

**YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND
REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND**

by

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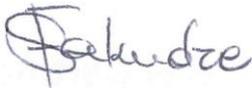
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DECLARATION

I declare that **YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other education institution.



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YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND

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ABSTRACT

The purpose of the study was to explore and describe young people's perceptions of access to sexual and reproductive health (SRH) services in Swaziland. The study provided insights into the SRH services currently available to the young people of Swaziland and reveals the opportunities that can be used to improve accessibility and utilisation of the current reproductive health services. The findings will inform policy-making and appropriate future interventions for young people's sexual and reproductive needs and services.

Data were collected through a descriptive exploratory study design. Colaizzi's seven steps of data analysis were used. The study provides ample evidence that young people face sexual health risks that justify their need to access and utilise SRH services. The findings revealed that access to service is an important but complex element of quality care, as it determines whether a client gets to the service provider.

KEYWORDS

Reproductive health; sexual and reproductive health; young people; young people's sexual and reproductive health.

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Dedication

To my family for their love and unwavering support throughout the study.

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LIST OF ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
ANC	Antenatal care
ASRH	Adolescent Sexual and Reproductive Health
CSE	Comprehensive Sexuality Education
DFID	Department for International Development
DoH	Department of Health
ENSF	Extended National Strategic Framework
FLAS	Family Life Association of Swaziland
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population Development
IEC	Information Education and Communication
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal Neonatal and Child Health (MNCH)
MoH	Swaziland Ministry of Health
MSF	M'edecins San Frontiers
NAFCI	National Adolescent-friendly Client Initiative
NERCHA	National Emergency Response Council on HIV/AIDS
NGOs	Non-Governmental Organizations
PAC	Post Abortion Care
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PRSAP	Poverty Reduction Strategy and Action Programme
PSI	Population Service International
PoA	Plan of Actions
RHS	Reproductive Health Service
SADC	South African Development Committee
SHOP	School Health Outreach Programme
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Fund for Population Activities
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YAM	Youth Action Movement

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This chapter provides an overview of the study. The experiences of young people regarding access to reproductive health and sexuality will be discussed, beginning with international context, followed by regional context, that is, South African Development Committee (SADC), then Swaziland. International efforts for addressing the sexual and reproductive health (SRH) problems of young people and an explanation of the importance of addressing these problems, especially in sub-Saharan Africa will further be discussed. The section also outlines definitions of general terms used throughout the research report, states the study aims and research questions.

1.2 BACKGROUND AND INFORMATION TO THE RESEARCH PROBLEM

Young people of the current generation worldwide are exposed to social shifts as well as health and developmental vulnerabilities in the area of sexuality and childbearing, therefore subjecting them to poor reproductive outcomes (UNFPA 2014). Young people between 10 to 24 years' age groups who also include the adolescents regarded as the 10-19 year age group are the largest in most countries in the world, including Swaziland (UNFPA 2014). The implication is that poor reproductive outcomes threaten the health of future generations.

Akinyi's (2009:1) study conducted in Kenya highlights that there were 1.7 billion young people aged 10-24 globally representing a quarter of world's population, with over 85% living in developing countries. The current census figures indicate that young people aged 10-24 years constitute 40% of the Swazi population (World Bank 2011). Sexual activity among young people in Swaziland is thought to be high, therefore resulting in exposure to high-risk situations such as increased incidence of STIs, including human immunodeficiency virus (HIV), unwanted pregnancies, illegal abortions, and at times maternal deaths (Mavundla 2015:8).

According to Mushoriwa (2013:511-513), 81.4% of rural high school students in Zimbabwe had engaged in sexual activity. The study further revealed that contraceptives and condom usage is low among the study group resulting in contracting STIs, including HIV and falling pregnant unintentionally (Mushoriwa 2013:511-513). According to UNAIDS (2014:2), Swaziland is one of the countries in the world with the highest HIV/AIDS, reporting 11000 new infections in 2013. This evidence explicitly indicates that the majority of young people do not use condoms to protect themselves against contracting STIs and HIV. The percentage is also high for the people who are clearly sexually active and yet not in marriage unions (WHO 2014).

The 1994 International Conference for Population and Development (ICPD) and UNFPA 2013 promoted Adolescent Sexual and Reproductive Health (ASRH). Special attention was to be paid on meeting the reproductive health needs of adolescents. The ICPD 1994 recommended that programmes be put in place by governments to ensure that people enjoy healthy reproductive life (ICPD 1995:75-76). This was a paradigm shift in human reproduction.

The ICPD plan of actions (PoAs) of 1994 and 2014 called for the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, the provision of appropriate services and counselling, especially for the adolescents (UNFPA 2014:75). Countries were urged to ensure that programmes and attitudes of health care providers are youth user-friendly and do not restrict youth access and utilisation of the services and information they need (UNFPA 2014:75). The adolescents were to enjoy their rights to privacy, confidentiality, respect, and informed consent while respecting cultural values and religious beliefs, duties and responsibilities of parents (ICPD 1995; UNFPA 2014) and ensuring that young people gain access to reproductive health information, education and communication (IEC) and health promotion activities while encouraging their active participation.

In pursuit of reproductive health agenda that was deliberated in the ICPD programme of actions, Swaziland adopted SRH programme, which is mandated to coordinate the health sector response to SRH through integrated service delivery and capacity building for health care providers. The programme seeks to satisfy the following interventions, nationally, maternal neonatal, child health (MNCH), adolescent and youth SRH and rights, family planning (FP), abortions and post abortion care (PAC), sexually

transmitted infections (STIs), HIV/AIDS and other reproductive health issues (Ministry of Health 2013a:13).

In spite of all the global affirmations, reproductive health services for young people in Swaziland have been inadequately addressed and partly neglected (Mavundla, Dlamini, Mac-Ikemenjani, & Nyoni 2015:61). The Department for International Development's (DFID 2011) study on school attendance and dropout in Swaziland confirmed that factors such as unintended pregnancies and substance abuse are responsible for poor school attendance and increased dropout rates (DFID 2011). Sexual debut is as early as 15 years for girls and 17 years for boys and yet contraceptive use rate among adolescent girls is as low as 10%, therefore leading to unintended pregnancies which amounts to 27% of the total number of pregnancies (UNAIDS 2014).

Against this background, this study intends to answer the following question: "What are young people's perceptions of accessing SRH services in Swaziland?"

1.3 STATEMENT OF THE RESEARCH PROBLEM

Swaziland is still faced with SRH challenges of such as high rates of unintended pregnancies, risky illegal abortions and high rates of STIs, including high prevalence of HIV and evidence of low condom usage (Mavundla et al 2015:50-51). The World Bank (2011) points to the unfriendly family planning services, leading to inaccessible contraception and unmet needs for young people.

Pregnancy among young people, especially the primary school-going pupils leading to a school dropout rate of 35% is a cause of concern (Mavundla et al 2015:64). Evidently, this confirms the inaccessibility of contraception to the young people of Swaziland mainly owing to the barriers to obtaining them (World Bank 2011).

The high incidence of illegal abortion among women aged 15-24 in Swaziland, which currently stands at 1.3% is also a concern (Mavundla et al 2015). Faced with the prospect of unwanted pregnancy forced many teenage girls then resort to abortion to avoid expulsion from school (Mavundla et al 2015). Lack of effective, affordable acceptable and accessible range of services particularly those relating to pregnancy,

HIV and STIs prevention, testing and treatment exacerbates the problem of illegal abortions, which could be fatal (Mavundla 2015:8).

Diseases such as STIs, including HIV, mostly affect young people. According to UNESCO (2013:18), STIs among young people accounts to 15%. HIV prevalence in Swaziland is the highest in the SADC region, with 5.9% of young men and 22.7% of women aged 15-24 infected (UNESCO 2013:18).

In light of the challenges discussed, young people do not appear to utilise available SRH care services (SRHC). It is for this reason that the researcher wants to explore the perceptions of young people toward access to SRH services in Swaziland.

1.4 PURPOSE OF THE STUDY AND OBJECTIVES

1.4.1 Research aim/purpose

The aim of the study was to explore and describe young people's perceptions of accessing SRH services in Swaziland.

1.4.2 Research objectives

The objectives of this study were to

- identify and describe SRH services for young people in Manzini, Swaziland
- explore and describe factors that hinder access to SRH services for young people in Manzini, Swaziland
- explore and describe factors that promote access to SRH services for young people in Manzini, Swaziland
- recommend interventions that could improve access to SRH services for young people in Manzini, Swaziland

1.4.3 Research questions/hypotheses

The main research question is: "What are the perceptions of young people regarding their access to SRH services in Swaziland?"

Sub-research questions:

- What are current SRH services for young people in Manzini, Swaziland?
- What are factors that hinder access to SRH services for young people in Manzini, Swaziland?
- What are factors that promote access to SRH services for young people in Manzini, Swaziland?
- What interventions can improve access to SRH services for young people in Manzini, Swaziland?

1.5 SIGNIFICANCE OF THE STUDY

The study assumes that understanding young people's perceptions of their SRH services will indicate the pattern demand and uptake of reproductive health services to address their reproductive health needs among this group. In addition, the range of reproductive health services available for young people as well as adolescents and the factors that determine the use of these services could be identified.

The findings from this study may be used to inform focused information, education and communication programmes as well as advocacy efforts for SRH for young people. It is envisaged that such interventions will hopefully contribute to improve reproductive outcomes.

1.6 DEFINITION OF KEY CONCEPTS

Access to health care services: It means having "the timely uses of personal health services to achieve the best health outcomes" (Institute of Medicine (IOM) 1993 quoted in Whitefield County Health Department 2013). For the purpose of this study, access shall mean awareness of existence of, availability, services within an accessible distance, affordable and responsive sexual and reproductive services.

Perceptions: According to the Hornby (2010:1087), perceptions are the ability to understand the true nature of something. For the purpose of this study, perception means recognising and interpreting a phenomenon.

Reproductive health: It is a state of complete physical, mental and social well-being in all matters relating to the reproductive system (UNFPA 2014:1).

In this study reproductive health adopts a broader ICPD perspective, such as may improve access to contraception and effective reproductive health care as well as legalising and making abortion services safe and freely available.

Sexual and reproductive health care: It includes the prevention, diagnosis and treatment as related to STIs and contraceptive service and counselling, pre and postnatal care, delivery care, treatment of STIs, safe abortion and post abortion care, and access to information and education to the above-mentioned issues (WHO 2016).

Young people: It is defined as young people aged 10-24 years and it includes the adolescents and youth (WHO 2014).

For the purpose of this study, young people shall mean individuals who are younger than 24 years but 15 years and older categorised into the following reproductive age groups: 10-14; 15-19 and 20-24 to ensure the inclusion of a range of young persons in the sample.

Young people's SRH: It means providing access to comprehensive sexuality education, services to prevent, diagnose and treat STIs, and counselling on family planning to young people and empowering young people to know and exercise their rights including the right to delay marriage and the right to refuse unwanted sexual advances (UNFPA 2014).

In this study, this means services provided for prevention, diagnosis and treatment of STIs, including HIV/AIDS to young people, as well as counselling on family planning to young people.

Utilisation of health service: It is the extent to which a given population group uses a particular service or several services in a specified period depending on the type of service (Shayo 2016). In this study, utilisation of health services simply means making use of the reproductive health services by young people.

1.7 STRUCTURE OF THE DISSERTATION

The dissertation consists of five chapters:

Chapter 1: The first chapter has introduced the theme and rationale for the study and presented research objectives and questions. It provides an explanation as to why efforts should be directed towards addressing SRH needs for young people.

Chapter 2: This section provides a review of literature, internationally and nationally on SRH needs and problems of young people. It also gives a general account of the Adolescent Sexual and Reproductive Health (ASRH) interventions that have been implemented across developing countries and in Swaziland, including observations made about interventions' effectiveness.

Chapter 3: This chapter describes the methodology. It outlines the study design, population and study setting, sampling and sampling procedures, data management, and ethical considerations.

Chapter 4: This chapter presents data analysis, presentation and interpretations of the research findings. These include data management and analysis, research results and the overview of the research findings.

Chapter 5: Conclusion and recommendations. These include a summary of the research design and method, summary and interpretation of the research findings, conclusions, recommendations, strengths, and limitations of the study.

1.8 SUMMARY

The discussion above provided an overview of the study. It discussed the state of SRH of young people globally, in the sub-Saharan region as well as in Swaziland. The chapter further highlighted the importance of young people and adolescents to fully exercise their right to health, including access to SRH, which violation thereof has emerged as a challenge in most parts of the world including Swaziland. The chapter highlighted that violation of the right to access to SRH services has had adverse effects in most parts of the world, including Swaziland such as high rates of adolescent

childbearing and unmet need for contraception leading to unwanted or unintended pregnancies. The chapter concludes with a presentation of the structure of the dissertation. Chapter 2 will present the related literature that has been reviewed for this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review involves reviewing documents that have been published comparable to the topic under study. Terre Blanch, Durrheim and Painter (2007) cited in Magerman (2011:4) state that a literature review puts a research project into context by showing how it fits into a particular field of study. Literature review for this study covers published work on young people's access to SRH services in Swaziland and the gaps yet to be filled. The information was derived from books, journals, articles, and the Internet as indicated below.

2.2 YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

Young people, adolescents and youth face a complex set of challenges that are integral to the developmental stage (Dalmini, Mabuza, Thwal-Tembe, Masangane, Dlamini & Simelane 2017a:1). Adolescence is a period of mental, emotional and physical maturation, which is often characterised by behavioural experimentation, identity versus role confusion, risk taking, formation of romantic relationships, sexual behaviour, and drug abuse (Brown, Macintyre & Trujillo 2014). Therefore, young people are vulnerable to sexually transmitted infections like HIV, unwanted pregnancy, experimenting with sex, alcohol, and drugs. Young people and adolescents have inadequately developed life skills and are at risk of being coerced into sexual relationships and have limited access to health care services (Kim, Kols, Nyakauru, Marangwanda & Chibatamoto 2014:11). With regards to sexually transmitted HIV, young people have been labelled as the point of the HIV epidemic and the 'faultless storm' (Abrahams 2015).

Globally, an estimated 21 000 000 adolescents are living with HIV, meaning that the overabundance of health research and health information does not necessarily benefit young people and therefore is not translated into practice (Dlamini et al 2017a:1). In developing countries, a majority of sexually active young people and adolescents experience difficulty in accessing health care services (Dlamini et al 2017a:1). This is

because culturally premarital sex is prohibited. Therefore, unmarried young people who are sexually active often face societal disapproval and blame (Jejeebhoy & Bott 2015:24). Much focus is directed on improving access to reproductive health services for female young people and adolescents. Yet issues of reproductive health affect both male and female adolescents. Ignoring the SRHSRH needs of male adolescents makes it even more difficult for male adolescents to access SRH services (Dlamini et al 2017a:1). Moreover, young people and adolescents have inadequate knowledge about contraception. Therefore, resulting to unwanted pregnancies as well as contracting sexually transmitted infections including HIV/AIDS.

A study conducted on adolescents' knowledge and perceptions of SRH services in Nepal identified barriers related to service and service provider's related factors. Lack of information about available SRH services, inadequate service accessibility, lack of confidentiality, service provider shortage, and young people's behaviour were identified as some of the barriers in utilisation of SRH services (Khanal 2016:60).

However, Mutai (2016:11) cited in Program for Appropriate Technology in Health [PATH] (2001) on a study done in China that was seeking to evaluate youth friendly services found out that despite there being some form of good infrastructure, good equipment, friendly health personnel, and conducive environment. Some young people and youths could not use reproductive health services because of lack of publicity, lack of full time health service providers, poor health care services, and a loose referral system.

Godia (2012:273) reports that young people's perceptions of available SRH services show variations between boys and girls concerning the model of service delivery. Young girls seeking antenatal care (ANC) and family planning (FP) services at integrated facilities characterised the available services as good. On the contrary, boys indicated that SRH services at integrated facilities have been designed for women and children, and so, they felt uncomfortable seeking services from these facilities.

2.3 YOUNG PEOPLE AND SEXUAL REPRODUCTIVE HEALTH IN SWAZILAND

Like most African countries, Swaziland also has a very youthful population, with about 34% of the population aged 10-24 years, which translates to over 400,000 young

Swazis. Apart from tackling with challenges that come with the changes that young people go through as they grow, they face other challenges, which include HIV/AIDS, gender based violence and teenage pregnancy. These challenges are compounded by poor access to ASRH information and services (Dlamini, Mabuza, Masangane, Silindza & Dlamini 2017b:5).

The National Policy on Sexual and Reproductive Health of 2013 postulates that comprehensive sexuality education, information, and integrated SRH and HIV services should be provided to children, adolescents, and youth people at all levels of health care systems and other relevant settings according to their age and needs (Ministry of Health 2013b:18). The Policy further stipulates that the Ministry of Health shall ensure an enabling environment and resources to availability and access to adolescent sexual and reproductive health (ASRH) services and that quality family planning information and care to be provided to all reproductive-age groups (defined as 15-49) women and men (Ministry of Health 2013b:19). The National Health Policy of 2007 had previously put emphasis on decentralisation of services to appropriate care at community levels, which is critical for young people to access necessary health care (Ministry of Health 2007:34-35).

The National Youth Policy of 2009 further called for improved access to HIV/AIDS treatment for youth and the integration of Life Skills Education curricula, which includes sexuality education into all institutions, the promotion of school and community-based health clubs, and scale-up of SRH services targeting all youth, to reduce STI prevalence and unplanned pregnancies (Ministry of Sports Culture and Youth Affairs 2009:33). All of these policies emphasise that health care delivery should be appropriate to the age of youth being served.

2.4 SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION FOR YOUNG PEOPLE IN SWAZILAND

Young people's access to SRH services in Swaziland is delivered as an integrated part of the family health service delivery. It is organised in a multisector system; (i) national referral hospitals, (ii) regional hospitals, (iii) primary health care facilities (health centres and clinic) and outreach sites, and (iv) non-governmental organisations (NGOs). In all the public health facilities provision of counselling and contraceptives is at a low cost,

which is affordable to both adults and young without getting permission from their parents (Mavundla et al 2015:51). In addition, Mahlalela (2016:17) quoted a study done by UNFPA, which states that 75% of health facilities provided adolescent health services. However, only 26% offered youth-friendly and integrated family planning services, therefore the unmet need for family planning.

However, Dlamini et al (2017b:5), on a study on HIV and Sexual Reproductive Health Status of Young People, found out that there seems to be some improvement in sexuality education and behaviour change interventions. There is gradual increase in age at sexual debut and in the proportion of adolescents reporting to be abstaining from sexual activity. This suggests that some interventions may have prevented some young people from sexual intercourse.

Although premarital sex is forbidden in the Swazi culture, the fertility rate of adolescents in Swaziland is very high, reported at 87 per 1000 live births (Central Statistics Office 2014:97). Adolescent fertility adversely affects the young woman's health, education, employment prospects as well as the infant. Adolescents sexual activity, within or outside the confines of marriage is associated with a high risk of negative reproductive health outcomes such as unintended pregnancy, STIs and HIV.

In Swaziland, the policy for the provision of SRH services is favourable to young people. This is evident by the availability of various policies in support of provision of SRH services to young people. There is also an excess of programmatic interventions regarding Sexual Reproductive Health and Rights (SRHR) in the country. However, teenage pregnancy in Swaziland remains a cause for concern. Adolescent fertility did decline slightly from 89/1000 to 87/1000 between 2010 and 2014. However, this decrease is quite small and does not signify great success in efforts to substantially reduce early pregnancies (Central Statistics Office 2014:99).

According to Buzi and Smith (2014:149-157), young people who are sexually active are aware and need SRH services, such as contraceptives. Nevertheless, they do not go to the clinic for fear of health care workers' attitude and the criticism associated with premarital sex. A majority of young people report attitudinal and institutional factors as main barriers to accessing SRH services (Buzi & Smith 2014:151). Institutional barriers include location of the clinic, privacy within the facility, the age, and gender of the staff

complement of the clinic (Godia, Olenja, Hofman & Broek 2014:9). Furthermore, Dlamini et al (2017:2) cited in Mngadi (2008:152) who examined health care worker's attitude as linked to the values and beliefs about pre-marital sex. Evidence has shown that culture, values and beliefs of health care workers play a critical role in deciding whether or not to provide contraception to adolescents. Therefore, health care workers battle between true, honest to their cultural and religious background, sensitive, and accommodative of adolescents' needs (Godia et al 2014:12).

Mushoriwa (2014:404) conducted a study on Sexual Practices among Urban High School Students in Swaziland. The study found out that condom use was very low despite the high prevalence of HIV/AIDS in the country. Only 50 (45%) of the males and 44 (43%) of the females who had engaged in sexual intercourse reported using condoms. The study also observed that only 95 (44%) of both male and female students reported using a condom in their first sexual intercourse. Some argued that since there was no real agreement (consensual sex), there was no time to put on a condom. One female student commented: "Boys apply force and therefore there is no time for putting on a condom even if they have it. Some of us contract diseases or become pregnant." One male student also commented: "I don't use condoms because they reduce sexual pleasure." There, more still need to be done in the fight against HIV/AIDS.

Mavundla (2015) noted problems associated with accessing public and standardised health facilities for young people. These include getting permission to go for treatment, getting money for treatment, distance to a health facility, having to take transportation, and not wanting to go alone. Another concern was that there might not be a youth-friendly health care provider available. Further concerns may be long queues, leading to prolonged waiting time for a health care provider and unavailability of drugs.

Young people are a particular target for HIV and SRH sensitisation. One of Family Life Association of Swaziland (FLAS)'s youth centres has its own radio studio, where young people make their own programmes concerning SRH issues, which are then broadcast at FLAS road shows, and, by major nationwide radio stations. Most importantly, FLAS peer educators also provide training to the country's Business Coalition against HIV/AIDS. Population Service International (PSI) is another youth preferred health services institution. Its services include the following: male circumcision services; HIV counselling and testing campaigns and services; female and male condom campaigns;

and information desks that provide information and educational material on delayed sexual debut; the dangers of concurrent sexual partnerships, informative and on HIV risk perception.

2.5 AVAILABLE SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE IN SWAZILAND

2.5.1 Family planning services

In every region of the world, impoverished, poorly educated and rural girls are more likely to become pregnant than their wealthier, urban, educated counterparts. Girls who are from an ethnic minority or marginalised group, who lack choices and opportunities in life, or who have limited or no access to SRH, including contraceptive information and services, are also more likely to become pregnant (UNFPA 2013:2). Therefore, involving young people is useful to find out information on the best options of contraceptive methods as well as facts about HIV/AIDS and many more of their needs.

2.5.2 Antenatal care services

Young people need access to quality youth-friendly services provided by health care providers trained to work with this population (Leah 2015:10). Leah (2015:10) further asserts that support during pregnancy has been associated with positive pregnancy outcome. Adolescent mothers are a group with special needs because they are children themselves and their bodies are not yet sufficiently developed to handle pregnancy and delivery. Therefore, it is necessary to encourage young women to attend antenatal clinics where they will be equipped with health information on how to care for themselves during pregnancy, delivery and after childbirth (Leah 2015:10).

2.5.3 Postnatal care

Ensuring access to postnatal services for new adolescent mothers often means providing financial support for health care and diet, advice about breastfeeding, help returning to school or training, shelter and services if they have been rejected by their families and contraceptive or birth-spacing information and services. Antenatal and postnatal care are not only essential for the health of the girl and her pregnancy, but

they also present opportunities to provide information and contraception that may help an adolescent to prevent or delay a second pregnancy (UNFPA 2013:39).

2.5.4 Post-abortion care

In Swaziland, abortions are not permitted unless it is for medical or therapeutic purposes. This could be either pregnancy is owing to rape, incest or unlawful sexual intercourse with a mentally challenged female as contained in the Constitution of the Kingdom of Swaziland 2005 (Ministry of Health 2013b:19). Post-abortion care aims at integrating post-abortion care and family planning services in health care systems as a means of breaking the cycle of repeated unwanted pregnancies and improving the overall health status of women.

Adolescents make up a large proportion of patients hospitalised for complications of unsafe abortions. A study done by Kothari, Wang, Head and Abderrahim (2012) cited in Leah (2015:12) revealed that compared to adults who have unsafe abortions, adolescents are more likely to experience complications such as haemorrhage, septicaemia, internal organ damage, sterility, and even death. Some explanations for worse health outcomes for adolescents are that they are more likely to delay seeking and having an abortion, resort to unskilled persons to perform it, use dangerous methods and delay seeking care when complications arise (UNFPA 2013:21).

Barriers to abortion care include legal and policy barriers, as well as a variety of other barriers such as provider attitudes. These barriers make safe abortions less accessible to some women, and these challenges particularly impact young women. It is imperative that the SRH of young people be improved. Therefore, abortion care should be provided to young clients non-judgmentally (Leah 2015:12).

2.5.5 HIV and testing services (HTS)

HIV/AIDS continues to be one of the most pressing challenges that young people in Swaziland are facing, with heightened vulnerabilities for girls and young women. HIV prevalence among young females aged 15-19 years stands at 10.2%, compared to 1.9% for males of the same age. In the age group 20-24, HIV prevalence among females is 38.2%, compared to 12.3% for males in the same age bracket. HIV

incidence is also significantly higher amongst young Swazi females (15-19) compared to the males same age group standing at 3.84% for females compared to 0.84% for males (Dlamini et al 2017b:1).

According to WHO/UNAIDS (2011:1), there are four core areas of action that target both risk and vulnerability reduction among young people that are reflected in the global goal of achieving universal access to services for HIV prevention, treatment and care. These include provision of information to develop knowledge, opportunities and support to develop life skills, provision of appropriate and accessible health services, and creation of a safe and supportive environment.

In Swaziland, HIV/AIDS epitomises a particular SRH threat to the health of young people, but there are many other STIs to consider as well. Youth sexual behaviour influences not only the acquisition of HIV, but of all other STIs, the presence of which makes youth more susceptible to HIV infection. Drivers of STIs for young people can include multiple partners and the inconsistency or absence of condom use (National Emergency Response Council on HIV/AIDS (NERCHA) 2014:20-21). Among sexually active young people aged 14-25, 37.3% of women and 40.9% of men had engaged in sex with a non-regular partner, though reported condom use was higher at 70.9% for young women and 93.4% for young men (Central Statistics Office 2014:205).

2.6 BARRIERS THAT YOUNG PEOPLE FACE IN ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

While adolescents generally enjoy good health compared with other age groups, they face particular health risks, which may be detrimental not only for their immediate future but for the rest of their lives. Estimates and data clearly show that adolescent ill health and death constitute a large portion of the global burden of the disease, and, therefore, need special attention (Chandra-Mouli, Svanemyr, Amin, Fogstad, Say, Girard & Temmerman 2015a:S2).

Young people and adolescents' vulnerability to poor SRH is compounded by the lack of availability of, and access to, youth-friendly services, and health products as well as by adolescents' insufficient inaccurate or complete lack of knowledge and information about safe sex and contraceptive use (Chandra-Mouli et al 2015a:S3). Apart from

tackling with challenges with the changes that young people go through as they grow, they face other challenges, which include HIV/AIDS, gender-based violence and teenage pregnancy. These challenges are compounded by poor access to ASRH information and services (Dlamini et al 2017b:2). Below are the challenges/ barriers compounding by poor access to ASRH services that were found out through studies conducted globally as well as in the sub-Saharan region.

2.6.1 Lack of information

Young people who lack complete and correct SRH information may be unaware of their own need for SRH services, uncertain about the safety and reliability of SRH services and contraceptive methods, and consequently, unwilling to use them. Lack of information about service locations and unfamiliarity with the health care system may pose barriers to access for young people who might otherwise make use of SRH services.

A study conducted in Uganda on understanding SRH needs of adolescents, adolescents reported that they never go to health facilities to seek SRH information. Reasons given were lack of information about availability of those services, while others feared to seek services in the same facilities with the older community members and with different sex of health workers (Atuyambe, Kibira, Bukonya, Muhumuza, Apolot & Mulogo 2015:6). On the same note, lack of sex education was seen as a gap among adolescents. In addition, Morris and Rushwan (2015:S41) posit that a range of people have an influence on adolescents' access to information and services, including peers, parents, family members, teachers, and health care workers. This is evident on a study conducted in Swaziland on Analysis of Socio-Cultural Factors Influencing Use of Sexual Reproductive Health Services by Young People, where findings from peers and family norms transpired to significantly increase the SRH service utilisation likelihood among young people where family had 39% and peer influence was at 28% (Dlamini et al 2017a:5).

According to a study conducted by Godia (2012), lack of information about available services, costly services, distance from the facility, being scared and being too busy were identified as some of the reasons that prevented young people from seeking health services. The conclusion drawn from this study is that it is possible to improve

existing services, even in the most remote settings, to address the SRH problems of young people. As a result, when young people are equipped with accurate and relevant information, decision-making, communication and critical thinking skills along with self-efficacy, and access to services, they are better able to make healthy decisions now and in the future, avoid unintended pregnancies and unsafe abortions and protect themselves against violence, STIs including HIV.

2.6.2 Lack of integration

Lack of integration is seen where services that might address counselling and family planning fail to include HIV/STI care. However, the SRH programme under the Swaziland Ministry of Health provides comprehensive sexuality education, information and integrated SRH services to all children, adolescents and young people at all levels of health care delivery systems and other relevant settings according to their age and needs (Ministry of Health 2013b:18). Literature has shown that young people value convenience; offering multiple services together saves clients time and effort. Moreover, combining SRH services with general health services offers young people a measure of confidentiality when seeking contraception, post-abortion care or HIV services. At integrated service delivery locations, young clients could just as easily be seeking a general health service as a contraceptive method. A study conducted in 2013 in Uganda shows that integration of ASRH services appeared to be more important for increasing uptake of modern family planning methods for young people. However, the challenge though is prolonged waiting time for clients.

2.6.3 Accessibility barriers

This entails the location of the facility providing SRH services, privacy within the facility, the age and gender of the staff complement of the clinic. Cost may prevent young people from seeking SRH services because they may be unable to afford them and may not feel comfortable asking friends or family to provide funds for such expenses. In addition, the location of SRH facilities far from where youth live, works, or attends school, and limited access to transportation can prevent young people from accessing SRH service providers (Leah 2015:14).

Young people in Uganda expressed that when faced with reproductive health problems they seek medical help when the problems persist. Reasons for this poor health seeking behaviour included cost, privacy issues and long queues. Some male adolescents reported “nosy” health care workers who ask many questions therefore making them uncomfortable (Atuyambe et al 2015:7). The same sentiments were reported on a study conducted in Nepal in 2012 where young people reported that insufficient drugs limit them to access health care, distance to health facility, shortage of staff, and lack of money (Khanal 2016:60).

Also noted on accessibility barriers is operating hours in health institutions. In a study on voluntary medical male circumcision (VMMC), male adolescents reported the clinic’s limited operating hours coinciding with school and work hours and an unwelcoming atmosphere with adolescents (Kaufman, Smelyanskaya, Van Lith, Mallalieu, Waxman & Hatzold 2016:5). In the same study, a study conducted in South Africa was cited where male SRH clients reported discomfort in waiting in lines with women and young children.

Atuyambe et al (2015:5) report that young people complained of infrastructure not conducive for young people, as male adolescents said that it was hard for them to collect condoms and other medications from general health facilities from which all adults including relatives and parents receive health care. However, they expressed willingness to freely do so if they had a separate medical centre.

Since most of young people are still attending school. As a result, the operating hours at facilities are not convenient for them, therefore hinders them from accessing services. On the hand, very limited number of health care facilities in Swaziland has youth-friendly services, and this deters young people from accessing SRH information and services from these institutions (Dlamini et al 2017a).

2.6.4 Provider and service delivery barriers

Access and utilisation of available reproductive health services by adolescents and the youth is determined by how the services are provided to them and how friendly the services are to them. According to Mbeba, Mkuye, Magembe, Yotham, Mellah and Mkuwa (2012:4), negative attitudes of health care workers have been identified as a limit to the utilisation of SRH services by young people. Health care workers are not

comfortable with provision of contraceptives to young people owing to the inherent side effects of the contraceptives (Mbeba et al 2012:4). In the same study, it was indicated that service providers feel and behave as parents when providing SRH services to young people, therefore making clinical judgements on their parental instinct. This has proven to be the most important barrier to access among young people. Similar results were shared in a study conducted in Kenya on health service providers' experiences on provision of SRH services among young people. This study found that health providers tend to be judgemental and easily condemn young people by being harsh and giving young people lectures when they presented with an SRH problem such as an STI or when in need of contraceptives or condoms (Godia, Olenja, Joyce, Lavussa, Deborah Quinney, Hofman & Broek 2013:7). In addressing this barrier, Godia et al (2013:11) suggest that service providers' trainings and facility improvements are pivotal initiatives to enhance the uptake of SRH services by young people and adolescents.

In addition, young people pointed out on the age of the health service provider as important. If the health care worker is not of their age group, young people cannot open up with their health problem. These findings from this study are similar with findings from a study conducted in South Africa and Zambia cited in Kaufman et al (2016), where adolescents reported that they wanted to attend clinics only while being accompanied by a peer-educator or to interact with and ask reproductive health related questions only from people of a similar age. In a study conducted in Uganda, adolescents highlighted that if the health care provider is not of the same age group that staff should at least be trained to handle young people and youth problems according to the adolescents' or young people's perceptions (Atuyambe et al 2015).

2.6.5 Socio-cultural factors

Adolescents have diverse experiences, given the varied socio-economic and cultural environments in which they grow. Some socio-cultural practices have a direct impact on the reproductive health status of adolescents, and consequently on their adult life. According to Ralph and Brindis (2010) as cited in Leah (2015:14), embarrassment and fear of social stigma prevent many young people from seeking information about SRH and from accessing services if they fear they might be seen or their information shared with family members. Access to reproductive health services by the youth has received minimal attention given that SRH service provision for many years has been tailored to

meet the needs of the adult population. Therefore, young people and adolescents have been neglected partly owing to cultural sensitivity that dictates what, when and how SRH information and services should be transmitted to them (Dlamini et al 2017a).

In Vanuatu, young people shared that fear and shame related to socio-cultural norms and attitudes regarding to adolescent sexual behaviours are reasons why young people find it difficult to access SRH services. In addition, negative attitudes from parents and community particularly for girls because they were afraid of the consequences if their parents found out were seen as common reasons. Culture contributed to stigma around young people and adolescents' sexual behaviours, therefore, inhibited open discussion of sexual matters and prevented SRH services (such as condoms) being provided in communities (Kennedy, Bulu, Harris, Humphreys, Malveris & Gray 2013:5). Working with communities to create a supportive environment for adolescent SRH was seen as critical to overcome significant socio-cultural barriers. Community support is recommended as an important predictor of adolescents' care seeking behaviour, and youth-friendly health services may be more effective if linked with community interventions (Kennedy et al 2013:7). Mutai (2016) shared the same results on the study that was conducted on assessment of factors influencing utilisation of youth-friendly reproductive health services in Kenya. The results showed that cultural beliefs prohibit pre-marital sex and pregnancy, and young people were reprimanded for using family planning.

On the contrary, in Uganda, parents viewed the decline of Sengas (people whom you think are able to talk with your child), as according to the Ugandan culture, it is really a secret as a parent to tell your child about sex. Condoms are unacceptable because obtaining them required an acknowledgement of sexual activity before marriage. To purchase a condom as an unwed adolescent was received as disregarding cultural norms. Inaccurate understandings of condoms' effectiveness also detracted from their use (Katz, Ybarra, Wyatt, Kiwanuka, Bangsberg & Ware 2013:5). Adolescent HIV risk-reduction programmes that integrate cultural norms, such as replacing the traditional Senga with contemporary communication modalities, such as the Internet may be both engaging and relevant for the youth. Prevention programmes should also target barriers of condom use and recognise that sexual risk-taking is a dynamic process influenced by social context (Katz et al 2013:6).

In contrast to what has been discussed above, a study conducted in Swaziland on “Analysis of Socio-Cultural Factors Influencing Use of Sexual Reproductive Health Services by Young People” showed that young people who relied on mothers for SRH information only reported to have accessed SRH services. Hence, family values were pointed out to be the most powerful towards uptake of SRH services (Dlamini et al 2017b). The results on this study further showed that community norms are influential towards the uptake of SRH services among adolescents, young people and youths in Swaziland.

2.7 INTERVENTIONS TO IMPROVE YOUNG PEOPLE’S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The International Conference on Population and Development (ICPD) in Cairo in 1994 promulgated a bold, clear and comprehensive definition of reproductive health. Nations were called to meet the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality (Chandra-Mouli et al 2015a).

2.7.1 Projects formulation

In Nepal, between 2012 and 2014, Ipas Nepal implemented a project to enhance the ability of young women of the ages of between 15 and 24 to prevent unwanted pregnancies and obtain safe abortion services. Peer educators worked with health facilities and results showed that working in consultation with health-care providers and other adults, young people could play a meaningful even essential role in improving the quality of SRH services for young people. In addition, results showed that young people, with appropriate training and support, can effectively inform and counsel their peers about SRH and rights, including abortion (Ipas 2015). This same approach was used in Kenya, where a multi-pronged approach was used. The Evidence Based-Interventions (EBIs) employed various approaches simultaneously to the same target group to address the holistic SRH needs of youth and have maximum effect (Kenya Ministry of Health 2013:7).

In Thailand the Ministry of Public Health has developed 350 Health Promoting Hospitals committed to health promotion and making health services more user-friendly (Rushwan 2015). A Friend Corner was established outside school/college hours in shopping malls

and community housing areas. The first point of contact is with adolescent peer counsellors. Health staff provided counselling or basic primary care, or referred adolescents to specialised services. The Friend Corner website combined music, fashion and health information. It has been praised for making information accessible in an attractive way (Rushwan 2015).

UNICEF Swaziland supported the MoH SRH Unit to strengthen capacity of health care workers through training of 44 nurses from 22 health facilities in Manzini region on youth-friendly services for ASRH and HIV/AIDS. This led to achieving the target of establishing 10 youth-friendly clinics in the region (UNICEF 2015). At least 80% of health care workers in each clinic were trained on ASRH/HIV youth-friendly services (UNICEF 2015).

2.7.2 Community involvement

Another approach is the community engagement that aims at transforming the norms and improves the physical surroundings in which young people live. Doing so helps create environments where adolescents feel safe and valued and that are supportive of their SRH (Plourde, Fischer, Cunningham, Brady & McCarraher 2016:2). In India, a programme was implemented to delay first birth and improve birth spacing among married adolescents in engaged community members in discussions about the health benefits of such practices. The programme resulted in a significant increase in contraceptive use among married adolescents (Plourde et al 2016:2).

In Swaziland, there are mentor mothers who act as a link between the community and the primary health care through their presence and connection to the local context. The mentor mothers have a smaller area of responsibility, are more focused toward a specific patient group, mothers and children, and have a higher level of supervision, training and demand for accountability. Therefore, this facilitates the possibility of a greater impact on health outcomes and assists the primary health care as it advocates in the community (Malqvist 2014:176).

2.7.3 Family involvement

This has been seen as an effective strategy to improve access of ASRH services. Programmes to strengthen family connections increase association with positive peer groups, and provide safe spaces for young people to meet with peers all afford adolescents the opportunity to form meaningful relationships and contribute to positive SRH outcomes (Plourde et al 2016). The role of parents and other home-based influences in protecting and promoting adolescent health is pivotal. A safe home where confronting issues are discussed openly is a starting point for self-respect, esteem and confident decision making as children progress through their teenage years (Chalk 2015:18). A randomised control trial examining the impact of an intervention to improve parent-adolescent communication about SRH found the intervention to be effective in improving young people's knowledge about condoms and their self-efficacy to use them (Plourde et al 2016).

2.7.4 Access to economic and academic opportunities

Positive access to economic and academic opportunities had a strong effect on SRH outcomes. When combined with other social support and life skills, building adolescents' financial capital can lead to reduced sexual risk-taking behaviour, increased health knowledge, and increased service seeking behaviour (Plourde et al 2016:2). Plourde et al (2016:2) further stated that, higher rates of participation in education are associated with lower HIV prevalence among adolescents, fewer pregnancies and delayed sexual debut.

The WHO in 2006 developed the "Do not go, Steady, Ready, Go" classification for a series of adolescent HIV/AIDS systematic reviews, including the review on health service use. Results showed that the classification is useful because it translates the evidence base for various interventions into policy recommendations. The criteria for the "Do not go, Steady, Ready, Go" classification in the 2006 review was based on the strength of evidence. It was measured against predefined evidence thresholds for each individual type of intervention. Factors such as feasibility, risk adverse outcomes and potential effect size with wide scale implementation were considered (Deno, Hoopes & Mouli 2014:S24).

2.7.5 Policy formulations

Adolescents, young people and the youth in Swaziland do not have adequate information and accessibility to services, which will enable them to make informed decisions on their sexuality and reproductive health. However, the Sexual Reproductive Health policy of 2013 observed decline in HIV prevalence among young people over the past year provides an opportunity for strengthening ASRH services (Ministry of Health 2013b). The national policy was developed to ensure proper coordination, integration and harmonious delivery of comprehensive SRH services in order to better the health and well-being of the population as well as to contribute to its socio-economic development as set out in poverty reduction strategy and action programme (PRSAP).

However, despite this undertaking, there exists a wide disparity between the aspirations of these policies and the realities of young people. The process of establishing and committing to policies has not been accompanied with actions that materially improve the situation of and outcomes for young people. For instance, young people's health challenges are exacerbated by their lack of access to nearby health services, which are youth friendly in nature. Furthermore, the rural health motivators have limited skills regarding the handling of youth issues and in extending health services provided by rural clinics (Dlamini et al 2017b).

2.8 SUMMARY

The chapter on literature review gave a detailed description of the situation of SRH among young people globally with a special emphasis on countries in sub-Saharan Africa. It gave the current trend in sexual behaviour and reproductive practices among young people. The second part of the literature review provided findings from systematic reviews and primary interventions implemented mainly in developing countries and the effectiveness of these interventions. In addition, the literature reviews mainly focused on examining the effectiveness of facility-based interventions for young people. The review also examined components of sexual reproductive health services as well as barriers to accessing SRH services by young people. Lastly, in the chapter, previous strategies implemented to improve young people's SRH were discussed.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research methodology is described. The chapter provides a detailed description the research design, the setting and population, the sample and sampling methods, data collection methods and procedures, data management and analysis, the ethical considerations. The study further discusses its significance and contributions as well as the scope and limitations. According to Grove, Burns and Gray (2012:23) a research methodology incorporates all the procedures that have been used, are currently used, or may be used to pursue knowledge.

3.2 RESEARCH APPROACH AND DESIGN

3.2.1 Research approach

In this study, the researcher used a qualitative approach. Cekmez, Yidiz and Bütüner (2012:78) cited in Marton (1989) posit that a qualitative approach is an observation and experienced based on an approach whose intention is to describe differences among different people in understanding, or perceiving a phenomenon. In the same vein, Grove, Burns and Gray (2012:3,23) concur that a qualitative research is a systematic, interactive, and subjective approach that allows the researcher to explore and describe life experiences of the participants and to present those experiences in a meaningful way. According to Brink, Van der Walt and Van Rensberg (2012:121), the main aim of qualitative research is to understand rather than to explain and predict phenomena. Qualitative research is mainly concerned with inductive generation of ideas and providing in-depth and rich explanations of individual's views and experiences (Jones 1995:376; Patton 2002:11; Pope & Mays 1995:43). In addition, Creswell (2013:49) asserts that the exploratory nature of the qualitative descriptive design is mostly related to the inquisitiveness of the researcher, and his/her determination to gain an understanding of the phenomenon.

3.2.2 Research design

Polit and Beck (2012:741) define research design as the overall plan for addressing a research question, including specifications for enhancing the study's integrity. According to Athanasou, Di Fabio, Elias, Ferreira, Gitchel, Jansen, Malindi, McMahon, Mpofu, Nieuwenhuis, Perry, Panulla, Pretorius, Seabi, Saklar, Theron and Watson (2012:81), a research design aims to provide credible results. The researcher used a descriptive exploratory study design to solicit, explore and describe the perceptions of young people on issues related to their SRH. The study was descriptive as it complied with the characteristics of descriptive research as stipulated by Babbie and Mouton (2011:80-81).

3.3 RESEARCH SETTING AND POPULATION

3.3.1 Research Setting

The study took place at the Family Life Association of Swaziland (FLAS) in Manzini, Swaziland. FLAS is a non-governmental organisation providing mainly SRH services. This site was selected because it is implementing the ASRH programme, including the youth.

3.3.2 Population

A study population is an aggregate of elements sharing some common set of criteria (Babbie 2016:119). The population is described in terms of the target population, inclusion criteria, and sampling method. In this study, the population was represented by young people aged 10-24. According to Polit and Beck (2012:274), target population is the aggregate of cases about which the researcher would like to generalise and the group from which the researcher wants to gather information and draw conclusions. The accessible population in this study consisted of young people, both female and male, seeking SRH services from this facility.

3.4 SAMPLE AND SAMPLING METHODS

A sample is a subset of the population elements, which are the most basic units about which data are collected (Polit & Beck 2012:275). Crossman (2014:2) asserts that when conducting research, it is sometimes impossible to study the entire population in which researchers are interested owing to extreme and costs. As a result, researchers use samples as a way to gather data. The representatives of the study were young people aged 10-24 seeking SRH services in a youth clinic.

3.4.1 Eligibility criteria

Accordingly, for one to be included in the study, one has to be eligible. Polit and Beck (2012:726) define eligibility criteria as the criteria used to select who is in the population; that is, the criteria that specify population characteristics. To be included in this study, the participant had to be a young person aged 10-24 and either female or male, seeking SRH services at a health facility.

3.4.2 Sample size

A sample size is the number of people who participate in the study (Polit & Beck 2012:742). The authors further state that there are no fixed rules for sample size in qualitative studies. The guiding principle in sample size is determined by the data saturation, that is, sampling to a point at which no new information is obtained and redundancy is achieved. Therefore, the sample size for this study was determined by data saturation.

3.4.3 Sampling procedure

According to Creswell (2012:206), purposeful sampling is used to intentionally select individuals or sites to learn or understand a central phenomenon. The author also accentuates that convenience sampling is the inclusion of readily accessible individuals in the study, who meet the criteria, as they are a convenient source of data. The researcher used convenience purposive sampling to select the study participants as follows:

Breaking the age group of young people who were in the 10-24 age group categories according to the following reproductive age groups: 10-14; 15-19 and 20-24 to ensure the inclusion of a range of young people in the sample. Participants for each age group were selected using convenience sampling methods. Using the convenient sampling technique benefited the researcher in the sense that participants were convenient accessible to her. Furthermore, the advantage of using convenience sampling was that it was easier for the researcher to obtain participants.

Sampling was terminated when category saturation was reached, that is, the point in data collection where new data no longer brought additional insights to the research questions. However, an effort was made to include both female and male young people in the sample. Nevertheless, there were no participants in the age group of 10-14. The reason might be that young people of this age group were still at lower grades in school and they had to be accompanied by their parents to hospitals. Another reason might be that most of the young people were not yet sexually active; hence, their health needs/problems were not related to reproductive health. Participants in this study were able to converse in both English and siSwati since these languages are official in Swaziland.

3.5 DATA COLLECTION METHODS AND PROCEDURES

3.5.1 Data collection

Data collection is the gathering of information to address a research problem (Polit & Beck 2012:725). It is one of the crucial aspects of any research study (Du Plooy-Cilliers, Davis & Bezuidenhout 2012:147). Athanasou et al (2012:88), emphasise that the research question guides the data collection method. The data collection process for this study is described in the sub-sections that follows:

3.5.1.1 Data collection approach and method

The interviews were conducted in a waiting area, which was adjacent to the consultation rooms. However, participants were requested to move away from the crowd. The researcher used semi-structured interviews to collect data from young people seeking SRH services who had consented to participate in the study.

“Semi-structured interviews consist of several key questions that not only help to define areas to be exposed, but also allow the interviewer and interviewee to diverge in order to pursue an idea or response in more detail” (Gill, Stewart, Treasure & Chadwick 2008:291). In this method, the researcher and participants become more flexible (De Vos, Strydom, Fouché & Delpont 2014:351). The researcher was taking notes verbatim while noting down non-verbal responses. Where necessary, questions were explained. Each interview lasted for about 25 minutes. A voice recorder was also used to record the interviews. De Vos et al (2014:359) cited in Smith, Harré and Van Langenhoven (1995:17), who asserts that a tape recorder allows a fuller record than notes taken during the interviews as the researcher can concentrate on how the interview is proceeding and where to go next.

3.5.1.2 Characteristics of the data collection instrument

The researcher had developed an interview guide comprising mostly of closed-ended questions on biographical information. Open-ended questions were designed to understand accessibility of SRH services for young people (see Annexure H). However, probing was done where necessary. The probing questions were not the same for each interviewee, and did not follow any order. The question in the interview guide were simply to direct the conversation to capture the young people’s perceptions of the reproductive health services in Manzini, Swaziland.

3.5.1.3 Data collection process

Data collection only commenced after permission was sought and granted by FLAS authorities. Consent was also sought from the study participants prior to data collection. Information was obtained from young people through face-to-face interviews. A voice recorder was used with the permission of the participants to record the interviews. A waiting area was used for the interview sessions. Data collection took place in October 2017.

3.5.2 Scientific rigor/trustworthiness

Trustworthiness for this study was based on Guba and Lincoln's (1994) framework (cited in Polit & Beck 2014:322). This framework has five criteria and these are discussed below: credibility, dependability, confirmability, transferability, and authenticity.

3.5.2.1 Credibility

Credibility refers to the confidence that readers will have that the research results depict the exact views of the participants (Grove, Burns & Grove 2015:392). In this study, credibility of the findings was maintained through ensuring that participants' views were captured by using member checks. Reflexive writing was also employed through the use of a diary as a form of self-interrogation (Polit & Beck 2012:326). The use of different reproductive age groups was a form of data triangulation and it enhanced credibility.

3.5.2.2 Dependability

Dependability is the ability of the researcher to depict the entire research process in a way that others can understand and follow to reproduce the same research in similar or different settings. It is similar to reliability in quantitative research. In the study, dependability was ensured through addressing research questions that were wholly consistent with the specified research purpose. The use of audio-recorded interview transcripts, note taking, transcripts, and functional audio recording device and audit trail addressed distortions or inadequacy in portraying phenomena as expressed by the participants.

3.5.2.3 Confirmability

Confirmability refers to the objectivity or neutrality of the data and interpretations (Polit & Beck 2012:723). It ensures that the findings are objective and that conclusion and recommendations are congruent with the data collected (Brink et al 2012:127). The authors further argue that the researcher's interpretation and the actual evidence should be in harmony. After describing comprehensibly, the data gathering and data analysis

steps, the researcher reported the conclusions in detail and linked the conclusions to the data analysis. In this research, utilising verbatim transcription ensured that the participants' perceptions were presented free of the researcher's bias. Confirmability was maintained through the member checking and the use of peer review.

3.5.2.4 Transferability

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck 2012:745; Du Plooy-Cilliers et al 2012:258). In this study, the findings were described in order to produce descriptions and meaning of the phenomenon. The researcher provided detailed description of contexts and analysis to assess applicability of findings in similar circumstances (Creswell 2013:252).

3.5.2.5 Authenticity

Authenticity refers to the degree to which the experiences, feelings and context of the study are portrayed (Polit & Beck 2012:585). In this study, the findings of this study portrayed the perceptions of the participants. Therefore, such findings must be authentic and be able to describe the realities of the participants clear.

3.6 DATA ANALYSIS AND MANAGEMENT

Data analysis and management began during the data collection process. Actually, data management as the first step of data analysis involves transcribing, organising, developing categories and coding data (Creswell 2013:44). Transcription of data was done within 24 hours of each interview. Transcription of data assisted the researcher to immerse herself into the data and to organise the data.

3.6.1 Data analysis

The data gathered from young people through face-to-face in-depth individual interviews were audio-recorded to ensure verbatim accuracy. Data analysis in this research has been adapted from the work of Colaizzi (1978:58) who emphasised that one must match the appropriate source of data with the appropriate method for data collection. This occurs simultaneously in qualitative research (Shosha 2012). Shosha

(2012:33) employed Colaizzi's seven-step analysis framework, (which the researcher plans to use), and cites Sanders (2003), Speziale and Carpenter (2007) as stating that the process of data analysis as described by Colaizzi consists of the following steps:

- Reading and re-reading each transcript to obtain a general sense about the whole content (page 59).
- Extracting significant statements from the transcripts that relate to the phenomenon under study (page 59).
- Formulating meanings from the significant statements (page 59).
- Organising formulated meanings into categories, clusters of themes (page 59).
- Integrating themes into an exhaustive description of the participants' statements (page 61).
- Describing the structure of the phenomenon (page 61).
- Validating the findings with the research participants (page 61).

Colaizzi's (1978) thematic analysis in this research study involved the search for and identification of common sequences that extend throughout the interviews and these themes are usually abstract (Shosha 2012:33). In order to identify recurring statements or themes in this research, the researcher read the transcript several times while listening to the tape recorder.

Statements began to emerge and were recorded as a word in the right margin beside the relevant text. Where there were two statements in any excerpt, the researcher saved the statement in two MS Word documents. The researcher conducted 14 interviews, meaning units emerged and some meaning units were similar. These meaning units were grouped together and saved in another Word document. Other meaning units remained singularly important and remained on their own. To aid in the development of theme clusters, the researcher read the transcripts and listened to the tape recordings of the interviews again. Following this, the researcher reviewed each meaning unit and found that some meaning units were related to others and could be grouped together to form "theme clusters". These "theme clusters" were used by the researcher to give a full description of how the participant's perceived access and utilisation of RHS.

3.6.2 Data management

The interview guides and collected data were kept under lock and key throughout data collection and analysis. The data collected were checked for completeness, accuracy and clarity by the researcher. Appropriate measures were taken on time to ensure completeness before the analysis. In line with the University's research data management policy, data will be kept for a period of five years. Thereafter, the data can be discarded with the approval of the University official if there have been no issues arising against the study that demands prolonged keeping of the data.

3.7 ETHICAL CONSIDERATIONS

Before conducting the study, research protocol was submitted for comment, guidance and approval to the research ethics committee; Unisa Ethics Committee: Department of Health Studies. After feedback and corrections in some elements of protocol, the study was ethically approved to carry out in respective site. Hence, the letter for ethical approval (see Annexure A) was attached to the letter requesting to conduct the study from FLAS (see Annexure B). The study was conducted after FLAS authorities granted a letter for permission (see Annexure C).

The participants were conveniently selected to participate in the study. An inclusion criterion was followed to identify, select and recruit the potential participants to participate in the study. The potential participants were then asked if they were willing to participate in the study and were informed of their right to refuse participation, withdraw from participation or not give information should they wish to. In addition, they were further informed of their right to ask questions relating to the study. The researcher then invited the selected participants to an area adjacent to where they were queuing for their services to obtain informed consent prior to face-to-face interviews.

3.7.1 Informed consent

As it was stated above, after Unisa Ethics Committee had approved the proposal, the ethical clearance letter was submitted to FLAS authorities to get approval to conduct the study. Prior to every interview, each participant was presented with the supporting documentation including the researcher's ethical clearance for the study by Unisa,

application and approval letter from FLAS. Each participant was briefed about the purpose of the study and was informed that his or her participation was entirely voluntary so s/he was free to participate or to withdraw any time s/he wish to do so. A written informed consent (see Annexure D) was acquired from participants prior to conducting the interview and was signed by the participant.

3.7.2 Assent form

From the recruited participants, one participant was less than 18 years. Hence, assent was obtained from the participants. The parent (mother) of the participant had accompanied the participant to the health facility. Therefore, the right to participate to the study was acquired from the parent after objectives, aim of the study were explained to the participants' parents. The parent was asked if she allowed her child to participate in the study and was informed of her right to refuse such participation, withdraw her child from participation or not give information should he wished to. The mother was further informed of the right of her child to ask questions relating to the study. The parent had to sign the informed assent form (see Annexure F) after agreeing for her child to participate in the study. The researcher then invited selected participant who was younger than 18 years, to an area adjacent to the service point to obtain informed assent prior to face-to-face interviews (see Annexure E).

3.7.3 Risks

As the study was qualitative in nature and exploring the views, perceptions and regarding the access of reproductive health care services from participants, there was no any physical harm associated while participating in the study. In addition, there were no specific direct benefits to the participants but to consider the discussion as of value for them and influence each other in health care seeking practices by participating in the IDIs.

3.7.4 Confidentiality

The principle of confidentiality was maintained as far as possible to protect the interests and identities of the participants even if the research participants did not perceive any danger to themselves of data disclosure; hence, a confidentiality binding form was

signed by both the participant and the researcher (see Annexure G). Information collected was not retained for participants' identity. The records of the study were kept strictly confidential. Research records were kept in a locked file and all electronic information was given pseudo names instead of real names. Collected data was shared with relevant staff at Unisa since the study was done for academic purposes. Participants were assured that the researcher and other relevant staff will not include any information in any report that might be published that would make it possible to identify them.

3.8 SIGNIFICANCE OF THE STUDY

From the study findings, it was clear that understanding of young people's perceptions of their SRH services indicate the demand and uptake of reproductive health services to address their reproductive health needs. In addition, the study identified range of reproductive health services available for young people as well as adolescents and the factors that determine the use of these services.

The findings from the study will be used to inform focused information, education and communication programmes as well as advocacy efforts for SRH for young people. Such interventions will hopefully contribute to improve reproductive health outcomes. The study is not only intended to give young people a voice but also find out what really matters to young people in accessing SRH services.

3.9 SCOPE AND LIMITATIONS OF THE STUDY

The study was based only in Manzini, Swaziland. Many young people in other regions of Swaziland, whose views and perceptions had not been represented in this study, were not involved in the study. Therefore, the findings of this study cannot claim to be a representative of the entire population of young people in Manzini or Swaziland. The research was undertaken in Manzini FLAS at a youth clinic all the information referred to young people who visited the youth clinic. Therefore, given the sample size of the findings are not generalised to the whole region.

3.10 SUMMARY

This chapter described the methodology used in this study in detail. The research adopted a qualitative approach employing a descriptive exploratory research study design. Convenience purposive sampling was used to recruit young people who met the inclusion criteria of the study. Individual semi-structured open-ended interviews were conducted with 14 participants (young people aged 10-24 both males and females) seeking SRH services at FLAS. Face-to-face interview guides were used as the mode of data collection. Data were analysed using Collaizi's seven steps approach (Shosha 2012). Trustworthiness was confirmed through Lincoln and Guba (1994) model and ethical considerations focused on the protection of participants and their identities. The prescribed ethical guidelines as approved by Unisa Department of Health Research Ethics Committee were followed. The confidentiality of the research participants was ensured throughout the study, protecting their identity by holding individual interviews in an area away from the crowd. Prior to each interview, a thorough explanation of what the study was all about was provided, a signed informed consent was obtained from each research participant. The chapter further presented limitations of the findings as well as the significance of the study to the health sector. The next chapter (chapter 4) will look at the findings of the study and these will be discussed in detail and verified against existing literature on perceptions of young people on accessing SRH services.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the study. These are presented in two main sections. The first section presents the sample demographics while the second one presents the research findings. The purpose of the study was to explore and describe young people's perceptions on access to SRH services in Swaziland. The following were the objectives of the study were to

- identify and describe SRH services for young people in Manzini, Swaziland
- explore factors that hinder access to SRH services for young people in Manzini, Swaziland
- explore factors that promote access to SRH services for young people in Manzini, Swaziland
- recommend interventions that could improve access to SRH services for young people in Manzini, Swaziland

Based on the objectives above, young people's perceptions on access to reproductive health services have been discussed as findings under the following subheadings:

- Understanding SRH services.
- Facilities providing SRH services for young people in Manzini, Swaziland.
- Factors that hinder access of SRH services for young people in Manzini, Swaziland.
- Factors that promote access of SRH services for young people in Manzini, Swaziland.
- Interventions to improve access of SRH services for young people in Manzini, Swaziland.

Data were collected in the month of October 2017 with the use of an interview guide and through face-to-face interviews. The data collection tool was developed in English and the interviews were conducted in English but where necessary, translated from English to the local language (siSwati). A recording device (an audio recorder) was used to capture information during all the interviews.

4.2 RESEARCH FINDINGS

4.2.1 Sample demographics

A sample of fourteen participants who were young people visiting the health facility to seek SRH services were interviewed. These were both females and males.

4.2.1.1 The age categories of the participants

The age categories of the participants are shown in Table 4.1.

Table 4.1 Sample demographics by gender and age (N=14)

Gender	Age range (years)			Total
	10-14	15-19	20-24	
Females	0	2	10	12
Males	0	1	1	2
Total	0	3	11	14

A close look at Table 4.1 above reflects that there were more females, that is, twelve, compared to only two males. Most participants, eleven, were aged between 20-24 years, followed by only three aged 15-19 years. There were no participants aged 10-14 years.

4.2.1.2 Educational attainment of young people

Young people were asked about their level of education and qualifications. The educational attainment of young people is presented in Table 4.2.

Table 4.2 Young people disaggregated by level of education (N=14)

Educational level	Head count
None	0
Primary	0
Secondary school	2
High school	5
Tertiary education	7
Total	14

Table 4.2 shows that most participants, that is, seven participants have reached a tertiary level of education, five had high school education and two had secondary level education. None of the young people was found to not have received any form of education. Below, young people’s perceptions on access to SRH services are discussed.

4.2.2 Young people’s perceptions on access to sexual and reproductive health services: An overview

Access to health care services means having "the timely use of personal health services to achieve the best health outcomes" (institute of Medicine (IOM) 1993 quoted in Whitfield 2013). For the purpose of this study, access meant awareness of existence or availability of services within an accessible distance, affordable and responsive sexual and reproductive services. Services and treatment must be affordable and be based on the principle of equity such that poor people do not bear a higher burden from the cost than wealthy people.

From the 14 participants interviewed, 13 participants perceived access to SRH services as negative. From the thirteen participants who viewed the services as negative, only four viewed services as both negative and positive. SRH services were said to be negative if service delivery is not youth-friendly. The negative services might not be able to attract and retain young people for continuing care and influence behavioural change among them and the community at large.

Participants (12) expressed fears, from seeking the SRH services, of being judged by the health-care workers. From the 12 participants who expressed fear from being judged by health care workers, two also feared being judged by community, six had additional fear of parents and three were scared being judged by peers.

Four young people found that opening hours were inconvenient for the young people because most of them (young people) are students and some are employed. This means that regardless of how well designed the SRH programmes are, social marketing and publicity are critical for uptake. Six participants regarded the SRH services as poor and inaccessible. Accordingly, young people might not know where to obtain such services. The four participants who viewed the services to be both negative and positive indicated the positive side of the services as follows:

- That some service providers were youth friendly and well trained (one participant).
- The SRH services were accessible at the clinic (FLAS) because the clinic had a Youth Action Movement (YAM) page on social network which is all about SRH services information (one participant).
- Though the waiting period was long, the staff were doing their work. The long waiting period was because of staff shortage (one participant).

The SRH services were meant for young people because FLAS had a mobile clinic, which often visited the rural areas to reach out to the youth. Furthermore, FLAS had a youth club where the youth meet every Fridays to ensure its availability and accessibility.

The discussion that follows presents the main themes and sub-themes as they emerged from the analysis. The themes and sub-themes respond to the objectives of the study. These are backed up by quotations from the participants, where applicable. Table 4.3 depicts a summary of themes and sub-themes on young people's perceptions on access to SRH services in Manzini, Swaziland.

Table 4.3 Summary of themes and sub-themes

Themes	Sub-themes
Understanding SRH services for young people	Pregnancy prevention services Family planning services and use of contraception STI services HIV-related services Counselling and SRH information Voluntary medical male circumcision services
Facilities that promote, provide and improve access to SRH services for young people in Manzini, Swaziland	Public facilities Private facilities
Factors that hinder access to SRH services for young people in Manzini, Swaziland	Lack of privacy and confidentiality Health workers' negative attitude Lack of knowledge about availability of SRH services Inaccessibility of services Fear of parents, community and peers Young people's ignorance Religion
Factors that promote access to SRH services for young people in Manzini, Swaziland	Knowledge of available SRH services and information Socio-cultural support Youth-friendly delivery services Awareness campaigns School visits Prolonged exposure to illness
Interventions to improve access to SRH services for young people in Manzini, Swaziland	Increase of SRH service facilities Community outreach activities Health education through peer educators Policy formulations

4.2.2.1 Understanding SRH services for young people

Young people in Swaziland were asked what they understand about SRH services. This question was asked as a grand tour question. The question was intended to source young people's perceptions on the prevention, diagnosis and treatment as related to STIs and contraceptive service and counselling, pre and postnatal care, delivery care, treatment of STIs, safe abortion and post abortion care, and access to information and education to the above mentioned issues in line with WHO (2016).

Young people viewed SRH services in the same light as WHO (2016) definition of SRH. The participants understood that SRH be a service that should

- include family planning (11)
- be related to pregnancy (nine)
- render HIV/AIDS related services (six)
- render STI care and treatment (five)

The participants further mentioned counselling and SRH right information (four); cervical cancer screening (three) and voluntary medical male circumcision (two) as the functions of SRH. These services are illustrated in Figure 4.1 below.

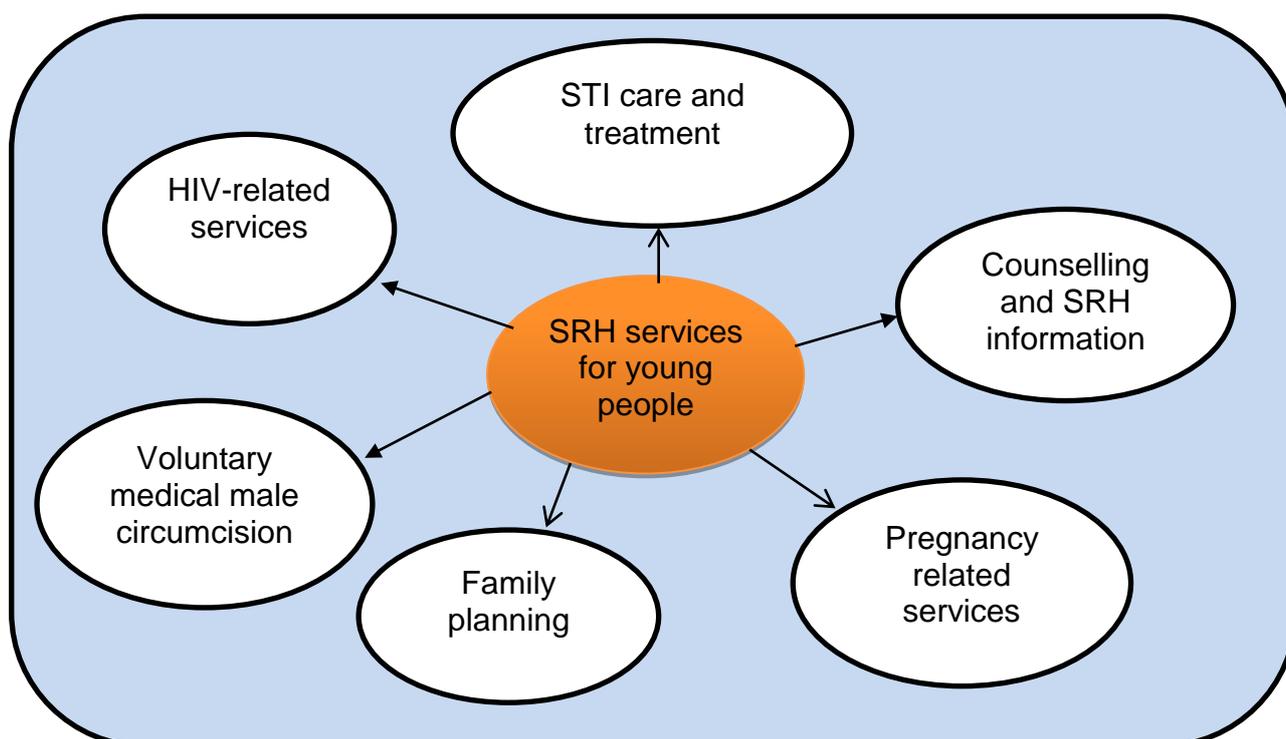


Figure 4.1 SRH services for young people in Manzini, Swaziland

- **Pregnancy prevention services**

Out of the 14 participants, six indicated that they already have been pregnant and have children. From the six who have been pregnant, only one pregnancy was planned. Four said their pregnancies were not planned though methods of contraceptives were used and one said her pregnancy was not planned and no method of contraception was used. Tito commented:

“I didn’t plan to be pregnant or have this child since I used a calendar method but I think this time around I didn’t count correctly my days. However, I don’t have a problem having this child because I’m working I’ll be able to take care of my child.” Tito (24 years; [Female]).

Another participant stated:

“... I didn’t plan to have a child, because I was on an injection of 3 months’ interval and I got pregnant, I don’t know how.” Buhle (23 years [Female]).

- **Family planning and use of contraception**

According to the participants, eight have visited family planning and have used contraception previously while six have never used contraception. Various reasons were given for using or not using contraception. Table 4.4 below portrays the use of contraception of young in Manzini, Swaziland.

Table 4.4 Young people disaggregated by use of contraceptives (N=14)

Pseudo names	Contraception use	Comments
Nisoo	Yes	Condom, to prevent impregnating girlfriend
Donald	Yes	Condom, to prevent contracting STIs
Rosemary	No	Haven’t yet engaged on sexual activities
Carol	Yes	Injections, to prevent unnecessary pregnancies
Precious	Yes	Condom
Swazi	No	Thought it is for adults only
Nobuhle	No	Scared that might not get children if started early
Tito	Yes	Calendar method
Girlie	Yes	Emergency pill, though it was not helpful at the end
Sthupha	No	Side effects
Zwile	No	Emergency pill
Buhle	Yes	Injectable, got pregnant on contraceptives
Nokwethu	No	Scared of side effects
Sixolile	Yes	Pill, forgetfulness

Table 4.4 above clearly stipulates different methods of contraception used by young people. As stipulated above, six participants already had children. Out of the six participants who had children, one planned to have children while five highlighted that their pregnancies were not planned. Three had used hormonal contraceptives prior to

their pregnancies and one used a calendar method. Two participants stated that they did not use methods of contraception.

One participant, Zwile had one boy child whom she did not plan to have. Zwile stated that she often used an emergency pill when she had unprotected sex. However, the emergency pill method did not work out well for her. Though she used the pill correctly, the reason for its ineffectiveness was that when it is used most often, it becomes less effective. Zwile further stated that she did not want to be on conventional methods because of their known side effects, such as gaining weight and irregular menstrual bleeding.

Sixolile's pregnancy was not planned and also had one boy child. She (Sixolile) mentioned that she used the combined oral pill. However, she was not consistent with it as she sometimes forgot to take the pill. Buhle pointed out that she used the injectable (Depo provera) but she fell pregnant while on contraceptives. Sthupha, who was pregnant with her first baby, revealed that she never used any method of contraception because of the side effects she heard people often talked about. However, her pregnancy was planned because she was already married and was building a family. Nobuhle said that she never used any contraceptives because she believed that she might not be able to have children later when she wishes to have them.

Nokwethu had one girl child whom she confessed that she was not on contraceptives when she conceived her. She indicated that the unpleasant side effects of hormonal contraceptives, which includes irregular menstrual bleeding, weight gain, nausea, vomiting, and persistent headache.

Tito also had one girl child and stated that although she was on a calendar method, she did not have a problem of having that child. According to Tito, she might have counted her days incorrectly. As a result, she fell pregnant.

Reasons for use of contraception

Reasons for use of contraceptives among young people ranged from delaying pregnancy, to being unstable in intimate relationships and being scared of school dropout owing to pregnancy.

Buhle was on an injectable depo provera when she conceived her child. She pointed out that she used contraceptives because her boyfriend was cheating on her. She further said that she did not use double protection because the health service provider at a nearby clinic told her that the three-month injection is very effective. What was shocking to the researcher was to learn that the participant never thought of being infected with HIV and other STIs as her boyfriend had multiple sexual partners.

Sixolile also had one boy child from an unplanned pregnancy, whom she conceived while on the combined oral pill. She confessed that she was not consistent with it as she sometimes forgot to take the pill. When asked why she did not use a condom when having sex as she was not taking a pill reliably... she stated that her boyfriend refused to use a condom.

Condom use among young people was pointed out to be good as it acts as a double protection- unwanted pregnancies and STIs, including HIV. The male participants stated that condom use should be encouraged among young people since they are likely to have many sexual partners and short-term sexual relationships. An extract from one of the male participants:

“... to be honest as a young person I do engage in sex but that girl I’m sleeping with I won’t get married with her, so I use a condom because I don’t want to impregnate her and to protect myself from getting bogcunsula (meaning sexually transmitted infections, such as, gonorrhoea, syphilis, chlamydia).” Nisoo (23 years [Male]).

Nisoo stated that he does not have a child. However, he pointed out that he uses a condom when engaging in sexual relations. He wore a condom to prevent unnecessary pregnancies since his intimate relationship was casual. Condom use also protected him from STIs including HIV. Donald shared the same sentiments.

Reasons for non-use of contraception

The reasons for non-use of contraception included fear of unpleasant side effects of hormonal methods, the myths that when the use of contraception started early, one cannot conceive later when wishes to; belief that contraceptives are for adults only; the belief that the youth are not sexually active. The participants further highlighted that girls who have not had their first child should not take hormonal contraceptive as this could affect their fertility in future.

When Nokwethu (22-year-old female who had one child) was asked why she did not use contraceptives, she responded that she was scared of their known side effects she heard people talk about. She further stated that she did not know much about contraception as she has not visited any health facilities before, to seek information on family planning and contraception and nor had any related discussion with her mother.

The other female participant Nobuhle who was pregnant for the first time at the time of the study did not plan her pregnancy and did not use contraceptives. Nobuhle also indicated that she lacked knowledge about SRH issues. She stated that she thought those who had children already and those who are married used contraceptives. Therefore, she was scared that she might be unable to conceive later when she wishes.

An extract below depicts her thoughts:

“If you start to use contraceptives when you had never had a child you may miss to get a baby by the time you wish to.” Nobuhle (23 years [Female]).

The researcher was stunned to hear that the two participants had never been exposed to sex education even when they were still schooling. When Nokwethu and Nobuhle were asked about condom usage, they both stated that their boyfriends did not want to use condoms and their sexual activities were unarranged. The unsafe sexual practices for these two young people rendered them not only unsafe to unplanned pregnancies but also to high risk of HIV infection and other STIs.

Heavy menstrual flow and weight gain were other reasons given by a majority of non-users of hormonal contraception's as birth control for young people. Although Zwile

knew about contraception, she was not on a conventional method; she opted to use an emergency contraceptive pill, which was ineffective at that time. She pointed to unpleasant side effects of contraceptives prevented her from being on a constant method. What was of note from Zwile's case was that she had poor knowledge on how often and when to take an emergency pill.

Tito, another female young person who had one child, did not plan to have a child. Though her pregnancy was not planned, she had no problem of having the child. She (Tito) was not on a hormonal method. She used a calendar method. Her reasons for not using the hormonal methods included fear of their known side effects, forgetfulness when using the combined oral contraceptive pill, scared of the needle if she would decide to use the injectables. Tito further pointed to the inconvenient clinic visits, which she might experience when she was on the hormonal methods; she had a full day employment. An extract from Tito below:

“... I didn't plan to have this child since I used a calendar method but I think this time around I didn't count correctly my days. However, I don't have a problem having this child because I'm working I'll be able to take care of my child.” Tito (24 years [Female]).

Another participant commented:

“... this is my first pregnancy, I wouldn't say that I had planned to be pregnant, but since I'm married I have to build a family, so I was not on contraceptives.” S'thupha (24 years [Female]).

Rosemary stated that she was not on any birth control method because she had not been on sexual activity. However, she mentioned that she was aware of the methods of contraception, though she had lack of knowledge about their mode of actions and side effects (Rosemary (19 years [Female])).

- **STI services**

Five participants stated that young people visit health care facilities for treatment of STIs. According to the participants, the STIs were illnesses, which compelled young people to seek health care services. A young person could go for treatment of STIs,

especially at a critical stage. It was established that seeking STI treatment is usually done as a last resort because of the unbearable pain they experienced. One participant commented:

“... If for example I am having an STI like having a sore on my private part, I will go to the hospital, even if I’m being treated by a female nurse I won’t mind because I want to be helped.” Nisoo (23 years [Male]).

What was of note was that even if no pain was experienced on the affected body organ i.e. the private part, one would go to the clinic for treatment. One participant stated:

“... like for an HIV test or STI treatment when I’m having a discharge from the vagina sometimes smelling badly and have a green colour I will go to the hospital. You know it won’t be painful, but that smell will push one to hospital.” Precious (21 years [Female]).

- **HIV-related services**

Six participants cited HIV-related services such as Voluntary Counselling and Testing (VCT) as reasons that made young people seek health services. The participants stated that young people sought these services when they just wanted to know their health status or sometimes it is provider-initiated. Going for VCT services was often referred to as “being tested for HIV” “knowing one’ HIV status”; “knowing if one is infected” or “having it”.

One participant said:

“... sometimes I might come to the hospital for a different service like family planning then the nurse will ask me my HIV status and maybe I tested long time and the nurse would then get me tested or else I would just come for it. It is a good thing to do though it’s scary especially if the results are positive.” (Carol (20 years [Female])).

Out of the 12 female participants, two stated that young female people are usually offered HIV related services when pregnant because it was necessary to prevent

transmission of HIV from the mother to the unborn child (PMTCT). Below is an extract from one of the participants:

“HIV-related services for pregnant women are a must to do, so as to prevent the virus from passing from the mother to the unborn child. I think it’s a good thing because ARVs are free in Swaziland even if you are HIV positive you will get treatment.” Rosemary (19 years [Female]).

The option B+ PMTCT programme has so many benefits. MSF (2013:1) stated that Option B+ increases maternal life expectancy, letting HIV positive mothers to live longer by reducing the risk of opportunistic infections and further prevents transmission of the virus in future pregnancies and the viral load would be suppressed. On the contrary, PMTCT provides an opportunity to early and comprehensive care for the mother, a partner and family members in need of HIV services (Ministry of Health 2015:93).

- **Counselling and SRH information**

From the 14 participants, four participants stated that young people sought SRH services for counselling and information on SRH services. However, counselling was often linked to HIV testing. One female participant stated that young people seek information on SRH services when experiencing problems such as painful breasts and menstrual problems such as irregular and painful menstruations.

A comment by Girlie:

“Like when you have your periods, sometimes you experience a lot of pain (cramps), you may wonder what is happening with you and then you end up seeking health care. Sometimes the breasts will be big and painful hence visiting the hospital becomes an option.” Girlie (22 years [Female]).

Another participant expressed his view:

“... sexual and reproductive health (SRH) information is one of the services young people should have full access to since it’s his/her right to have such information and the young person’s right should not be violated. For example, if I say no to sex, it’s my right. If I want information about condom use and or even a

demonstration about how to use it, that too is my right to demand. I should be given the information about family planning as a young male person.” Nisoo (23 years [Male]).

In addition, one participant mentioned that:

“... information about SRH services is important because I have to know about it. I once visited Nazarene Hospital; I wanted to know about the methods of family planning. When I reached there at Nazarene, I was referred to the family planning room where I was given information about all the methods and what to expect when I am using them. The nurse there even showed me the pills, injections, implant, loop, and female condoms. That information helped me because I was able to choose which method to use.” Sixolile (23 years, [Female]).

- **Voluntary medical male circumcision services**

Male circumcision was stated as another SRH service for young people which young people seek from health care facilities.

Donald commented:

“I think sexual and reproductive health (SRH) services for young people include circumcision. As a boy I can go to hospital for circumcision.” Donald (17 years [Male]).

Another male participant expressed the same sentiments:

“... For us males, circumcision is a service that we need. But the unfortunate part not all clinics provide it, only the hospitals and one male clinic in Matsapa. Here at FLAS it was once provided but now the service is not provided.” Nisoo (23 years [Male]).

The results resonate with a study done in Zimbabwe, where young people mentioned that the issue of centralising voluntary medical male circumcision to hospitals as a barrier for not utilising this service (Chibaya 2016:40). In addition, Kaufman et al (2016:14), male adolescents noticed improved hygiene as a key benefit of VMMC and

associated the procedure with being modern and increased ability to sexually satisfy partners.

4.2.2.2 Facilities that promote, provide and improve access to SRH services for young people in Manzini, Swaziland

Participants were asked to state the facilities that promote, provide and promote SRH services in Manzini, Swaziland. Out of the fourteen participants, two mentioned being aware of existing private clinics and eleven stated being aware of existing of both private and public health facilities.

- **Public facilities**

Six participants figured public health facilities as being cheaper and affordable. However, the long waiting-time in public hospitals was pointed out as a big hindrance to accessing SRH and that all public health facilities had no youth clinics.

One participant highlighted that:

“... Public clinics are better when it comes to charges, for instance at RFM for pregnancy check-up it’s just E8.00 while here at FLAS its E90.00. But the problem at RFM are the long queues.” Buhle (23 years [Female]).

These findings were similar to those from Kenya where young people identified both public and private health facilities as sources of health care (Godia et al 2014). Public health facilities were preferred because they were cheaper and affordable (Godia et al 2014).

- **Private facilities**

On the other hand, seven participants stated that they preferred private facilities because there are no long ques hence, no long waiting time. However, the challenge with private facilities was that the services are costly. One of the participants commented:

“I prefer here at FLAS because of the youth clinic, though the nurses are slow but I like it because they are youth friendly. However, it is expensive.” Donald 17 years [Male]).

Precious expressed the same sentiments when she said:

“I like this facility because the youth clinic is just for us young people, even my mother can be here she cannot see me because adults are being helped at the adult clinic.” Precious (21 years [Female]).

4.2.2.3 Factors that hinder access to SRH services for young people in Manzini, Swaziland

All 14 participants viewed SRH services to be inaccessible owing to the following obstacles:

- Lack of privacy and confidentiality
- Health workers’ negative attitude
- Lack of knowledge about availability of SRH services
- Inaccessibility of services
- Fear of parents, community and peers
- Young people’s ignorance
- Religion

Ignorance of young people was mentioned by five participants. Only three mentioned religion. This means that regardless of how well designed the SRH programmes are, social marketing and publicity are critical for uptake. The above results are in line with the study conducted by Nkonde-Bwalya (2016) on “Factors Affecting Access to and Utilisation of Reproductive Health Services among adolescents in Lusaka”.

- **Lack of privacy and confidentiality**

Participants (ten) in this study viewed lack of privacy and confidentiality as limiting factors in accessing SRH services. Young people feared that being seen at the health facilities might raise suspicions and questioning about their reasons for seeking health

care services, and were anxious that their parents might know that they had sought SRH services.

One participant commented:

“Young people don’t even know how condoms are used and where to get them even those which are free. But even if they know where they can get them especially in the shops, they become scared to take them because the shopkeeper is from the same community would say “...the boy has started sleeping [around].” Nisoo (23 years [Male]).

Similar findings were reported by Nkonde-Bwayla (2016:67). The researcher established that the issue of privacy and confidentiality was cardinal if adolescents were to adequately access and utilise reproductive health services.

“There is no privacy when accessing family planning pills because lessons are conducted in a group (classroom arrangement for all the women) so young people like us feel shy to go there. Confidentiality is the most important aspect and should be observed.” Rosemary (19 years [Female]).

Similar observations were made by Kumi-Kyereme, Awusabo-Asare and Darteh (2014) in in-depth interviews with young people in a study conducted in Ghana. Results showed that attitudes of health providers in respecting young people as individuals, ensuring confidentiality and meeting their needs for information and services emerged as important considerations for young people who either sought or contemplated seeking health care (Kumi-Kyereme et al 2014:150).

The findings of this study correspond with those of Kambikambi (2014) on a study conducted on ‘Young Males’ Perceptions and Use of Reproductive Health Services in Zambia’. Kambikambi (2014:48) found that participants distrusted that the information shared with health providers at the local clinic would be kept confidential. This mistrust was related to the feeling of being familiar with the health care providers. The participants feared that in such circumstances, health care providers would not maintain confidentiality and that young people were less likely to be respected. The researcher further established that participants also expressed fear of the possibility that adults who

might know their parents would see them at the clinic and inform them that they had been seeking SRH services.

- **Health care workers' negative attitude**

Participants (nine) strongly perceived that health professionals' behaviour and attitude toward their work and toward young people discouraged them from accessing SRH services. These findings corroborate with study conducted by Ramathuba, Lebeso, Maputla and Khoza (2013:37) who discovered that in South Africa, negative attitudes of nursing personnel lead to negative attitudes towards SRH services by adolescents resulting to unwanted pregnancy.

One participant expressed:

"You know my sister, the nurses there in the clinics they shout at you especially when you are young and they become judgemental, act like mothers. For example, if I go for family planning service they will say "you have started sleeping around with different boys so you are scared that you will be pregnant and you won't know the owner of that pregnancy" then you end up delaying to go for the services." Zwile (21 years [Female]).

Another participant shared the same sentiments:

"... Sometimes nurses are not youth friendly; For example, if I am having an STI, the nurse would say: "You have started sleeping around young as you are", thus I feel hurt or bad and ask myself why I came for a service. I might have preferred not to tell my parent at home thinking that the nurse will listen to me better than my mother and only to find that it is not that." Nisoo (23 years [Male]).

The participant expressed disgruntlement at such comments so much that he feared going to health facilities. The same sentiments were reported in a study done in Kenya, which showed that health service providers tend to be judgemental when attending to young people (Godia et al 2013:7). Health workers easily condemn young people by being harsh and giving them lectures when they presented with an SRH problem such as an STI or when in need with of contraceptives or condoms (ibid).

- **Lack of knowledge about available SRH services**

Lack of knowledge about service and facility locations and unfamiliarity with the health care system seemed to pose hindrance for young people who might otherwise make use of SRH services. Young people as expressed by six participants highlighted that lack of knowledge about where the services are being a cause for not being able to access the services.

Nisoo commented:

“Mmmm lack of knowledge, especially family planning services, some young people don’t even know the family planning methods, how they operate, they rely on hearsays. Young people don’t even know how condoms are used and where to get them even those which are free. But even if they know where they can get them especially in the shops, they become scared to take them because the shopkeeper is from the same community would say “the boy has started sleeping around.” Nisoo (23 years [Male]).

Lack of awareness of available SRH services could also mean that the interventions are not reaching the target audience. Similar reports were seen in Uganda where adolescents reported that they never go to health facilities to seek SRH information (Atuyambe et al 2015:6). The study revealed that other young people feared to seek services in the same facilities with older community members and with health workers of opposite sex (ibid).

- **Inaccessibility of services**

Young people expressed that services were inaccessible owing to many factors, including the following:

- Long distance to clinics and inconvenient operating hours (four participants each)
- Lack of money for transport (seven participants)
- Services regarded costly (four participants)

Only two participants cited long waiting time as a cause for inaccessible services.

Precious, one of the participants highlighted:

“Sometimes being far from the clinic because you might find that, as a young person I do not have money to go to the clinic in that way I will end up not accessing the services.” Precious (21 years [Female]).

These results concurred with the results of a study conducted in South Africa where young people mentioned that poor access to SRH services was owing to lack of money as most adolescents still attending school and not working (Ramathuba et al 2013:36).

Precious continued:

“... The time the clinics they operate it is during school hours, for me to come here I had to miss classes of which a young person ends up not coming to hospital for any service.” Precious (21 years [Female]).

The same results were presented in a study on ‘Adolescent Sexual and Reproductive Health (ASRH) Services and Implications for the Provision of Voluntary Medical Male Circumcision’; male adolescents highlighted that limited clinics’ operating hours coincided with school and work hours (Kaufman et al 2016:4).

Inaccessibility of services was also linked to shortage of staff resulting to long waiting hours as Donald confirmed:

“The long waiting time due to shortage of staff, it is not encouraging at all, like here at FLAS it is not busy but they are slow, probably because the staff is not enough.” Donald (17 years [Male]).

In response to the shortage of health professionals, the government of Swaziland implemented task-shifting strategies whereby some of the doctors’ duties are shifted to professional nurses and some of the professional nurses’ duties were shifted to the lay cadres. This was done in an effort to reduce the workload from qualified personnel (National Emergency Response Council on HIV/AIDS 2014:6). However, report indicates that the workload of nurses remains overwhelming because there are specific

duties that these lay people cannot do (Dlamini-Simelane & Moyer 2017:11). This also correlated with the long waiting hours and long queues that young people alluded to.

- **Fear of parents, community and peers**

Participants cited fear as a hindrance to access SRH services. Six participants stated fear of parents, while three mentioned fear of being spotted other familiar young people (peers). One participant commented:

“Parental fear is the key hindrance, as telling my parent that I am going to hospital for a STI care and treatment. My parent would ask me how I contracted the disease. My mother would start to accuse me at home hence I will hide my illness. I will tend to worry that if my own mother is questioning me, how much more the person who doesn't know me such as a health professional... then I will stay and not seek health care help.” Nisoo (23 years [Male]).

Fear of parents was also associated with lack of knowledge of parents about SRH services. Young people understood that if parents were not educated on these services, they would not be able to encourage them to seek services. Donald expressed the same sentiments as follows:

“Most parents are not educated and they are not aware of the SRH services for young people, thus parents will not discuss SRH issues with their children.” Donald (17 years [Male]).

In a study conducted by Dlamini et al (2017a:5) in Swaziland, the youth who perceived their parents as supportive towards utilisation of SRH services were likely to perceive the community as less judgemental towards uptake of such services. The same results were shared in Western Ethiopia; young people witnessed their mothers as their source of SRH issues information (Shiferaw, Getahun & Asres 2014:6).

The results of fear from this study were also linked to parental adolescent lack of communication on SRH matters, which was very low. This is typical of most cultures in Africa. The study revealed that only one participant was comfortable to discuss sexual matters with parents. These results resonate with the findings by Nkonde-Bwalya

(2016:63-64) in Zambia, who discovered that the majority of the respondents did not communicate about sexual matters either with their mother or father. These findings imply that despite having health concerns, adolescents were less likely to seek guidance and information from their parents on matters pertaining to sexuality. As a result, these adolescents would end up getting information of SRH services from peers and in most cases, this may not be accurate.

This occurred when young people, who had previous negative experience about a particular facility or service, discouraged their peers from accessing the same. Sometimes young people would fear to be seen by their peers when they visit health facilities as demonstrated below:

“Maybe it could be an STI, you will shy off because you do not want people to know that because these diseases you get through immoral behaviour; you find that you will not go, so you shy off from going there.” Donald (17 years [Male]).

Another participant expressed her view as follows:

“Friends, friends, have a big impact, if my friends do not go for these services even me I will not go for because they are not encouraging, sometimes I will even be shy to share my illness with them as they might laugh at me.” Nokwethu (23 years [Female]).

- **Young people’s ignorance**

From fourteen participants, five saw ignorance as a barrier in accessing SRH services. Ignorance was further associated with less courage in taking proper care of oneself; not willing to go to hospital if sick and it was also associated with religious beliefs.

One participant remarked as follows:

“... Young people do not like to go to hospitals when they are sick. As we are not the same, some believe on traditional medicines so they will tell you that for a certain illness you mix certain herbs to be treated.” Nisso (23 years [Male]).

Although the participants knew about SRH services, they viewed these services as meant for adults, and not for young people. One participant expressed her view:

“I think the stigma attached to these services, is that the services are thought to be for adults only, thus young people think they should not receive these services.” Tito (24 years [Female]).

Similar findings were presented in Vanuatu. Adolescents’ perceived SRH services to be meant for married people only not adolescents (Kennedy et al 2013:7). Zwile shared the same sentiments as follows:

“... We live in our own world; we feel that illness is for old people not us.” [she said this while laughing] Zwile (21 years [Female]).

Ignorance was also associated with the lack of awareness about the various services provided at the nearest facilities. These results corroborate with findings reported in Zimbabwe, where adolescents reported that they had limited knowledge about ASRH services available in their community. In the same study, participants highlighted that they knew that SRH services were being provided to the nearest clinic but they had not been to the clinic for such services (Kurebwa 2017:23).

- **Religion**

From the fourteen participants, three cited religion as another factor that hinders young people from accessing SRH services.

One participant stated:

“Religion is a hindrance especially on family planning services, like in the Roman Catholics women do not use contraceptives. However, these young people then are not taught how to take care of themselves.” Tito (24 years [Female]).

Similar findings were found on a study conducted in Nigeria. Adolescents were subject for religious norms that tended to view the use of contraceptives as sinful (Nmadu 2017:42). The same results were also reported in Kenya. Religious beliefs reflected

strict religious teachings and practices on reproductive health issues, especially family planning methods (Mutai 2016:48).

Another participant commented:

“Some believe on traditional medicines so they will tell you that for such and such illness, one can mix certain herbs to be treated for STI. Also religion is a big hindrance; some families believe that prayer alone is the key.” Nisoo (23 years [Male]).

Religion seemed not to be accommodative of SRH service utilisation despite the rate of teenage pregnancy in churches and communities at large (Dlamini et al 2017a:7). This finding highlights the need to strengthen community-based education programmes in order to ensure that harmful socio-cultural factors do not hinder efforts designed to promote SRH service uptake among young people.

The above findings indicate that service and service provider-related factors were barriers in accessing SRH services by young people. Lack of information about available ASRH services, inadequate services, service accessibility, lack of confidentiality, were recognised in this study as well as in previous studies (Chibaya 2016; Khanal 2016; Nkonde-Bwalya 2016; Mutai 2016).

4.2.2.4 Factors that promote access to SRH services for young people in Manzini, Swaziland

Becker (1978) in the Health Belief Model postulates that one of the reasons for behaviour change is the perceived benefits of preventive action. Hence, people are more likely to conform to health advice when they believe that a particular intervention will be helpful in preventing, detecting or treating disease and consequently reduce the threat to them (Becker 1978). The study revealed knowledge of available SRH services and information, socio-cultural support, youth-friendly delivery services, awareness campaigns, school visits, and prolonged exposure to illness to be promoting access of SRH services in Manzini, Swaziland.

- **Knowledge of available SRH services and information**

From the fourteen participants, six participants mentioned that having knowledge of SRH services and information and where these services are provided could promote access to service utilisation. Participants believed that having knowledge about the services would empower them. One participant commented as follows:

“Young people should be given information through sensitisation; share motivational information other than scary information and the information should be proper and detailed” Nokwethu (22 years [Female]).

Young people indicated that channels of awareness creation could be used to provide educational materials, including giving informational pamphlets to clients visiting the facility. The materials could be placed on the exit point at facilities, in libraries and other places which young people frequent in visiting them. A study conducted in Ethiopia demonstrated that level of knowledge was paramount. Advocating and increasing awareness about SRH services were crucial to the success of ASRH effort (Abajobir & Seme 2014:9).

- **Socio-cultural support**

Five participants viewed social environment at community level to be influential to young people's access to SRH services utilisation. Parents as part of society were seen as supportive especially if they were knowledgeable about the SRH services. Ayelew, Mengiste and Semahegn (2014) conducted a study in Ethiopia on 'Adolescent - parent communication on SRH issues among high school students'. The results showed that adolescents recognised the importance to discuss about SRH issues with their parents and most parents shared that they discussed with their adolescents about SRH issues (Ayelew et al 2014:5). The same results were reported in in Ghana on study on "Attitudes of Gatekeepers towards Adolescent Sexual and Reproductive Health (ASRH)" (Kumi-Kyereme et al 2014:147). The results in that study revealed that mothers tended to talk to their daughters more than to their sons. They argued that when premarital pregnancy occurred, it is always the girls who suffer and the mother is blamed. The findings further showed that parents have to be educated on sexual issues to promote access to SRH services. In that way, they will be able to communicate freely

with their children on SRH issues (Kumi-Kyereme et al 2014:147). One participant commented as follows:

“I think our parents have to be empowered on sexuality, in that way they will be advise appropriately on sexual issues because we spend most times with them.”
Swazi (18 years [Female]).

The findings are in line with the results by Ngilangwa, Rajesh, Kawala, Mbeba, Sambili, Mkuwa, Noronha, Meremo and Nyagero (2016) in Tanzania. In addition, Ngilangwa et al (2016:4) highlight that parents suggested that there was need for parents’ education to equip them with necessary knowledge and skills related to sexuality matters. The same results were presented in a study conducted in Bolivia, Ecuador and Nicaragua. Moreover, participants suggested that parents themselves need sexuality education in order to address sexual matters more skillfully with their children. The aim would be to train parents in sexuality to enable them to guide an adolescent (Jaruseviciene, Orozco, Ibarra, Ossio, Vega, Auquilla, Medina, Gorter, Decat, Meyer, Temmerman, Edmonds, Valius & Lazarus 2013).

An extract from one participant:

“Open communication with parents about reproductive health issues, like importance of visiting a health facility especially when as a young person I am sick. Also to add on that our parents should teach us about what we should expect as we grow up. For example, when I started having menstrual periods I was scared to tell my mother because I thought she will beat me as she never told me anything about it.” Precious 21 years [Female]).

The findings from this study are supported by a study conducted in Nigeria on ‘Access and Utilization of Reproductive Health Services among Adolescents’. The results highlighted that adolescents reported parental encouragement, support and good communication with parents about SRH issues would make it easier for them to access reproductive health services (Nmadu 2017:44).

- **Youth-friendly delivery services**

From the 14 participants, four stated that friendliness and welcoming attitudes from the health care personnel could overshadow the rudeness of the nurses, who may otherwise be a deterrent. Adolescents in Vanuatu, viewed youth-friendly health services as a youth-friendly health provider who is non-judgemental (Kennedy et al 2013:8). From this study, one participant commented as follows:

“I think youth friendliness of nurses would in that way make young people feel free and comfortable.” Nisoo (23 years [Male]).

Furthermore, participants stated that a warm reception at a health facility could encourage one to visit the clinics. These findings are supported by results from a study conducted in Bolivia, Ecuador and Nicaragua. Adolescents indicated that health care workers need to treat adolescents with more respect from the moment they make an appointment until they leave the health facility (Jaruseviciene et al 2013).

These were the extracts from the participants:

“The staff should be young nurse of our age like mid-twenties. However, if it’s an old nurse that nurse should be trained on adolescents.” Precious (21 years [Female]).

“A warm welcoming into the hospital allows easy access to services. Also the doctor-patient confidentiality.” Rosemary (19 years [Female]).

- **Awareness campaigns**

Out of the 14 participants, four stated that awareness campaigns such as roadshows on SRH services can increase uptake of services. The same results were shared in Kenya where young people stated that campaigns could be done through outreach activities in the community, schools and churches. One participant’s view is as follows:

“I think campaigns do promote access of SRH services by young people such as roadshows. Also on newspapers there should be columns about reproductive

health issues and the types of services that are available.” Rosemary (19 years [Female]).

The same views were shared in a study done in Zambia on ‘Young Males’ perceptions of reproductive health services’. Adolescents considered media as an effective way of disseminating information to the community on various issues including the availability of reproductive health services (Kambikambi 2014:59).

- **School visits**

Participants from this study viewed visiting schools especially high schools and colleges as another promoting factor on access of SRH services for young people. Extracts from the participants are as follows:

“Schools’ visitation both high and primary schools for empowering the young ones to avoid teenage pregnancies and teenagers will have knowledge about prevention of STIs.” Zwile (21 years [Female]).

The results were the same with those from a study conducted by Chibaya (2016) in Zimbabwe on ‘Effectiveness of Sexual Reproductive Health and Rights Services on Young People’. Chibaya (2016:45) highlighted that adolescents in schools should be taught about SRH and be encouraged to seek SRH services in order to reduce high drops out owing to teenage pregnancy.

“Nurses should visit high schools and colleges to provide services such as HIV testing. On weekends, they can visit communities to reach those who are not schooling.” Zwile (21 years [Female]).

In response to school health visits in Swaziland, Bantwana developed the School Health Outreach Programme (SHOP) with Swaziland’s Ministry of Health and Social Welfare (MoHSW), school leadership, and parents, guardians, and local leaders in targeted communities (Bantwana Initiative 2018). School health nurses and youth peers facilitate health education sessions about important youth issues, such as early marriage and gender roles. Furthermore, Jaruseviciene et al (2013) in Bolivia, Ecuador and Nicaragua discovered that adolescents perceived schools as promoters of health

care services and comprehensive sexuality education (CSE) was pointed as being essential in all schools. Chandra-Mouli, Lane and Wong (2015b:336) also discovered that comprehensive sexuality education had been well evaluated and had been shown to improve adolescent SRH knowledge, attitudes and behaviours when implemented well. However, many school-based CSE programmes are not implemented with adequate attention; hence the curriculum content tends to be weak (Chandra-Mouli et al 2015b:336).

- **Prolonged exposure to illness**

Two participants viewed severity and prolonged exposure to the illness as another reason young people will seek medical help. These results are in line with findings of study conducted in Uganda where young people expressed that when they were faced with sexual reproductive health problems, they seek medical help when the problem worsened (Atuyambe et al 2015:7). From this study, one participant expressed her view as follows:

“Prolonged exposure to a sickness, for example if I contract an STI and when it becomes worse, I tell you none will tell me to go to hospital I will go myself.” Zwiile (21 years [Female]).

The results concurred with results of a study done in Nepal where it was highlighted that adolescents visit the hospital if the illness worsens (Khanal 2016:54).

“I think exposure to illnesses especially if it’s painful or else if I have vaginal discharge that smells badly, I will go to the clinic for help.” Carol (20 years [Female]).

4.2.2.5 Interventions to improve access to SRH services for young people in Manzini, Swaziland

The International Conference on Population and Development (ICPD) in Cairo in 1994 laid out a bold, clear and comprehensive definition of reproductive health. Countries were called to meet the educational and service needs of adolescents to enable them to

deal in a positive and responsible way with their sexuality (Chandra-Mouli et al 2015a:S1).

Participants made several suggestions on how access of SRH services could be improved. An increase of SRH service availability, suggested by five (5) participants; community outreach activities on available SRH services was recommended by eight participants; health education through peer educators mentioned by four participants and only two participants were the main suggestions that were raised. These were to be the responsibility of the MoH all in an effort to address the SRH problems of young people.

- **Increase of SRH service facilities**

Participants (six) suggested setting up more service delivery areas, as a way of increasing access to SRH services. Increase of SRH service facilities was linked to establishing youth centres in some public health facilities as well as in communities, thus improving service accessibility and utilisation. One participant suggested:

“I think Government has to build more clinics, especially youth clinics where young people could meet sometimes to discuss RH issues, thus, this will let one be able to help each other.” Nisoo (23 years [Male]).

The establishment of more services in the rural areas was also mentioned as another strategy to improve access of SRH services in Swaziland, including using mobile clinics to reach young people who were in the most remote areas. One participant suggested the following:

“More clinics should be built especially in the rural areas as young people in rural areas feel ignored.” Donald (17 years [Male]).

Increased availability of service delivery was linked to convenient opening times. One participant indicated that health care facilities be opened even on Saturdays from 9 am to 2 pm, which one could access with no appointment, was an enabling factor to accessing the service. In addition, affordable, fast services that are not shared with adults were perceived to be attractive to young people.

One participant suggested that health needs that can be met within the same roof or programme, the greater the assurance that they will receive the care they need.

One of the participants suggested the following:

“I prefer a one-stop centre other than moving door-to-door for different services, however, if that nurse is not skilled enough I would not mind to be referred to a competent nurse”. Rosemary (19 years [Female]).

This approach was implemented in Zambia, where adolescents accessing a one-stop shop centre benefited from improved care (Ng`ambi 2016:203).

- **Community outreach activities**

Participants (six) proposed that sensitisation of the community by all stakeholders on the available services for young people as critical to the utilisation of SRH services. It was said to be important to reach out to young people instead of only expecting them (young people) to come to the health facilities.

“On weekends nurses can visit communities to reach those who are not schooling. The schools should form youth clubs to promote reproductive health services and share information about the services.” Rosemary (19 years [Female]).

Young people in this study suggested that reaching out to youths could be done through the media. One participant suggested the following:

“... like FLAS has the Youth Action Movement (YAM) where it’s all about young people on SRH issues just guiding each other. Also young people can access TUNE ME application which is all about SRH information.” Nisoo (23 years [Male]).

From this study, participants had a suggestion for parents and community guidance and counselling services to educate parents about young people’s SRH issues, and to make

parents and community leaders comfortable to openly share sexuality matters with them (young people).

One participant suggested the following:

“I think parents’ involvement can help a lot because young people might be scared to share their illnesses with parents.” Tito (24 years [Female]).

Chandra-Mouli et al (2015b:336) reported that inter-personal communication and information education communication materials had been used successfully to communicate health information to adolescents. On that same note, interaction between health centres and communities in relation to ASRH was seen as a success.

- **Health education through peer educators**

Participants (three) expressed that peer educators can play an important role to improve access of SRH services for young people. A study conducted in Northwest Ethiopia reported that young people who participated in peer-to-peer education were more likely to utilise the services (Ayehu, Kassaw & Hailu 2016:7).

One participant’s view from this study is as follows:

“I think peer educators play an important role because they facilitate in communities, especially the SRH services for young people, in that way awareness is being created so it becomes easy for those young people to seek such services. As a peer educator in the community will help other young people who will be open and I can give advice.” Nisoo (23 years [Male]).

The researcher established that young people, with appropriate training and support, could effectively inform and counsel their peers about SRH and rights. Tito’s comment:

“Young people learn about sexuality during their biology classes at school. The scope is not enough since it goes up to puberty development without equipping young people and adolescents with life skills on how to go about SRH issues.” Tito (24 years [Female]).

The suggestion made by young people in this study concurred with the same approach that was used in Kenya, where a multi-pronged approach was used. The Evidence Based-Interventions (EBIs) employed various approaches simultaneously to the same target group to address the holistic SRH needs of youth and have maximum effect (Kenya Ministry of Health 2013:7).

- **Policy formulations**

To a lesser extent, two participants suggested how policy measures could contribute to better ASRH care. Participants suggested that the government should formulate policies that will guide both young people and health service providers on SRH issues. Precious suggested:

“... Government should establish laws for young people specifically on (SRH) issues so that it will serve as a guide even to young people what is expected of them.” Precious (21 years [Female]).

Another participant shared the same sentiments:

“... Policy formulations for young people specifically on sexual and reproductive health (SRH) issues so that it will serve as a guide even to young people what is expected of them.” Tito (24 years [Female]).

The Swaziland National Policy on Sexual and Reproductive Health of 2013 stipulates that the MoH shall ensure an enabling environment and resources to availability and access to ASRH services. It further states that quality family planning information and care to be provided to all reproductive-age (Ministry of Health 2013b:18-19). What was of note was that young people wished for an improvement on these policies.

In Bolivia, Ecuador and Nicaragua, Jaruseviciene et al (2013:5-6) discovered that participants suggested supportive policies to improve ASRH care. In that study, participants suggested that policies would better contribute to ASRH care by promoting the development of clinical guidelines; by improving the management of adolescents' health data; by creating incentives for health care providers; and by coordinating a multi-sectoral approach.

Dlamini et al (2017a) in Swaziland identified policy environment for the provision of SRH and HIV services to young people being favourable. This is evident by the availability of various policies in support of provision of SRH and HIV services to the young people. All of these policies emphasise that health care delivery should be appropriate to the age of youth being served. The Government of Swaziland in partnership has also put coordinated multi-sectoral interventions in place with stakeholders to improve the SRH status of youth and their access to SRH services.

4.3 SUMMARY

In this chapter, analysis, presentation and interpretation of findings collected from young people was presented. The findings were presented in two sections: demographic characteristics of participants, which covered age, gender and level of education. The second section presented the research findings, which covered understanding of SRH services; facilities where these services are provided and the perceptions on access to SRH services. This section had subsections, which included factors that hinder young people had on accessing SRH services. The aim was to elicit the challenges young people face when accessing the services. Another subsection presented findings on factors that promote access to SRH services. The aim was to find out what motivates young people to have access on the services. Lastly, suggestions on how to improve access to ASRH services were made. The purpose was to make recommendations for strengthening reproductive health services for young people in Swaziland.

Chapter 5 will present a summary of findings, recommendations, limitations, and conclusions drawn from this study. The chapter will in addition suggest future research studies on perceptions of young people's access to SRH services in Swaziland, with the aim of building on the current study.

CHAPTER 5

SUMMARY OF FINDINGS, RECOMMENDATIONS, LIMITATIONS, AND CONCLUSIONS

5.1 INTRODUCTION

This last chapter gives a summary of the findings, recommendations and limitations of the study. It also seals the whole research study with the concluding remarks.

5.2 SUMMARY OF THE STUDY FINDINGS

The researcher used a qualitative, exploratory, descriptive research design. The researcher was interested in understanding young people's perceptions of accessing SRH services in Swaziland. The study participants were young people aged 10-24, both males and females. The perceptions of the participants on access to SRH services were explored and described.

The permission for this study was obtained from FLAS, a youth centre in Manzini. The accessible population consisted of young people, both female and male, seeking SRH services from this facility. The researcher was given permission by FLAS management to access the participants.

The researcher used convenience sampling to select the study participants. Young people were selected based on being well informed about access to SRH services in Swaziland. Sample size was not predetermined but was done until data saturation was reached with the 14 participants.

The researcher developed and used an interview guide, which was comprised mostly open-ended questions with a few closed-ended questions on biographical information and used it to conduct face-to-face interviews on the selected participants. The questions on the interview guide simply directed the conversation to capture young people's perceptions on accessing SRH services in Manzini, Swaziland. The estimated

interview time after the pilot study was 30 to 40 minutes and the average interview time on actual data collection was 25 minutes.

Colaizzi's steps of qualitative data analysis were adopted and adapted to analyse the data (Shosha 2012). The researcher read and re-read transcriptions to familiarise with the data; identified significant statements and phrases; formulated meanings from these statements; identified themes and sub-themes and described in detail the young people's perceptions on access to SRH services in Manzini, Swaziland. Validation of the participants' responses was done at the end of each interview session through debriefing.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

Fourteen participants comprising young people between the ages 10 to 24 either male or female interviewed about their perceptions on access to SRH services. Data collection was conducted from FLAS, a youth centre in Manzini, Swaziland. Face-to-face interviews were the means of data collection. The main findings of this study showed that participants showed knowledge of methods of contraception, although hormonal contraceptives were not used owing to their unpleasant side effects; hence, most of the study participants had children.

5.3.1 Sample demographics

Fourteen young people, both males and females, participated in the study. Their ages ranged between 10 and 24. Regarding educational status, none of the young people was found to not have received any form of education. Seven participants have reached a tertiary level of education, five had high school education and two had secondary level education.

The study further found that the 20-24 age groups freely accessed and consumed SRH services compared to other age groups such as 15-19 years and lower ones. The majority of the participants were not married but had children whom they did not plan to have.

5.3.2 Themes and sub-themes

The main research findings were presented in themes and sub-themes based on the objectives as follows:

5.3.2.1 Theme 1: Understanding of SRH services for young people

The findings from this study showed that ten participants understood SRH in relation to the SRH services. However, four participants defined SRH as the state of health of reproductive health organs and having sex when one is ready to have children. The study revealed that services such as family planning; sexually transmitted infections; pregnancy related services; HIV/AIDS services; counselling and SRH information, and voluntary medical male circumcision.

5.3.2.2 Theme 2: Facilities that promote, provide and improve access to SRH services for young people in Manzini, Swaziland

Both public and private health facilities were cited as where the services are being provided. Six participants viewed public facilities as cheaper as compared to private health facilities. However, the long-waiting time at public facilities was viewed as an obstacle. Hence, private facilities were mostly preferred for their short queues.

5.3.2.3 Theme 3: Factors that hinder access to SRH services for young people in Manzini, Swaziland

The study found privacy and confidentiality mainly owing to the location of the SRH services in the clinic premises lead to mixing with adults. Therefore, young people felt embarrassed to seek SRHS. Furthermore, lack of knowledge about existing SRH services and their location, combined with limited service availability, long waiting time and added to a list of major impediments to accessing SRHS. Operational hours of facilities also overlap with the class schedules working hours.

5.3.2.4 Theme 4: Factors that promote access to SHR services for young people in Manzini, Swaziland

Youth-friendly services that are designed exclusively for young people; socio-cultural support, school visits, prolonged exposure to illness i.e. when the illness worsens that is when young people would visit health facility for treatment. Freely available information and education material to share knowledge about SRHS for the youth were perceived as factors that would promote access to SRH services in this study were enabling factors to access SRH services.

5.3.2.5 Theme 5: Interventions to improve access to SRH services for young people in Manzini, Swaziland

An expressed view in this study is that there is need to increase SRH services facilities, community outreach activities, health education through peer educators and formulation of policies. These could be made possible by the policies that inform action to promote and support specific adolescent-friendly environment in Swaziland.

5.4 RECOMMENDATIONS FROM THIS STUDY

5.4.1 Training

The use of peer educators as service providers for SRH for young people is perceived to be the viable option to improving access to service utilisation by young people. This suggests the need to train more school and college peer educators to compliment the operational duties of health service providers.

More health service providers are crucial in dealing with young people so that they provide friendly health services. The training of health service providers should address: attitudes of service providers towards the youths; and confidentiality about youth sexuality.

5.4.2 Community and parents' involvement

The community and parents in particular need to be educated about the importance of getting involved in matters that concern the youth to support young people's SRH. Intergenerational communication in support of young people's SRH is paramount. This will enable community members to learn more about SRH issues in culturally sensitive ways while the youth feel accepted and free to discuss SRH with the community. Therefore, this increases the prospects for attitude change. Involvement of community gatekeepers can also generate wider community support and also increase the prospects for attitude change. Community involvement should also involve dialogue between young people and community members using youth groups.

5.4.3 Open communication and education of young people

This could be done by increasing the reach of the youth by among others, telephone hot lines that are operated by trained counsellors from the clinic site. In addition, young people should be encouraged to go to the clinic for information or counselling. Alternatively, peer educators and health service providers can go into the community to deliver services. This is to ensure that they have sufficient information on SRH services in order to be able to make informed decisions.

Awareness creation on SRH through use of the mass media and other large-scale communication to motivate discussions about reproductive health issues among young people is vital. In addition to conducting outreach activities from the health facility into the community, schools and churches by HSPs and youth peer educators are ways of increasing awareness of available SRH services among young people and community members.

5.4.4 Political will

This study suggests a need for policy support and advocacy regarding youth-friendly SRH services. This is to ensure that issues concerning ASRH are on the policy agenda.

5.5 RECOMMENDATIONS FOR FURTHER STUDIES

This study has contributed important information that can help narrow the gap between reality and the perceptions on access and utilisation of services by young people in Swaziland in Manzini. However, more research needs to be done to get more insight into young people's perceptions about access to SRH services in other areas of Swaziland. A comparative study between the urban and rural adolescents/young people should be done to gauge their access and utilisation patterns for reproductive health services and to inform policy adjustments and formulation. A study is also recommended to explore how the social and cultural norms of the community can be more supportive of ASRH needs.

5.6 LIMITATIONS OF THE STUDY

Firstly, this was a qualitative study, which took place in an urban youth facility. Hence, the results presented may not be generalised to the whole region. The study was based in one youth clinic in Manzini, Swaziland. Other young people in different settings may not share the same views. Urban young people may differ in their knowledge, experience and practices related to access and use of SRH services and how gender power relations impact on them compared to rural young people.

5.7 CONTRIBUTIONS OF THE STUDY

The study provides ample evidence that young people face sexual health risks that justify their need to access and utilise SRH services. Sexual and reproduction related issues are considered as private matter and sensitive. Therefore, the use of qualitative approach with in-depth interview as a method of data collection was found to be effective. The qualitative insights enable the researcher to capture diverse view of young people's reproductive health issues. This study provides important results, which can have practical significance to promote SRH among young people. The research also adds to the available evidence-based findings for the need to integrate comprehensive young people's SRH care to the reproductive health and rights programme in Swaziland. It also highlights current inadequate access to appropriate SRH services for young people in Swaziland.

5.8 CONCLUSION

The purpose of the study was to explore and describe young people's perceptions of access to SRH services in Manzini, Swaziland. The study found that young people in Manzini, Swaziland had an understanding of sexual and services offered in both public and private health facilities. The findings revealed that access to service is an important but complex element of quality care, as it determines whether a client even gets to the service provider. The interventions such as community outreach activities; health education through peer educators and policy formulations could counter barriers to inaccessibility such as lack of knowledge about existing SRH services and lack of privacy and confidentiality. At policy level, the best approach to scaling-up health service interventions is to ensure that issues concerning ASRH are on the policy agenda. In the formation of SRH policy, it is crucial that government health providers are given proper guidelines on how to provide services to young people, and that reporting requirements are rationalised to meet young people's needs for privacy and confidentiality.

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UNESCO see United Nations Educational, Scientific and Cultural Organization.

UNFPA see United Population Fund.

UNICEF see United Nations Children's Fund.

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WHO see World Health Organization.

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ANNEXURES

ANNEXURE A
UNISA ETHICAL CLEARANCE CERTIFICATE



RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

2 August 2017

Dear Miss S Fakudze

Decision: Ethics Approval

HS HDC/695/2017

Miss S Fakudze

Student: 5356-363-8

Supervisor: Dr RM Mmusi-Phetoe

Qualification: D Litt et Phil

Joint Supervisor: -

Name: Miss S Fakudze

Proposal: Young people's perceptions of access to sexual and reproductive health services.

Qualification: MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 2 August 2017 to 2 August 2019.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 August 2017.

The proposed research may now commence with the proviso that:

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

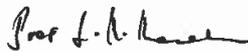
3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,



Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za



Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Approval template 2014

University of South Africa
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ANNEXURE B
APPLICATION LETTER TO CONDUCT STUDY

PO BOX C1385
HUB
MANZINI
SWAZILAND

25 August 2017

The Director
The Family Life Association of Swaziland
PO Box 1051
Manzini

Dear Sir/Madam

APPLICATION FOR PERMISSION TO CONDUCT A STUDY IN YOUR FACILITY

I hereby request for permission to conduct a study in your facility. I am a nurse by profession currently enrolled with the University of South Africa for a Master's Degree in Public Health. The study is entitled "**Young People's Perceptions of Access to Sexual and Reproductive Health Services in Swaziland**".

Your facility has been chosen because it caters for a majority of these participants as there is a youth clinic which serves as the right setting for the study. The study has no financial interest associated with the participants. Data will be collected using an interview guide. The interviewer will take notes as said by the participant and might be tape recorded. The ethical principles will be observed during the course of the study and the identity of the participants will not be revealed.

The full nature of the study will be explained to the participants and they will be asked to fill and sign a consent form for agreeing to participate in the study. Data will be kept in a safe place that will only be accessible by the researcher and the supervisor. The participants will benefit from awareness drive by the health care providers targeting young people as it will equip them with adequate information to access sexual and reproductive health services. In line with the purpose of the essence of this study, the findings will inform efforts to facilitate maximum utilisation of available reproductive

health services to respond to the demands to the services thus meeting sexual and reproductive health needs of young people in this regard.

Please note that the permission to conduct this study has been sought from the UNISA Research Ethics Committee: Department of Health Studies, which is attached to this letter, and it has been attached to this letter.

Contact details for the UNISA Ethics Committee are as follows.

Prof JE Maritz

Chair of the University of South Africa

Department of Health Studies, Research Ethics Committee

UNISA

Email address: maritje@unisa.ac.za.

The supervisor for this study is:

Dr RMM Mmusi-Phetoe

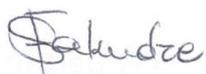
Room 7-168

Department of Health Studies

UNISA

Email address: emphetrm@unisa.ac.za.

Yours faithfully



Simangele Fakudze

Contact details: +268 7647 1307

Email address: simangelefakudze@gmail.com

ANNEXURE C

LETTER GRANTING PERMISSION TO CONDUCT STUDY

The Family Life Association of Swaziland "Temndeni"



P.O. Box 1051
MANZINI
Tel: (+268) 2505 3586/2505 3082/2505 5852
Fax: (+268) 2505 3191
E-mail: info@flas.org.sz



Direct all correspondence to Executive Director
28th September 2017

Ms. Simangele Fakudze
P.O. Box C1385
HUB
MANZINI
SWAZILAND

Dear Madam,

RE: YOUR APPLICATION TO CONDUCT A STUDY

In response to your letter dated 25th August 2017, please be informed that the Association accedes to your request. FLAS is a Non-Governmental Organisation that primarily work on Sexual and Reproductive Health (SRH) including HIV providing services and information.

Your direct contact in this regard shall be Ms. Bukiwe Ntiwane who is in charge of the Research and Evaluation Unit.

FLAS strongly believes that this study will come up with recommendations that will strategically position the Association for better resource mobilisation in this highly competitive and resource constraint environment.

We hope that your study shall be beneficial to both parties and warmly welcomes you on board.

Yours faithfully

BONGANI MSIBI (Mr.)
ACTING EXECUTIVE DIRECTOR



Awarded Gold Medal by Foundation for Excellence in Business Practices (FEBP) in Geneva, Switzerland for best business practices, 2005



A signatory to the NGO Code of Good Practice

National Executive Committee: President: Mr. Howard Mabuza, Vice President: Ms Margaret Thwala-Tembe, Treasurer: Dr. Dumsile Vilakati
Immediate Past President: Mr. Mathokoza Mletwa, Members & Chair of Subcommittees:
Resource Mobilization and Investment: Ms Maria Mabuza, Programmes: Dr. Jonathan Dlamini, Finance and Audit: Vacant
Youth Representatives: Mr. Mfundo Hlatshwako & Ms Sakhile Mhlanga, MOH Representative: Ms Phumzile Mabuza
Secretary & Executive Director: Ms Zeldi Nhlabatsi

ANNEXURE D

PARTICIPATION INFORMATION AND CONSENT FORM TO PARTICIPATE IN THE STUDY

Topic: YOUNG PEOPLE'S PERCEPTIONS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Researcher: Simangele Fakudze

Introduction

You are asked to participate in a research study. You were selected as you might have visited or might visit a health facility to seek help on health problems. As you grow, you might experience problems related to maturity leading to loving relationships and intimacy. I am asking you to read this form and ask any questions that you may have before your participation this study.

Purpose of the study

The aim of this study is to find out what young people's thoughts are on accessing health services in relation to intimate relations they may be involved in and their implications. The information will help us to learn more about how to assist young people as they go through a normal process of growing, maturing and probably have intimate relationships with others. The findings will help the government and other facilities to address young people's concerns to improve the services so that they are friendly and helpful.

Description of the study procedures

If you decide to be involved in this study you will be asked to answer the questions in relation to accessing health services by young people and their health concerns. Some questions may be of a personal and/or sensitive nature. You may choose not to answer these questions without being punished. You may also refuse to take part in the study at any time without affecting the relationship with the researcher.

Confidentiality

The researcher will not include any information that you provide in any report that would make it possible to identify you. False names instead of real names will be used, should it be necessary to share some information. Therefore, your actual name or identity will not be known to anyone else related to the research.

Research records will be kept in a locked file. Published data will be shared with relevant staff at University of South Africa since this study is done for academic purposes.

Benefits

The interview will last approximately 15 to 20 minutes. I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. There is no compensation or other direct benefits to you as a participant, however, there will be an overall benefit of the research because the findings will give us more information on how health facilities can be easily accessible in providing services to young people could be enhanced.

Risks

There is no anticipated physical, social or mental harm. However, should you experience some distress from the discussion, the centre will provide appropriate some support to him or her.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact:

The researcher (student); +268 7647 1307.

If you have any questions or concerns about your rights as a research participant, please contact the University of South Africa Ethical Committee as follows:

Prof JE Maritz

Chair of the University of South Africa,

Department of Health Studies, Research Ethics Committee

UNISA

Email address: maritje@unisa.ac.za.

The supervisor for this study is:

Dr RMM Mmusi-Phetoe

Room 7-168

Department of Health Studies

UNISA

Email address: emphetrm@unisa.ac.za

ANNEXURE E

ASSENT FORM FOR PARTICIPANT UNDER 18 YEARS (for the under 18 years including 10-13 years)

Topic: YOUNG PEOPLE'S PERCEPTIONS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Researcher: Simangele Fakudze

Introduction

You are asked to participate in a research study. You were selected as you might have visited or might visit a health facility to seek help on health problems. As you grow, you might experience problems related to maturity leading to loving relationships and intimacy. I am asking you to read this form and ask any questions that you may have before your participation this study.

Purpose of the study

The aim of this study is to find out what young people's thoughts are on accessing health services in relation to intimate relations they may be involved in and their implications. The information will help us to learn more about how to assist young people as they go through a normal process of growing, maturing and probably have intimate relationships with others. The findings will help the government and other facilities to address young people's concerns to improve the services so that they are friendly and helpful.

Description of the study procedures

If you decide to be involved in this study you will be asked to answer the questions in relation to accessing health services by young people and their health concerns. Some questions may be of a personal and/or sensitive nature. You may choose not to answer these questions without being punished. You may also refuse to take part in the study at any time without affecting the relationship with the researcher.

Confidentiality

The researcher will not include any information that you provide in any report that would make it possible to identify you. False names instead of real names will be used, should it be necessary to share some information. Therefore, your actual name or identity will not be known to anyone else related to the research.

Research records will be kept in a locked file. Published data will be shared with relevant staff at University of South Africa since this study is done for academic purposes.

Benefits

The interview will last approximately 15 to 20 minutes. I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. There are no compensation or other direct benefits to you as a participant, however, there will be an overall benefit of the research because the findings will give us more information on how health facilities can be easily accessible in providing services to young people could be enhanced.

Risks

There is no anticipated physical, social or mental harm. However, should you experience some distress from the discussion; the centre will provide appropriate some support to him or her.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact:

The researcher (student); +268 7647 1307.

If you have any questions or concerns about your rights as a research participant, please contact the University of South Africa Ethical Committee as follows:

Prof JE Maritz

Chair of the University of South Africa

Department of Health Studies, Research Ethics Committee

UNISA

Email address: maritje@unisa.ac.za.

The supervisor for this study is:

Dr RMM Mmusi-Phetoe

Room 7-168

Department of Health Studies

UNISA

Email address: emphetrm@unisa.ac.za

ASSENT

Your signature below indicates that you have decided to participate as a research subject of this study and that you have read and understood the information provided above.

ANNEXURE F

INFORMED ASSENT CONSENT (Parent or Guardian) FOR PARTICIPATION IN THE STUDY

Topic: YOUNG PEOPLE'S PERCEPTIONS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Researcher: Simangele Fakudze

Introduction

Your child has been asked to participate in a research study. He/she was selected as a possible participant because he/she has or might have visited the health facility to seek reproductive health services in future. I am asking you to read this form and ask any questions that you may have before your participation this study. It is the form that will also be given to your child to read and either agree or refuse to participate in the study. The study is voluntary.

Purpose of the study

The aim of this study is to find out young people's perceptions on **accessing** sexual and reproductive health services in Manzini, Swaziland. The findings from this study may be used to inform plans to assist young people in accessing sexual and reproductive health services should they need them in future. Such interventions will hopefully contribute to improve health problems they might be exposed to as they grow and mature.

Description of the study procedures

If your child decides to partake in this study he/she will be asked to answer the questions in relation to perceptions of young people's access to sexual and reproductive health services.

Confidentiality

This study is anonymous. We will not be collecting or retaining any information about your identity or your child's identity. The records of this study will be kept strictly confidential. Research records will be kept in a locked file and all electronic information will be coded instead of real names and secured using a password protected file. Published data will be shared with relevant staff at University of South Africa since this study is done for academic purposes. We will not include any information in any report we may publish that would make it possible to identify you.

Right to refuse/withdraw

The decision to participate in this study is entirely voluntary. The participants may refuse to take part in the study at any time without affecting the relationship with the researcher. The participants have the right not to answer any single question as well as to withdraw completely from the interview at any point during the process without penalty.

Risks

The study does not have any serious physical, mental and social harm except some discomfort because of some discussion around sexuality. However, should you or your child experience some distress from the discussion, the centre will provide appropriate support to him or her.

Contact information

Should you have any questions or concerns about this study, please contact the researcher at 76471307. If you have any questions or concerns about the rights as a research participant, please contact the University of South Africa Ethical Committee or supervisor as follows:

Prof JE Maritz
Chair of the University of South Africa,
Department of Health Studies, Research Ethics Committee
UNISA
Email address: maritje@unisa.ac.za.

The supervisor for this study is:
Dr RMM Mmusi-Phetoe
Room 7-168
Department of Health Studies
UNISA
Email address: emphetrm@unisa.ac.za.

Consent

Your signature below indicates that you allow your child to participate as a research subject of this study and that you have read and understood the information provided above.

Parent's or Guardian name:.....

Signature:.....

Date.....

Researcher's signature:.....

Date.....

**ANNEXURE G
CONFIDENTIALITY BINDING FORM**

Date.....

Names:

Participant.....Researcher: Simangele Fakudze

Type of business

This is a study being undertaken by a Master of Public Health student who is studying with the University of South Africa (UNISA).

Reason for disclosure

Information collected from this interview will be kept in confidence. Besides the researcher, the only other persons who may access the information if need arises are the research supervisors and examiners from UNISA.

Information to be protected

The information gathered will relate to Young People’s Perceptions on Access to Sexual and Reproductive Health Services.

Signatures:

Participant.....Researcher.....

ANNEXURE H
INTERVIEW GUIDE

TOPIC: YOUNG PEOPLE'S PERCEPTIONS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN SWAZILAND

SECTION A: DEMOGRAPHIC INFORMATION

Code Name (What name would you want me to call you by? Not your real name)

.....

1 Age in years

10-14 15-19 20-24

2 Schooling currently

Yes No

3 If no, what was your last year of schooling?.....

4 Highest qualification gained

Primary level certificate Secondary level education
 High School Tertiary

5 Are you married?

Yes No

6 Number of children if you have

7 If you have children, did you plan to have those children?

Yes No

If no, why didn't you use contraception?

.....
.....
.....

SECTION B: PERCEPTIONS ON ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN SWAZILAND

The next set of questions is about your perception regarding access to sexual and reproductive health services in Manzini.

1 What do you understand by sexual and reproductive health services?
.....
.....

2 Which facilities do you know that provide sexual and reproductive health services in Manzini?
.....
.....

3 In your view, what factors hinder access to sexual and reproductive health services in Manzini for young people?
.....
.....

4 In your view, what factors promotes access to sexual and reproductive health services for young people in Manzini?
.....
.....

5 What should be done to improve access to sexual and reproductive health services for young people in Manzini, Swaziland?
.....
.....

6 Share any other information on accessing sexual and reproductive health services in Swaziland.
.....
.....

END OF INTERVIEW: THANK YOU FOR YOUR PARTICIPATION AND COOPERATION

ANNEXURE I

EDITING AND PROOFREADING CERTIFICATE

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

26 September 2018

TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Ms S Fakudze's dissertation entitled, **YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND.**

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:

Jack Chokwe

Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

Professional
EDITORS
Guild



ANNEXURE J

TURNITIN ORIGINALITY REPORT

Dissertation

by Masters Student Mmmusi Phetoe Student

Submission date: 13-Nov-2018 12:18PM (UTC+0200)

Submission ID: 1038076633

File name: simangele_Fakudze_final_for_exam_25_Oct_18.doc (2.67M)

Word count: 29696

Character count: 179240

[Open Rubric](#)

1
**YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND
REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND**

by

SIMANGELE FAKUDZE

2
submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

3
at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR MM MMUSI-PHETOE

November 2018

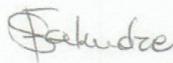
Student number: 5356-363-8

DECLARATION

I declare that **YOUNG PEOPLE'S PERCEPTIONS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MANZINI, SWAZILAND** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other education institution.



25 October 2018

.....

.....

SIGNATURE

DATE

Simangele Fakudze

Dissertation

ORIGINALITY REPORT

6%	6%	0%	0%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.omicsonline.org Internet Source	3%
2	uir.unisa.ac.za Internet Source	3%

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Exclude bibliography On

Exclude matches < 3%