same clinic. While this study was able to report on these adolescents' experiences, the experiences of adolescents at other clinics are still unknown. Reasons for the small sample size of adolescents include the low adolescent attendance at other clinics, as well as the small window for data collection due to (i) the government tightening and easing COVID19 lockdown restrictions during the duration of this study, and (ii) the school exams and the school holidays falling in the duration of data collection. The times were not suited to

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adolescent needs and a recommendation is to make appointments with adolescents, for interviews, well in advance for when they attend the clinic.

Finally, it is extremely important to note results obtained may have been skewed to adolescents who have had positive experiences. Since data collection took place at the clinics, the adolescents who were being interviewed where already regularly attending the clinic for SRH services, thus were likely to have mostly positive experiences since they had made the decision to return for their appointments. Furthermore, interviewing the adolescents in the clinic environment may have, unintentionally, created a relationship where there was a power dynamic, where adolescents may have felt hesitant to disclose information about the HCWs in the clinic where they seek SRH services. In future, it is recommended that data collection takes place away from the clinic and includes adolescents/women who are no longer attending the clinic.

5.7. Conclusion

In this study, I sought to understand the experiences of adolescent girls when seeking SRH services, as well as the opinions of the HCWs who provide them with these services. The findings of my study showed that adolescents had mostly positive experiences with the HCWs at the clinic they attended for SRH services. The adolescent participants were well educated on topics of sex and SRH, and often attended the clinic with their peers. Adolescents identified peers and parents as the influences on them deciding to seek SRH services from the clinic. Peer interactions and sex conversations were also identified as influences in adolescent participants deciding to engage in sexual activity. In this study, adolescents reported enjoying their consultations with HCWs and felt comfortable asking questions and speaking about SRH. Adolescents mentioned that their mothers occasionally attempted to discuss these topics with them, however, adolescents reported feeling too

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uncomfortable, and thus unable to speak to their mothers about sex and SRH. These feelings of discomfort are explained by various socio-cultural factors, such as adults deeming topics of sex taboo for adolescents and certain cultures deeming it inappropriate for adolescents to have these conversations with adults and caregivers. In this study, HCWs had their personal beliefs and values about adolescents engaging in early sexual debut, however, HCWs reported to still be motivated to provide SRH services in adolescent-friendly ways. HCWs mentioned various factors that hindered their provision of these services to adolescents, including clinic operating hours not accounting for adolescents traveling after school, school governing bodies not allowing HCWs to attend schools to provide SRH education and advice, and the clinic being understaffed and not fully equipped to provide the SRH services that they wished. HCWs also recommended that adolescents should have their own clinic for SRH services, to further ensure adolescents' privacy, as well as allow adolescents to be more comfortable utilising SRH services. Findings from this study highlight adolescents' willingness to utilise SRH services with HCWs and in environments that they feel comfortable in. Adolescents, from this study, seem to display a sense of responsibility towards their SRH health by regularly attending SRH consultations with their peers. Furthermore, the findings from this study suggests that it is possible for HCWs to have firm personal beliefs and views against premarital sex, while still being able to provide adolescent-friendly SRH services. It appears that adolescents are able to take charge of their SRH education and services utilisation when they have the supporting systems to do so including positive peer influence, parent-adolescent communication, as well as adolescent-friendly SRH services and clinics.

Stellenbosch University https://scholar.sun.ac.za

References

Afifi, T. D., Joseph, A., & Aldeis, D. (2008). Why can't we just talk about it?: An observational study of parents' and adolescents' conversations about sex. *Journal of Adolescent Research,* 23, 689 721. https://doi.org/10.1177/0743558408323841.

Agaba, P. A., Makai, R., Bankat, C. T., Chebu, P. R., Apena, T., Iyaji-Paul, O., & Idoko, J. A. (2016). Sexual behavior and risk factors for HIV infection among young people aged 15-24 years in North-Central Nigeria. *Journal of Medicine in the Tropics*, *18*(2), 60.

Agampodi, S. B., & Agampodi, T. C. (2008). Adolescents' perception of reproductive health Care services in Sri Lanka. *BMC Health Services Research*, *8*(1), 98. http://doi.org/10.1186/1472-6963-8-98.

Ali, M. M., & Dwyer, D. S. (2011). Estimating peer effects in sexual behavior among adolescents. *Journal of Adolescence, 34*, 183–190. https://doi.org/10.1016/j.adolescence.2009.12.008.

Amoateng, A. Y., Kalule-Sabiti, I., & Arkaah, Y. J. (2014). The Effect of Socio-Demographic Factors on Risky-Sexual Behaviours of Adolescents in the North West Province of South Africa. *African Population Studies, 28*(1). https://doi.org/10.11564/28-1-502.

Amuyunzu-Nyamongo, M., Biddlecom, A. E., Ouedraogo, C., & Woog, V. (2015). Qualitative Evidence on Adolescents' Views of Sexual and Reproductive Health in Sub-Saharan Africa. *Occasional Report, 16.*

Arnett, J. J., Zukauskiene, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18–29 years: Implications for mental health. *Lancet Psychiatry, 1*(7), 569–576. https://doi.org/10.1016/S2215-0366(14)00080-7.

Stellenbosch University https://scholar.sun.ac.za

Atuyambe, L. M., Kibira, S. P., Bukenya, J., Muhumuza, C., Apolot, R. R., & Mulogo, E. (2015). Understanding sexual and reproductive health needs of adolescents: evidence from a formative evaluation in Wakiso district, Uganda. *Reproductive Health, 12*(1):1. https://doi.org/10.1186/s12978-015-0026-7.

Bandura, A. (1971). Social learning theory. *General Learning Press.*

Bastien. S., Kajula, L., & Muhwezi, W. (2011). A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*, *8*(1), 25. http://doi.org/10.1186/1742-4755-8-25.

Baumeister, R. (1990). Meanings of life. Guilford Press.

Beksinska, M., Closson, K., Smit, J., Dietrich, J., Hornschuh, S., Smith, P., Nduna, M., Brockman, M., Ndung'u, T., Gray, G., & Kaida, A. (2021). Adolescent pregnancy and current contraceptive use among adolescent and young women aged 16-24 years in Durban and Soweto, South Africa. *BMC Women's Health*, 1–19.

Benzaken, T., Palep, A. H., & Gill, P. S. (2011). Exposure to and opinions towards sex education among adolescent students in Mumbai: A cross- sectional survey. *BMC Public Health, 11*(1), 805-805. http://doi.org/10.1186/1471-2458-11-805.

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475.

Bhana, D., & McAmbi, S. J. (2013). When schoolgirls become mothers: Reflections from a selected group of teenage girls in Durban. *Perspectives in Education*, *31*(1), 11–19.

Bhatt, Bhatt, B., Neupane, B., Karki, A., Bhatta, T., Thapa, J., Basnet, L. B., & Budhathoki, S. S. (2021). Perceptions of family planning services and its key barriers among

Stellenbosch University https://scholar.sun.ac.za

adolescents and young people in Eastern Nepal: A qualitative study. *PloS One*, *16*(5), e0252184–e0252184. https://doi.org/10.1371/journal.pone.0252184.

Biddlecom, A. E., Munthali, A., Singh, S., & Woog, V. (2007). Adolescents' Views of and Preferences for Sexual and Reproductive Health Services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health, 11*(3), 99–100. https://doi.org/10.2307/25549734.

Biney, Ewemooje, O. S., & Amoateng, A. Y. (2020). Predictors of sexual risk behaviour among unmarried persons aged 15-34 years in South Africa. *The Social Science Journal (Fort Collins)*, 1–16. https://doi.org/10.1080/03623319.2020.1727225.

Bjork, J. M., & Pardini, D. A. (2015). Who are those "risk-taking adolescents?" Individual differences in developmental neuroimaging research. *Developmental Cognitive Neuroscience*, 11(C), 56-64. https://doi.org/10.1016/j.dcn.2014.07.008.

Both, R., & Samuel, F. (2014). Keeping silent about emergency contraceptives in Addis Ababa: a qualitative study among young people, service providers, and key stakeholders. *BMC Women's Health*, *14*(1), 1-19. http://doi.org/10.1186/s12905-014-0134-5.

Bracken, S. (2009). Discussing the importance of ontology and epistemology awareness in practitioner research. *Worcester Journal of Learning and Teaching, 4*.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101, https://doi.org/10.1191/1478088706qp063oa.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589- 597. https://doi.org/10.1080/2159676X.2019.1628806.

Stellenbosch University https://scholar.sun.ac.za

Braun, V., Clarke, V., Braun, V., & Clarke, V. (2021). Qualitative Research in Psychology One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238.

Bronfenbrenner, U. (1979). Ecology of human development. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723-742. https://doi.org/10.1037/0012-1649.22.6.723.

Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of child development.* 187-249.

Buseh, A. G., Glassa, L. K., McElmurryb, B. J., Mildred, M., & Nonhlanhla, A. S. (2002). Primary and preferred sources for HIV/AIDS and sexual risk behaviour information. *International Journal of Nursing Studies, 39*(5), 525-538. https://doi.org/10.1016/S0020-7489(01)00058-X.

Busse, P., Fishbein, M., Bleakley, A., & Hennessy, M. (2010). The role of communication with friends in sexual initiation. *Communication Research, 37*, 239–255. https://doi.org/10.1177/0093650209356393.

Campbell, K. A., Orr, E., Durepos, P., & Li, L. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*, *26*(6), 2011–2028. https://doi.org/10.46743/2160-3715/2021.5010.

Stellenbosch University https://scholar.sun.ac.za

Clark, S., Koski, A., & Smith-Greenaway, E. (2017). Recent Trends in Premarital Fertility across Sub-Saharan Africa. *Studies in Family Planning, 48*(1), 3–22. https://doi.org/10.1111/sifp.12013.

Creswell, J. W., Hanson, W. E., Plano Clark, V. L., & Morales, A. (2007). Qualitative Research Designs: Selection and Implementation. *The Counselling Psychologist, 35*(2), 236-264. https://doi.org/10.1177/0011000006287390.

Crocetti, E. (2017). Identity formation in adolescence: The dynamic of forming and consolidating identity commitments. *Child Development Perspectives*, *11*(2), 145-150. https://doi.org/10.1111/cdep.12226.

Crone, E. A., & van Duijvenvoorde, A. C. K. (2021). Multiple pathways of risk taking in adolescence. *Developmental Review*, *62*, 100996. https://doi.org/10.1016/j.dr.2021.100996.

de Boer, A., Peeters, M., & Koning, I. (2017). An Experimental Study of Risk Taking Behavior Among Adolescents: A Closer Look at Peer and Sex Influences. *Journal of Early Adolescence*, *37*(8), 1125–1141. https://doi.org/10.1177/0272431616648453.

Donovan, C., Mellanby, A. R., Jacobson, L. D., Taylor, B., & Tripp, J. H. (1997). Teenagers' views on the general practice consultation and provision of contraception. The Adolescent Working Group. *The British Journal of General practice, 47*(424), 715-718.

Erulkar, A. S., Onoka, C. J., & Phiri, A. (2015). What is youthfriendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe. *African Journal of Reproductive Health, 9*(3), 51-58. https://doi.org/10.2307/3583411.

Feleke, S. A., Koye, D. N., Demssie, A. F., & Mengesha, Z. B. (2013). Reproductive health service utilization and associated factors among adolescents (15–19 years old) in

Stellenbosch University https://scholar.sun.ac.za

Gondar town, Northwest Ethiopia. *BMC Health Service Research*, *13*(1), 294. https://doi.org/10.1186/1472-6963-13-294.

Feleke, S. A., Koye, D. N., Demssie, A. F., & Mengesha, Z. B. (2013). Reproductive health service utilization and associated factors among adolescents (15 – 19 years old) in Gondar town, Northwest Ethiopia. *BMC Health Services Research, 13*(1). http://doi.org/10.1186/1472-6963-13-294.

Florio-Ruane, S. (1991). Conversation and narrative in collaborative research, in: Stories lives tell: narrative and dialogue in education. *Teachers College Press*, 234–256.

Forbes, E. E., & Dahl, R. E. (2010). Pubertal development and behavior: Hormonal activation of social and motivational tendencies. *Brain and Cognition*, 72, 66-72.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229–1245. https://doi.org/10.1080/08870440903194015.

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P. and Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health*, 25(10). 1229-1245. https://doi.org/10.1080/08870440903194015.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report*, *20*(9), 1408–1416. https://doi.org/10.46743/2160-3715/2015.2281.

Geary, R. S., Gómez-Olivé, F. X., Kahn, K., Tollman, S., & Norris, S. A. (2014) Barriers to and facilitators of the provision of a youth-friendly health services programme in

Stellenbosch University https://scholar.sun.ac.za

rural South Africa. *BMC Health Services Research*, *14*(1):1. https://doi.org/10.1186/1472-6963-14-259.

Goddings, A. L., Beltz, A., Peper, J. S., Crone, E. A., & Braams, B. R. (2019). Understanding the Role of Puberty in Structural and Functional Development of the Adolescent Brain. *Journal of Research on Adolescence*, *29*(1), 32–53. https://doi.org/10.1111/jora.12408.

Godwin, J., Szabo, G., Sass, J., Sauvarin, J. (2014). Righting the mismatch between law, policy and sexual and reproductive health needs of young people in the Asia-Pacific region. *Reproductive Health Matters*. *22*(44):137–47 https://doi.org/10.1016/s0968-8080(14)44808-0.

Gough, B. (2017). Reflexivity in qualitative psychological research. *Journal of Positive Psychology*, *12*(3), 311–312. https://doi.org/10.1080/17439760.2016.1262615.

Govender, D., Naidoo, S., & Taylor, M. (2019a). Knowledge, attitudes and peer influences related to pregnancy, sexual and reproductive health among adolescents using maternal health services in Ugu, KwaZulu-Natal, South Africa. *BMC Public Health*, *19*(1), 1–17. https://doi.org/10.1186/s12889-019-7242-y.

Govender, D., Naidoo, S., & Taylor, M. (2019b). Prevalence and risk factors of repeat pregnancy among South African adolescent females. *African Journal of Reproductive Health*, *23*(1), 73–87. https://doi.org/10.29063/AJRH2019/V23I1.8.

Govender, D., Taylor, M., & Naidoo, S. (2020). Adolescent pregnancy and parenting: Perceptions of healthcare providers. *Journal of Multidisciplinary Healthcare*, *13*, 1607–1628. https://doi.org/10.2147/JMDH.S258576.

Stellenbosch University https://scholar.sun.ac.za

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries, *Educational Communication and Technology Journal, 29,* 75–91.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903.

Guiella, G., & Madise, N. J. (2007). HIV/AIDS and Sexual-Risk Behaviours among Adolescents: Factors Influencing the Use of Condoms in Burkina Faso. *African Journal of Reproductive Health, 11*(3), 182-196. https://doi.org/10.2307/25549739.

Hall, K. S., Morhe, E., Manu, A., Harris, L. H., Ela, E., Dana, L., Giselle, K., Dozier, J. L., Challa, S., Zochowski, M. K., Boakye, A., Adanu, R., Dalton, V., & Dalby, A. R. (2018). Factors associated with sexual and reproductive health stigma among adolescent girls in Ghana. *PloS ONE, 13*(4), e0195163. http://doi.org/10.1371/journal.pone.0195163.

Holder, M. K., & Blaustein, J. D. (2021). Frontiers in Neuroendocrinology Puberty and adolescence as a time of vulnerability to stressors that alter neurobehavioral processes. *Frontiers in Neuroendocrinology*, *35*(1), 89–110. https://doi.org/10.1016/j.yfrne.2013.10.004.

Holman, A., & Koenig Kellas, J. (2018). "Say something instead of nothing": Adolescents' perceptions of memorable conversations about sex-related topics with their parents. *Communication Monographs*, *85*(3), 357–379. https://doi.org/10.1080/03637751.2018.1426870.

Holt, K., Lince, N., Hargey, A., Struthers, H., Nkala, B., McIntyre, J., Gray, G., Mnyani, C., & Blanchard, K. (2012). Assessment of Service Availability and Health Care Workers' Opinions about Young Women's Sexual and Reproductive Health in Soweto, South Africa. *African Journal of Reproductive Health*, *16*(2), 283–293.

Stellenbosch University https://scholar.sun.ac.za

Imaledo, Peter-Kio, O. B., & Asuquo, E. O. (2012). Pattern of risky sexual behavior and associated factors among undergraduate students of the University of Port Harcourt, Rivers State, Nigeria. *The Pan African Medical Journal*, *12*, 97–97.

Jacobson, L., Richardson, G., Parry-Langdon, N., & Donovan, C. Z. (2001). How do teenagers and Primary healthcare providers view each other? An overview of key themes. *British Journal of General Practice*, *51*(471), 811-816.

Jerman, P., & Constantine, N. A. (2010). Demographic and psychological predictors of parent-adolescent communication about sex: A representative statewide analysis. *Journal of Youth and Adolescence,* 39, 1164–1174. https://doi.org/10.1007/s10964-010-9546-1.

Johnston, K., Harvey, C., Matich, P., Page, P., Jukka, C., Hollins, J., Hons, B., & Larkins, S. (2015). Increasing access to sexual Health care for rural and regional young people: Similarities and differences in the views of young people and service providers. 257-264. Providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu. *BMC Health Services Research*, 13(1), 1-22.

Jonas, K., Crutzen, R., Krumeich, A., Roman, N., Van Den Borne, B., & Reddy, P. (2018). Healthcare workers' beliefs, motivations and behaviours affecting adequate provision of sexual and reproductive healthcare services to adolescents in Cape Town, South Africa: A qualitative study. *BMC Health Services Research*, *18*(1), 1–13. https://doi.org/10.1186/s12913-018-2917-0.

Kail, R. V., Cavanauhg, J. C., & Muller, J. (2019). Human development: A life span view, 6th ed. *Reference & Research Book News, 27*(5).

Kennedy, E. C., Bulu, S., Harris, J., Humphreys, D., Malverus, J., & Gray, N. J. (2013). "Be kind to young people, so they feel at home": a qualitative study of adolescents' and service. *BMC public health*, 14, 770. https://doi.org/10.1186/1471-2458-14-770.

Stellenbosch University https://scholar.sun.ac.za

Kennedy, E. C., Bulu, S., Harris, J., Humphreys, D., Malverus, J., & Gray, N. J. (2013). "Be kind to young people, so they feel at home": a qualitative study of adolescents' and service. *BMC public health*, 14, 770. https://doi.org/10.1186/1471-2458-14-770.

Kennedy, E. C., Bulu, S., Harris, J., Humphreys, D., Malverus, J., & Gray, N. J. (2013). "be kind to young people so they feel at home": A qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu. *BMC Health Services Research*, *13*(1). https://doi.org/10.1186/1472-6963-13-455.

Kennedy, E. C., Bulu, S., Harris, J., Humphreys, D., Malverus, J., & Gray, N. J. (2013). "Be kind to young people so they feel at home": a qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu. *BMC Health Services Research, 13*(1). http://doi.org/10.1186/1472-6963-13-455.

Kumi-Kyereme, A., Awusabo-Asare, K., Darteh, E. K. M. (2014). Attitudes of gatekeepers towards adolescent sexual and reproductive health in Ghana. *African Journal of Reproductive Health. 18*(3):142–153.

Leech, N. L., & Onwuegbuzie, A. J. (2007). *An Array of Qualitative Data Analysis Tools : A Call for Data Analysis Triangulation*. *22*(4), 557–584. https://doi.org/10.1037/1045-3830.22.4.557.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An Array of Qualitative Data Analysis Tools: A Call for Data Analysis Triangulation. *Education for Information*, 22(4), 557–584. https://doi.org/10.1037/1045-3830.22.4.557.

Liang, M., Simelane, S., Fillo, G. F., Chalasani, S., Weny, K., Canelos, P. S., Jenkins, L., Moller, A., Chandra-Mouli, V., Say, L., Michielsen, K., & Engel, D. M. C. E. (2019). The

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State of Adolescent Sexual and Reproductive Health. *Journal of Adolescent Health*, *65*(6S), S3–S15. https://doi.org/10.1016/j.jadohealth.2019.09.015.

Lince-Deroche, N., Hargey, A., Holt, K., & Shochet, T. (2015). Accessing Sexual and Reproductive Health Information and Services: A Mixed Methods Study of Young Women Needs and experiences in Soweto, South Africa. *African Journal of Reproductive Health, 19*(1), 73-81.

Lince-Deroche, N., Pleaner, M., Harries, J., Morroni, C., Mullick, S., Firnhaber, C., Mulongo, M., Holele, P., & Sinanovic, E. (2016). Achieving universal access to sexual and reproductive health services: the potential and pitfalls for contraceptive services in South Africa. *South African Health Review*, *2016*(1), 95-108.

Lincoln, Y. S., & Guba, E. G. (1985) *Naturalistic inquiry*. Sage.

LoveLife Organisation. (2021). https://lovelife.org.za/en/

Maina, B. W., Ushie, B. A., & Kabiru, C. W. (2020). Parent-child sexual and reproductive health communication among very young adolescents in Korogocho informal settlement in Nairobi, Kenya. *Reproductive Health*, *17*(1), 1–14. https://doi.org/10.1186/s12978-020-00938-3.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444.

Maneli. (2011). *An investigation into the role of attitudes in inhibiting parents from talking about sexuality to their adolescents*. Stellenbosch: University of Stellenbosch.

Stellenbosch University https://scholar.sun.ac.za

Marshall, W. A., & Tanner, J. M. (1969). Variations in pattern of pubertal changes in girls. *Archives of Disease in Childhood*, *44*(235), 291–303. https://doi.org/10.1136/adc.44.235.291.

Matich, P., Harvey, C., Larkins, S. L., & Page, P. (2015). Young people's perceptions of sexual and reproductive health in regional and rural Queensland: capturing the views of adolescents through reference groups and a user-friendly electronic survey. *Sexual Health, 12*(3), 231-239. http://doi.org/10.1071/SH13131.

Mensele, C., Nel, K., Nel, E. C., Louw, L. A., Mensele, C., Nel, K., Nel, E. C., & Louw, L. A. (2016). Stereotypical attitudes amongst black students at a rural historically black South African university. *Journal of Psychology in Africa, 25(*5), 477-481. https://doi.org/10.1080/14330237.2015.1101281.

Merriam, S. B. (1998). *Qualitative research and case study applications in education*. Jossey-Bass Publishers.

Mfono, Z. (1998). Teenage Contraceptive Needs in Urban South Africa: A Case Study. *International Family Planning Perspectives*, *24*(4), 180–183. https://doi.org/10.2307/2991977.

Mkhwanazi, N. (2010). Understanding teenage pregnancy in a post-apartheid South African township. *Culture, Health and Sexuality*, *12*(4), 347–358. https://doi.org/10.1080/13691050903491779.

Modise, M. A. (2019). Parent sex education beliefs in a rural South African setting. *Journal of Psychology in Africa*, *29*(1), 84–86. https://doi.org/10.1080/14330237.2019.1568047.

Stellenbosch University https://scholar.sun.ac.za

Muntean, N., Kereta, W., & Mitchell, K. R. (2015) Addressing the Sexual and Reproductive Health Needs of Young People in Ethiopia: An analysis of the Current Situation. *African Journal of Reproductive Health, 19*(3), 87-99.

Nair, M. K. C., Leena, M. L., George, B., Thankachi, Y., & Russell P. S. S. (2013). Reproductive health needs assessment of adolescents and young people (15-24) a qualitative study on 'perceptions of community stakeholders'. *Indian Journal of Pediatrics, 80*(2), S214-S221.

Nastasi, B. K., & Schensul, S. L. (2005). Contributions of qualitative research to the validity of intervention research. *Special issue of Journal of School Psychology*, 43, 177–195. https://doi.org/10.1016/j.jsp.2005.04.003.

Nwokolo, N., McOwan, A., Hennebry, G., Chislett, L., & Mandalia, S. (2002). Young people‘s views on the provision of sexual health services. *Sexually Transmitted Infections*, *78*(5), 342-345. https://doi.org/10.1136/sti.78.5.342

O’Reilly, M., & Parker, N. (2013). “Unsatisfactory saturation”: A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, 13, 190–197. https://doi.org/10.1177/1468794112446106.

O’Sullivan, L. F., & Brooks-Gunn, J. (2005). The timing of changes in girls’ sexual cognitions and behaviors in early adolescence: A prospective, cohort study. *Journal of Adolescent Health*, 37, 211–219. https://doi.org/10.1016/j.jadohealth.2004.08.019.

Omobuwa, O., Asekun-Olarinmoye, E. O., & Olajide, F. O. (2012). Knowledge and perception of reproductive health services among in-school adolescents in Ile-Ife, Osun State. *Journal of Medicine and Medical Sciences*, *3*(7), 481-488.

Stellenbosch University https://scholar.sun.ac.za

Onukwugha, F. I., Hayter, M., & Magadi, M. A. (2019). Views of service providers and adolescents on use of sexual and reproductive health services by adolescents: A systematic review. *African Journal of Reproductive Health*, *23*(2), 134–147. https://doi.org/10.29063/ajrh2019/v23i2.13

Onukwugha, F. I., Hayter, M., & Magadi, M. A. (2019). Views of Service Providers and Adolescents on Use of Sexual and Reproductive Health Services by Adolescents: A Systematic Review. *African Journal of Reproductive Health, 23*(2), 134–147. http://doi.org/10.29063/ajrh2019/v23i2.13.

Oris, L., Seiffge-Krenke, I., Moons, P., Goubert, L., Rassart, J., Goossens, E& Luyckx, K. (2015). Parental and peer support in adolescents with a chronic condition: a typological approach and developmental implications. *Journal of Behavioral Medicine*; *39* (1), 107–119. https://link.springer.com/article/10.1007/s10865-015-9680-z.

Panday, S., Makiwane, M., Ranchod, C. & Letsoala, T. (2009). Teenage pregnancy in South Africa: with a specific focus on school-going learners. http://hdl.handle.net/20.500.11910/4711.

Parkes, A., Wight, D., Henderson, M., Parkes, C. A. (2004). Teenagers use of sexual health services: perceived need, knowledge and ability to access. *Journal of Family Planning and Reproductive Health Care*, 30(4), 217–224.

Patel, S. H., Muyinda, H., Sewankambo, N. K., Oyat, G., Atim, S., & Spittal, P. M. (2012). In the face of war: examining sexual vulnerabilities of Acholi adolescent girls living in displacement camps in conflict-affected Northern Uganda. *BMC International Health and Human Rights, 12*(38). http://doi.org./10.1186/1472-698X-12-38

Pilgrim, N. A., & Blum, R. W. (2021). Protective and Risk Factors Associated with Adolescent Sexual and Reproductive Health in the English-speaking Caribbean: A Literature

Stellenbosch University https://scholar.sun.ac.za

Review. *Journal of Adolescent Health*, *50*(1), 5–23. https://doi.org/10.1016/j.jadohealth.2011.03.004.

Salam, R. A., Faqqah, A., Sajjad, N., Lassi, Z. S., Das, J. K., Kaufman, M., Bhutta, Z. A. (2016). Improving Adolescent Sexual and Reproductive Health: A Systematic Review of Potential Interventions. *Journal of Adolescent Health*, *59* (4), S11-S28. https://doi.org/10.1016/j.jadohealth.2016.05.022.

Santelli, J. S., Kaiser, J., Hirsch, L., Radosh, A., Simkin, L., & Middlestadt, S. (2004). Initiation of sexual intercourse among middle school adolescents: The influence of psychosocial factors. *Journal of Adolescent Health, 34*, 200–208. https://doi.org/10.1016/j.jadohealth.2003.06.004.

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The Lancet Child and Adolescent Health*, *2*(3), 223–228. https://doi.org/10.1016/S2352-4642(18)30022-1

Selikow, T. A., Ahmed, N., Flisher, A. J., Mathews, C., & Mukoma, W. (2009). I am not "umqwayito": A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. *Scandinavian Journal of Public Health*, *37*(SUPPL. 2), 107–112. https://doi.org/10.1177/1403494809103903

Sewpaul, R., Crutzen, R., Dukhi, N., Sekgala, D., & Reddy, P. (2021). A mixed reception: perceptions of pregnant adolescents' experiences with health care workers in Cape Town, South Africa. *Reproductive Health*, *18*(1), 1–12. https://doi.org/10.1186/s12978-021-01211-x

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63–75. https://doi.org/10.3233/EFI-2004-22201.

Stellenbosch University https://scholar.sun.ac.za

Shrage, L. J., & Stewart, R. S. (2015). *Philosophizing About Sex*. 249-251.

Shrestha, S., & Wærdahl, R. (2020). Girls' access to adolescent friendly sexual and reproductive health services in Kaski, Nepal. *Asia Pac Policy Stud., 7*, 278–292. https://doi.org/10.1002/app5.305

Silva, R. N. A., Raat, H., Reitz, E., Plat, M., Deković, M., & Daphne Van De Bongardt, D. (2020,) Longitudinal Associations Between Sexual Communication With Friends and Sexual Behaviors Through Perceived Sexual Peer Norms. *The Journal of Sex Research, 57*(9), 1156-1165. https://doi.org/10.1080/00224499.2019.1691969.

Silverman, D. (2001). Interpreting qualitative data: methods for analysing talk, text and interaction. *Sage*, *2*.

Simmonds, J. E., Parry, C. D. H., Abdullah, F., Burnhams, N. H., & Christofides, N. (2021). "Knowledge I seek because culture doesn't work anymore … It doesn't work, death comes": the experiences of third-generation female caregivers (gogos) in South Africa discussing sex, sexuality and HIV and AIDS with children in their care. *MBC Public Health, 21*(1), 470. http://doi.org/10.1186/s12889-021-10494-5.

Singh, J. A., Siddiqi, M., Parameshwar, P., & Chandra-mouli, V. (2019). World Health Organization Guidance on Ethical Considerations in Planning and Reviewing Research Studies on Sexual and Reproductive Health in Adolescents. *Journal of Adolescent Health*, *64*(4), 427–429. https://doi.org/10.1016/j.jadohealth.2019.01.008

Sisk, C. L., & Foster, D. L. (2004). The neural basis of puberty and adolescence. *Nature Neuroscience, 7*(10), 1040–1047. https://doi.org/10.1038/nn1326.

Statistics South Africa. (2016). Marriages and divorces. Statistical Release P0307. www.statssa.gov.za/publications/P0305/P03052014.pdf

Stellenbosch University https://scholar.sun.ac.za

Steinberg, L. (2008). A social neuroscience perspective on adolescent risk-taking. *Developmental Review, 28*(1), 78–106. https://doi.org/10.1016/j.dr.2007.08.002

Strang, N. M., Chein, J. M., & Steinberg, L. (2013). The value of the dual systems model of adolescent risk-taking. *Frontiers in Human Neuroscience*, *7*, 223. https://doi.org/10.3389/fnhum.2013.00223.

Sturman, D. A & Moghaddam, B. (2012). Striatum processes reward differently in adolescents versus adults. 109(5), 1719-1724. https://doi.org/10.1073/pnas.1114137109.

Tilahun, M., Mengistie, B., Egata, G., & Reda, A. A. (2019). Health workers' attitudes toward sexual and reproductive health services for unmarried adolescents in Ethiopia. *Reproductive Health, 9*(1):19. https://doi.org/10.1186/1742-4755-9-19.

Toska, E., Pantelic, M., Meinck, F., Keck, K., Haghighat, R., Cluver, L., & Sued, O. (2017). Sex in the shadow of HIV: A systematic review of prevalence, risk factors, and interventions to reduce sexual risk-taking among HIV-positive adolescents and youth in sub-Saharan Africa. *PloS ONE, 12*(6), e0178106-e0178106. http://doi.org/10.1371/journal.pone.0178106.

Ugoji, F. N. (2014). Determinants of risky sexual behaviours among secondary school students in Delta State Nigeria*.* *International Journal of Adolescence and Youth, 19*(3), 408–418. https://doi.org/10.1080/02673843.2012.751040.

van de Bongardt, D., Reitz, E., Sandfort, T., & Deković, M. (2015). A Meta-Analysis of the Relations Between Three Types of Peer Norms and Adolescent Sexual Behavior. *Personality and Social Psychology Review*, *19*(3). https://doi.org/10.1177/1088868314544223.

Stellenbosch University https://scholar.sun.ac.za

Varga, C. A. (2003). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning, 34*(3), 160–172. https://doi.org/10.1111/j.1728-4465.2003.00160.x.

Warenius, L. U., Faxelid, E. A., Chishimba, P. N., Musandu, J. O., Ong'any, A. A., & Nissen, E. B. M. (2006). Nurse-Midwives' Attitudes towards Adolescent Sexual and Reproductive Health Needs in Kenya and Zambia. *Reproductive Health Matters*, *14*(27), 119–128. https://doi.org/10.1016/S0968-8080(06)27242-2

Western Cape Government. (2018). School Governing Bodies. https://www.westerncape.gov.za/general-publication/school-governing-bodies-sgbs

Whitaker, D. J., & Miller, K. S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behavior. *Journal of Adolescent Research*, *15*(2), 251–273. https://doi.org/10.1177/0743558400152004

Wood, K., Jewkes, R. (2006). Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters, 14*(27):109–18.

World Health Organization. Adolescents: health risks and solutions. (2018). Facts sheet 345. http://www.who.int/mediacentre/factsheets/fs345/en/.

Young, M., Cardenas, S., Donnelly, J., & J. Kittleson, M. (2016). Perceptions of Peer Sexual Behavior: Do Adolescents Believe in a Sexual Double Standard? *Journal of School Health*, *86*(12), 855–863. https://doi.org/10.1111/josh.12455

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APPENDIX A

DEMOGRAPHIC INFORMATION SHEET

Participant code: ______________________

Date of interview: ______________________

Time of interview: ______________________

1. **What is your current age?** ____

2. **What is your gender?** Female ☐ Male ☐ Other ☐

3. **With which ethnic group do you identify with?**

White ☐ Black ☐ Coloured ☐ Indian ☐ Other ☐

4. **What is your home language?**

Afrikaans ☐ English ☐ Xhosa ☐ Zulu ☐ Other ☐ ______________

5. **What is your highest level of education?**

Primary school ☐ Grade 9 ☐ Grade 12 ☐ Tertiary ☐ Other ☐_____________

6. **What is your marital status?**

Married ☐ In a relationship ☐ Single ☐ Other ☐ ____________________

7. **Does your partner live with you?** Yes ☐ No ☐

8. **How many people are in your household?** ______________________________________

9. **How many children do you have?** ____

10. **How old is your child attending primary school?** ______________________________

11. **What is your relationship to the child?**

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Biological parent ☐ Family member ☐ Foster parent ☐ Other ☐________

12. Does the child live with you? Yes ☐ No ☐ Other ☐______________

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APPENDIX B

SEMI-STRUCTURED INTERVIEW SCHEDULES

ADOLESCENTS

When was the first time you attended the clinic? What made you come to the clinic the first time?

What is it like for you to visit this clinic? Tell me about your experiences here.

Tell me about some of your experiences while seeking SRH services.

How often do you see boys/males attending the clinic for SRH? Why do you think they don't attend?

How comfortable are you with speaking about your sexual knowledge &/ experiences?

What do you know about sex?

Describe the sexual education that you have received. (Probe: What more would you have wanted to know about?)

Do your parents know you are attending the clinic for SRH services? (Probe: What concerns you about them finding out?)

Tell me some of the things that would make it difficult for you to talk about sex with your parents.

What conversations have you had with your friends about sex and sexual experiences?

How do you know whether you are ready to have sex?

Why is preventing pregnancy important to you? (Probe: What will getting pregnant mean for your life?)

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What protection do you use regarding sex?

What would it mean for you if you had to contract a STI? (HIV?)

How do you feel when you come to the clinic?

Have you had any experiences with the staff that made you feel uncomfortable/upset? (Probe: What happened? How did you feel?)

How does coming to this clinic help you avoid falling pregnant/getting an STI?

What are the staff at the clinic like? Who do you usually see when you come to the clinic?

What are the nurses like?

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HEALTHCARE WORKERS

When do you think young people are ready to have sex?

How would you determine if an adolescent is ready for sex?

How would you know when she is not ready?

Do you have any dilemmas or issues around assessing sexual readiness in young people?

How do you resolve these when you are faced with a young person who in your view is not ready for sex?

What do you think a young person is thinking and feeling before they come to an adult for sexual health information and advice?

How do you think young people are feeling when they come to this clinic for the first time? Would this be the same for all?

How do you think the average young person is feeling as they leave this clinic?

How do other adolescents differ from the average young person leaving the clinic?

If you were to change anything about this clinic to make it more suitable to young people's needs, what would it be?

Which adolescents are your clinic not reaching?

Do you think boys/ male adolescents need sexual and reproductive health services?

Why do you think the rate of pregnancy and STI’s among adolescents is so high?

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APPENDIX C

OBSERVATION SCHEDULE

Date of observation	Location	Observer
Tuesdays and Thursdays	Waiting room of clinic A's SRH section	Thania Narker
Mondays, Wednesdays, Thursdays, and Fridays	General waiting room of clinic B	Thania Narker

Time	Observed in clinic environment
Late morning (11h00) until afternoon (2h00) at Clinic A	Patients that attend the clinic: whether it was majority adults, children, or adolescents.
Mid-afternoon (14h30) until closing (16h00) at Clinic A	Amount of HCWs in the clinic on the particular day of observation.
Early afternoon (1h00) until closing (16h00) at Clinic B	Clinic setting, such as arrangement of waiting rooms, different consultation sections, reception location, and information posters on the walls. The interactions between adolescents and HCWs. The interactions between adolescents and LoveLife staff. The interactions between adolescents and peers when in clinic.

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APPENDIX D
PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

Please see Section 8 of our Health Research Ethics Committee (HREC) Standard Operating Procedures (SOPs) for more detailed information about requirements for Informed Consent (IC). You will find the SOPs here:
http://www.sun.ac.za/english/faculty/healthsciences/rdsd/Pages/Ethics/SOP.aspx.
(Please delete this paragraph before submitting your Informed Consent Form (ICF) to the HREC)

TITLE OF RESEARCH PROJECT:	
Adolescent girls' experiences of sexual and reproductive health services in public clinics in the Western Cape	
DETAILS OF PRINCIPAL INVESTIGATOR (PI):	
Title, first name, surname: Ms Thania Narker and Prof SA Kagee	**Ethics reference number:** **N19/01/003**
Full postal address: Department of Psychology. Stellenbosch University, Private Bag X1, Matieland, 7602	**PI Contact number:** **Thania Narker: 0769810620** **Prof SA Kagee: 0827314280/0218083442**

I would like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no: it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty or loss of benefits or reduction in the level of care to which you are otherwise entitled to. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University.** The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC) Ethical Guidelines for Research

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(2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

What is this research study all about?

- *The study will be conducted at community clinics, namely, Dr Ivan Toms Clinic, Eerste River Clinic, Sir Lowrys Pass Clinic, Somerset West Clinic, and Bluedowns Clinic. We aim to recruit 30 participants or approximately 4-5 participants at each clinic.*
- *The study aims to understand how adolescent females experience the sexual and reproductive health services provided by public health clinics in the Western Cape. We would like to understand how the information provided by the clinics are understood and considered useful in the daily lives of adolescents. We would like to understand how adolescent females understand the ways they make decisions about having sex.*
- *We are studying the experiences of adolescent females who seek reproductive health services from public health clinics. We plan to interview participants and ask them about their experiences when engaging with clinic staff such as nurses and doctors.*
- *After your routine consultation, you will be informed briefly about the research by the attending nurse. If you are interested in learning more about the study will be told about the study by a research assistant in a private office. The research assistant will explain the study to you. If you agree to participate in the study, you will be asked to complete and sign an assent form.*

Why do we invite you to participate?

- *You are being asked to participate because you are seeking sexual and reproductive health services at the clinic.*

What will your responsibilities be?

- *You will be asked to participate in an interview with a research assistant and answer questions about your experiences at the clinic.*

Will you benefit from taking part in this research?

- *There are no direct benefits to you. However, the information you give us may help us provide advice to the clinic to improve its services. In this way, future patients may benefit from this research.*

Are there any risks involved in your taking part in this research?

- *There are no risks associated with participating in this research.*

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If you do not agree to take part, what alternatives do you have?

- *You are under no obligation to participate in thus research. if you choose not to participate, your treatment at the clinic will not change in any way.*

Who will have access to your medical records?

- *The information we collect will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participants will remain anonymous. Only the researchers associated with the study will have access to the information you give us.*

Even though it is unlikely, what will happen if you get injured somehow because you took part in this research study?

In the unlikely event that you are injured in the study you will be referred to a nurse at the clinic for treatment.

Stellenbosch University will provide comprehensive no-fault insurance and will pay for any medical costs that came about because participants took part in the research.

Will you be paid to take part in this study and are there any costs involved?

- You will not be financially compensated to take part in the study. However, you will be given a grocery voucher or refreshments as a token of appreciation of the time you have taken to be in the study.

Is there anything else that you should know or do?

- You can phone Thania Narker at 0769810620 if you have any further queries or encounter any problems.
- You can phone the Health Research Ethics Committee at 021 938 9677/9819 if there still is something that your study doctor has not explained to you, or if you have a complaint.
- You will receive a copy of this information and consent form for you to keep safe.

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in a research study entitled Adolescent girls' experiences of sexual and reproductive health services in public clinics in the Western Cape.

I declare that:

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- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is **voluntary,** and I have not been pressurised to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan that we have agreed on.

Signed at (*place*) ....…........…………….. on (*date*) …………...……….. 2019.

Signature of participant

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Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

- I explained the information in this document in a simple and clear manner to …………………………………..
- I encouraged him/her to ask questions and took enough time to answer them.
- I am satisfied that he/she completely understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) ....…........……………….. on (*date*) …………....……….. 2019.

Signature of investigator

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APPENDIX E

HEALTHCARE WORKER PARTICPANT VOUCHER LIST

Participant Name	Amount on Voucher	Participant Signature
	R150	
	R150	
	R150	
	R150	
	R150	
	R150	

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APENDIX F

ETHICS APPROVAL NOTICE: 1

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Notice

New Application

05/03/2019

Project ID :8863

HREC Reference # N19/01/003

Title: Adolescent girls' experiences of sexual and reproductive health services in public clinics in the Western Cape

Dear Prof Shaheen Kagee,

Your responses to modifications requested on your **New Application** received on 26/02/2019 10:22 was reviewed by members of **Health Research Ethics Committee** via **expedited** review procedures on 05/03/2019 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval date: 05 March 2019

Protocol Approval expiry: 04 March 2020

Please remember to use your project ID (8863)on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Departement of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/ProjectView/Index/8863

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Mrs. Melody Shana ,

Coordinator,

HREC1

Stellenbosch University https://scholar.sun.ac.za

ETHICS APPROVAL NOTICE: 2

Approval Letter
Progress Report

25/02/2020

Project ID: 8863

Ethics Reference No: N19/01/003

Project Title: Adolescent girls' experiences of sexual and reproductive health services in public clinics in the Western Cape

Dear Prof Shaheen Kagee

We refer to your request for an extension/annual renewal of ethics approval dated 10/02/2020 10:49 .

The Health Research Ethics Committee reviewed and approved the annual progress report through an expedited review process.

The approval of this project is extended for a further year.

Approval date: 25 February 2020

Expiry date: 24 February 2021

Kindly be reminded to submit progress reports two (2) months before expiry date.

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your Project Id 8863 and ethics reference number N19/01/003 on any documents or correspondence with the HREC concerning your research protocol.

Yours sincerely,

Mrs. Melody Shana

Coordinator

Health Research Ethics Committee 1

National Health Research Ethics Council (NHREC) Registration Number:
REC-130408-012 (HREC1)•REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1)•IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects; the South African Department of Health (2006).Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.