AN EVALUATION OF A SEXUAL AND REPRODUCTIVE HEALTH (SRH) PROJECT ON FRIENDLY HEALTH SERVICES UTILISATION BY ADOLESCENTS IN LESOTHO

by

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DECLARATION

I declare that an **EVALUATION OF SEXUAL AND REPRODUCTIVE HEALTH PROJECT ON ADOLESCENTS' FRIENDLY HEALTH SERVICE UTILISATION AMONG ADOLESCENTS IN LESOTHO** is my own work. I have further acknowledged the sources used in the study by means of complete reference. I also declare that this work has not been submitted before for any other degree at any other institution.

Signature: **Date:** 31 October 2020

DEDICATION

I dedicate this dissertation to myself, for the hard work and passion I had while pursuing this degree, despite the myriad challenges I encountered during my studies. Nothing succeeds without hard work.

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I thank The Almighty for all of the blessings He has bequeathed on me. I would not have succeeded on my own without His eternal grace.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASRHS	Adolescent Sexual and Reproductive Health Services
AYFS	Adolescent's Friendly Services
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BBGH	Butha-Bothe Government Hospital
BB	Butha-Buthe
CGPU	Child Gender Protection Unit
CICT	Client-initiated Counselling and Testing
CSE	Comprehensive Sexuality Education
CHAL	Christian Health Association of Lesotho
DHMT	District Health Management Team
DNA-PCR	Polymerase Chain Reaction
EU	European Union
EAC	Enhanced Adherence Counselling Sessions
FP	Family Planning Services
FBC	Full Blood Count
FMG	Female Genital Mutilation
GBV	Gender Based Violence
GoL	Government of Lesotho
HSUT	Health Service Utilization Theory
HAART	Highly Active Antiretroviral Therapy
HTCS	HIV Testing and Counselling Services
HIV	Human Immune Deficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
IPT	Isoniazid Preventative Therapy
IPV	Intimate Partner Violence
KIIs	Key Informant Interviews
LDHS	Lesotho Demographic Health Survey
LNSP	Lesotho National Strategic Plan
LFTU	Lost to Follow Up
LGBTQI	Lesbians, Gay, Bisexual, Transgender, Questioning and Intersex
MSN	Men Having Sex with Other Men
MUAC	Mid upper arm circumference
MDGs	Millennium Development Goals
MPP	Minimum PMTCT Package
MoH	Ministry of Health (Lesotho)
MCHC	Mother and Child Health Care
MNCC	Mother Neonatal and Children's Care
NVP	Nevirapine
OPD	Outpatient Department

PLWHA	People Living With HIV and AIDS
PNC	Post-Natal Care
PrEP	Pre-exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PITC	Provider Initiated Testing and Counselling
RSA	Republic of South Africa
SRE	School-based Sex and Relationship Education
SRH	Sexual and Reproductive Health
SOP	Standards Operating Procedure
STI	Sexually Transmitted Infection
SADC	Southern African Development Communities
TAC	Theory of Access to Care
ToP	Termination of Pregnancy
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
VAWC	Violence Against Women and Children
VDRL	Venereal Disease Research Laboratory
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organisation
YFS	Youth Friendly Service

ABSTRACT

Background: Lesotho is one of the countries that have adopted and implemented strategies to address the challenges that impede negatively on utilisation of adolescent- friendly sexual and reproductive health services. In this regard, the Lesotho SRH and HIV linkage project of 2011 serves as the foremost point of reference for both the research problem and aim of the study.

Aim: This study seeks to evaluate the sexual and reproductive health (SRH) and HIV linkage project on friendly health service provision and utilisation by adolescents in Lesotho. The evaluation will be based on the way services are offered to the targeted population at the selected healthcare site. Factors influencing access to and utilisation of health services were also explored.

Methods: The qualitative, exploratory and descriptive design was used. Purposive sampling was employed for the selection of a total sample size of 21 adolescents and 5 (five) primary healthcare professionals who were sampled according to a pre-determined selection criteria. Two self-designed in-depth semi-structured interview guides were developed for data collection from the adolescents and nurses at the selected research sites. Clinical records were checked to assess utilisation of services by adolescents. The information gathered was triangulated with data collected from face-to-face interviews and analysed thematically. The data were transcribed considering content analysis for thematic aspects and patterns of the data obtained.

Results: The results indicated that adolescent females utilise most of the sexual reproductive services than the males. Most of these adolescent females were pregnant and lactating, and visited healthcare centres for contraceptives as well. The results further indicated a significant decline in the use of sexual and reproductive health services for reasons such as: lack of human resources, poor infrastructure, fixed working hours; as well as location and attitudes of the healthcare workers, which influenced the accessibility and acceptability of services being provided. Most critically, the findings revealed that the selected healthcare site does not provide adolescents with friendly services.

Conclusion and recommendations: The study recommends that a separate adolescent sexual reproductive healthcare facility be built at the same research site to provide the required level of service in a very conducive environment away from adults. Team building,

school visits, and sporting activities are also recommended as part of up-scaling adolescent friendly services to the community in a tangible manner. The results of this study should not be generalized. Rather, a study of the same nature would be ideal to explore the phenomenon of adolescent-friendly sexual reproductive healthcare services in other settings.

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CHAPTER ONE
OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The current chapter fundamentally focuses on a synoptic overview of the study as a whole, and basically captures the essential aspects and core tenets of the research topic itself. Such a trajectory of the introductory chapter of a research study is supported by authors such as Clark, Foster and Bryman (2018), Du Plessis and Kamper (2015) and Thomas (2017). It is worth emphasizing that these core research-related aspects are perennially highlighted and captured in varying degrees of detail in different chapters throughout this research study. In that regard, the current chapter essentially introduces the study; its background and context; the research problem being investigated; the research aim, objectives, and questions; the clarification and contextualization of essential concepts; the study's delimitations (scope or boundaries); the research design and methodology opted for; the study's significance; as well as the outline or structure of the various chapters according to which the entire research process was undertaken and structured.

It is the researcher's concerted view that such a trajectory and sequential arrangement of the current chapter's structure is also a reflection of both the logical and thematic inter-connectedness of the various aspects and components of the study as proposed by research methodology scholars such as Babbie (2018), Du Plessis and Kamper (2015), Efron and Ravid (20190, and others. Furthermore, such a logical sequencing and arrangement of both the current and ensuing chapters is intended to eventually allocate a degree of coherence in order to obviate both "red-herring argumentation" and "*non-sequitur* reasoning" in relation to the eventual study findings, conclusions reached, as well as the recommendations proposed (Mouton, 2014). Whereas the notion of "red-herring argument" relates to a researcher's mentioning of peripheral, irrelevant, or unrelated side issues to the primary argument or topic being investigated, "*non sequitur* reasoning" itself applies in situations of conclusions or side issues that are not logically connected or relevant to the collected data and consequent evidence presented in the findings (Mouton, 2014:120).

From the researcher's viewpoint, four composite factors or aspects are entailed in this research study; all of which have also shaped and directed the course of presentation and discussions throughout the study's different chapters. These composite aspects are: sexual reproductive health/ SRH (as well as its contextual manifestation and implications in a particular setting (i.e., Lesotho); adolescence as a growth stage for which the efficacy or

otherwise of sexual reproductive health services is determined in a specific context or setting; youth-friendly health services and extent of their utilization; as well as evaluation as both the methodological and empirical approach measurement mechanism in terms of which the efficacy or otherwise of the sexual reproductive health services in Lesotho is determined in this study. As stated earlier, these critical research variables are outlined and presented in more detailed emphasis in different chapters of the study, as advocated by De Vaus (2018), Mouton (2014), and other research scholars and luminaries. However, the researcher deems it relevant to introduce and contextualise these four aspects briefly in this part of the study (see Section 1.6) in order to emphasise both their indispensability and relevance; as well as obviating any ambiguity, red-herring, or *non-sequitur* connotations associated with these four terms throughout the study.

1.2 CONTEXT AND BACKGROUND OF THE STUDY

Whereas the preceding section focused largely on the introduction of the research topic in particular, the current section seeks to integrate the 'context' and 'background' of the problem under investigation (see ensuing Section 1.3) in terms of both its broader and narrower contexts. In the researcher's view, both contexts are also entailed in the ensuing chapter (Chapter 2, Literature Review). In the latter regard, however, the study makes a concerted distinction between the notion of a 'research problem' and 'literature review', since these terms may be complementary, but are certainly not synonymous (Thomas, 2017). Such a differentiation has enabled the researcher's mitigation of the possible overlapping effect between the broader and narrower contexts of the research problem on the one hand; as well as the intersecting research variables in both the current chapter and the ensuing chapter.

1.2.1 The Broader/ Macrocosmic Context of Adolescent Sexual Reproductive Health

The researcher asserts that the current sub-section is largely premised on the broader (global or macrocosmic) context of SRH, and not necessarily localised on its narrower Lesotho setting - which is the subject of discussion in Sub-section 1.2.2.

There appears to be no universal consensus on an appropriate definition on the term, 'youth' (United Nations International Children's Emergency Fund/ UNICEF, 2022a). Nonetheless, it has been adopted that the term, 'adolescence' (as part of the stages of youth) shall generally refer to "the phase of life between childhood and adulthood, from ages 10 to 19 … [and is characterized by] rapid physical, cognitive and psychological growth … [which] … affects

how they feel, think, make decisions, and interact with the world around them" (WHO, 2020a: 3). There are currently 1.3 billion adolescents globally, which represents more than 16% of the world population (UNICEF, 2022b; WHO, 202Oa). India has the world's largest adolescent population of 253 million, "and every fifth person [in India] is between 10 to 19 years [of age]. India stands to benefit socially, politically and economically if this large number of adolescents are safe, healthy, educated and equipped with information and life skills to support the country's continued development" (UNICEF, 2022b:1).

It is worth noting that all of the world's adolescent population is protected by the Convention on the Rights of the Child, which, amongst other purposes, ensures that the adolescents' rights as human beings are not violated, exploited and abused by adults, whether they are at home, in school, or in their communities (Barden-O'Fallon, 2017; Gubbels, van der Put & Assink, 2019). Such protection could not be under-estimated, given that more than 3, 000 adolescents die daily throughout the world from a variety of causes, including death caused by adults (WHO, 2020c). It is also approximated that among developed countries, about 20% of adolescent girls are either in formal or informal marriages or unions before the age of 18 years (WHO, 2020c). Meanwhile, 36% of adolescent girls in least developed countries are married by the age of 18 years, while 10% are already married before they are 15 years of age (WHO, 2020c).

Problems that adolescents encounter continuously in different parts of the world include (but not limited to): education and information paucity induced by factors such as inadequate and/ or unequitable access to properly resourced health facilities and services - particularly for safe contraception and legally protected termination of pregnancies (ToPs) and the perils of sexually transmitted infections (STIs) and HIV; injurious or invasive traditional practices (e.g., female genital mutilation (FGM); exponentially high occurrence rates of unplanned or unwanted pregnancies (e.g., 777,000 girls under 15 years of age in least developed countries giving birth annually); forced marriages; child labour; child soldiering; intimate partner violence (IPV); drug, alcohol, and sexual abuse; gender-based violence (GBV); gender inequalities; as well as the burden of disease induced by malnutrition and exposure to HIV/ AIDS, (STIs) and the recent Covid-19 pandemic (Aventin, Rabie, Skeen, Tomlinson, Makhetha, Siqabatiso & Stewart, 2021; Neal, Mahendra, Bose & Camacho, 2016; Odo, Samuel, Nwagu, Nnamani & Atama, 2018; UNESCO, 2022).

The range of problems listed above differ from country to country as a product of variables such as economic development, health policy orientation, and socio-cultural factors (Fatusi,

2016; UNICEF, 2022a; 2022b; WHO, 2017a). Given such a gamut of challenges that adolescents are facing, it is then irrefutable that they need supportive information, services and environments that advance their overall development and growth (UNFPA, 2022; WHO, 2017b; WHO, 2022a).

1.2.2 The Specific Context and Background of the Lesotho SRH and HIV Linkage Project

In 2011, the Government of Lesotho (GoL) through its Ministry of Health (MoH) initiated and eventually launched the Sexual and Reproductive Health and HIV Linkage Project in partnership with, and financial support of the European Union (EU) (GoL, 2011; GoL, 2012a). By its very definition, the project was mainly aimed at linking SRH and HIV/AIDS services as an emphasised manifestation of the government's prioritisation of the provision of friendly adolescent SRH services and improving overall health service delivery in all health facilities across Lesotho. Moreover, such a momentous initiative was a response to the crucial need for developing conducive health policies and programmes that meaningfully address problems such as the untenable adolescent HIV and unintended pregnancies, both of which are some of the highest in Southern Africa and the world (Aventin, Rabie, et al., 2021; GoL, 2018).

A pivotally significant section of the reviewed literature (Chapter 2) has been devoted to the general adolescent SRH situation in Lesotho, particularly is Section 2.4. It is against such a contextual premise that the Lesotho government supported a coordinated and integrated universal access approach of prevention, treatment, care and support in relation to policies and programmes that effectively confront SRH, HIV and AIDS (Till, Vesely, Mairhofer, Braun & Niederkrotenthaler, 2019). In its pursuit of the 2011 Sexual and Reproductive Health and HIV Linkage Project, the Lesotho Ministry of Health decidedly focused on HIV prevention, maternal health, and adolescent sexual reproductive health (ASRH (GoL, 2014a; Miller, 2013). Accordingly, through its Ministry of Health, the Lesotho government embarked on a protracted pilot strategy at selected healthcare facilities in order to serve as models or prototypes for integrated (linked or coordinated) SRH and HIV/AIDS services in Lesotho (African Institute for Development Policy (AFIDEP), 2011).

At its pilot phase in 2011, the SRH and HIV linkage project was launched at ten (10) district hospitals, namely: Butha-Buthe, Leribe, Berea, Mokhotlong, Maseru, Mafeteng, Mohale's Hoek, Quthing, Maluti, Qacha's Nek. These were considered as leading health facilities,

working collaboratively in providing comprehensively integrated SRH and HIV services (AFIDEP, 2011). Accordingly, it was expected that the piloted healthcare facilities would work collaboratively in implementing the SRH and HIV Linkage Project and also adopt best practices in this regard, which would further serve as a model for other Lesotho healthcare facilities. The implementability of the linkage project was enabled by providing the piloted facilities with the required financial, infrastructural, and human resources in the form of regular workshops and training of staff (AFIDEP, 2011; Aventin, Rabie, et al., 2021). The following provisions and considerations were applied in order to render each of the 10 piloted healthcare facilities fully functional (AFIDEP, 2011; GoL, 2014a):

- Providing a comprehensive and integrated regime of quality integrated SRH and HIV services that are devoid of deleterious factors such as stigmatisation;
- Strengthening systems that are compliant with implementing the requisite operational framework (i.e., standards, guidelines, and protocols) for integrating SRH and HIV services such as referrals effectively and sustainably in the facility, in order to track and reduce loss to follow-ups (LTFU);
- Exemplary and active governance and management structures for ensuring efficient and equitable allocation of the available human, infrastructural, and financial within each healthcare facility;
- Monitoring staff and project performance with reliable and continuous monitoring and evaluation systems to enable the piloted facility's capacity to accomplish the desired outcomes effectively without compromisation of quality of care; and
- Enhancing staff development and skilling through shared learning and curriculum-linked initiatives for provision of integrated healthcare services.

It is against the above-cited backdrop (expanded in Section 2.4 of Chapter 2) that the researcher sought to evaluate the 2011 Lesotho SRH and HIV linkage project and the extent to which it achieved (or failed to achieve) its fundamental goal of addressing and improving the lives and health needs of adolescents in Lesotho as its intended principal beneficiaries. Overall, the anticipated outcomes and performance indicators regarding the success and efficacy of the SRH and HIV linkage project would include: increased utilisation of the project services, including pertinent information concerning HIV, gender, and behavioural change communication (BBC) interventions (Denno, Hoopes & Chandra-Mouli, 2015; GoL, 2015; 2020). Therefore, it is the researcher's well-considered view that the ensuing discussion on the research problem is inextricable from the SRH and HIV linkage project itself.

1.3 RESEARCH PROBLEM

A research problem relates to the difficulty or difficulties posed by the prevalence of a phenomenon, a particular state of affairs or situation identified by the researcher within a particular field of study or discipline, or the methods and practices that prevail within the particular field (Ferraro, 2015; Polit & Beck, 2017). The identified research problem also enables the researcher's articulation of the research aim, objectives, and questions on the one hand; as well as the data collection and data analysis on the other (Thomas, 2017). Furthermore, Clark et al. (2018) and Flick (2020) inform that, it is on the basis of an accurately identified and specified research problem that both the scope/ delimitations and structure of the entire study could be established and formulated convincingly.

In its generalised context, the research problem in this study is fundamentally located within the interstitial spheres of healthcare as a discipline, as well as the scientific methods applied to render it meaningful and practical to the intended beneficiaries or key populations in the actual or real-life settings (Gray, 2014; Ferraro, 2015; Phakisi, 2018). Specific to the current research study, the research problem is then largely premised on a determination of the extent of efficacy and congruence (or lack thereof) in respect of the intended goals and actual achievements (or lack thereof) of the Lesotho government's 2011 SRH and HIV linkage project for the provision of friendly adolescent healthcare services. In this regard, it is the researcher's contention that the theoretical and policy development and implementation parameters also provide an argumentation framework or context for the further development of the research problem, a situation that justifies and answers the aspect of ***evaluation*** as an indispensable and pivotal factor in this study.

Accordingly, an evaluation of the afore-mentioned linkage project would be incomplete by focusing only on its goals and (projected and actual) outcomes in the absence of the international or global context for comparative benchmarking. Such benchmarking complements the project evaluation chain in its entirety in terms of the goals, processes, impact, and outcomes attendant to the self-same project. In fact, it is asserted that:

> "Project evaluation is the process of measuring the success of a project, program or portfolio. This is done by gathering data about the project and using an evaluation method that allows evaluators to find performance improvement opportunities. Project evaluation is also critical to keep stakeholders updated on the project status and any changes that might be required to the budget or schedule" (Landau (2022:1).

As indicated in Section 1.2.1, the global/ international context of SRH among adolescents indicates that this youth category faces daily existential problems (Fatusi, 2016; Neal et al., 2016). The problems attendant to the Lesotho SRH and HIV linkage project of 2011 could render the attainment of the Sustainable Development Goals 3, 4, 5, and 6 for universal healthcare coverage difficult to achieve (AFIDEP, 2011; Godia, Olenja et al., 2013). Notwithstanding some of its notable successes, the SRH and HIV linkage project was also besieged by problem and challenges whose effects could inadvertently reflect the project's as a failure. The entirety of factors and challenges affecting adolescents are detailed in Sub-section 2.3.3 of Chapter 2. However, it is noteworthy that these varied challenges are lodged within the policy, systems, and service delivery contexts (AFIDEP, 2020; GoL, 2020).

According to UNICEF (2022a), the adolescent population (aged 10-19 years) in 2020 for Lesotho was about 500,000, which is about 21% of the entire population. In 2020, the mortality rate was 14 deaths per 1,000 adolescents. In 2019 the unemployment rate was 29% for the 15-19 years age cohort. In the same year (2019), the main causes of death among this cohort were: HIV/AIDS, interpersonal violence, maternal factors, self-harm, road injuries, lower respiratory infections, Tuberculosis, and diarrhoeal diseases. The suicide (self-harm) mortality rate in that same year was 50 deaths per 100,000 adolescents. Meanwhile, the youth literacy rate for 2018 was 50%, mostly located in urban areas. The alcohol abuse rate was 15% among the adolescent population in 2016. In 2018, 33% of adolescents were in child marriage by the age of 18, mostly from the poorest families in Lesotho. It should be noted that the years mentioned here, come after 2011, the year in which the Lesotho SRH/ HIV linkage project was instituted by the Ministry of Health.

Of the estimated 38.4 million people living with HIV globally in 2021, 2.73 million were children aged 0-19 years (UNICEF, 2022a). In the same year (2021), about 850 children were HIV-infected globally, with about 301 dying from AIDS-related factors, such as insufficient access to HIV testing, prevention, care, and treatment services. In Lesotho, HIV occurrence ranks amongst the highest in the Southern African Development and Cooperation (SADC) region, with an infection rate of 13.6% among 15-24-year-old females; and 4.2 % among males of the same age group (WHO 2016). In 2021, about 30,000 adolescents were HIV-infected in Lesotho, which is relatively low when compared to 69,1000 for South Africa and is linked to sexually transmitted infections (UNICEF, 2022a). Ironically, the Lesotho adolescent HIV-infection rate occurred in spite of the high 2021 HIV testing and status awareness rate of 63.8% among the country's overall population, and a further high

62.3% rate of condom use (UNAIDS, 2021). Adding to the above-cited problems was the annual 6% of early childbearing by 15-19 year old female adolescents (Morris & Rushwan, 2015). Other health services related problems experience by Lesotho adolescents included: unfriendly service provision and paucity of detailed information and knowledge concerning the types of available and relevant services (e.g., contraception and family planning); which has the potential to render the service delivery system ineffective (AFIDEP, 2011; Godia, Olenja et al., 2013).

Particularly in tradition-steeped rural settings, certain cultural practices and taboos on subjects such as sex, sexuality, and reproductive health posed a communication challenge between the older and younger generations (Abaerei, Ncayiyana & Levin, 2017); Ngilangwa, Rajesh, Kawala & Mbeba, 2018). In addition to health policy related problems, adolescents have been a neglected social cohort on the decades-old perception that they are a disease-free generation (Neal et al., 2016). It is on this account that the Lesotho government instituted the SRH and HIV linkage project to provide for comprehensive adolescent-friendly services as part of strengthening the healthcare system (GoL, 2012; GoL, 2020). It is the researcher's contention that such strengthening of the healthcare system against the backdrop of a myriad of healthcare service provision or delivery problems is also a critical instrument for enhancement of adolescents' meaningful participation in the healthcare system itself. To this effect, UNICEF (2022b:12) informs that:

> " … participation has often been measured in terms of the presence of enabling factors which support participation … Meaningful participation occurs when adolescent girls and boys, either individually or collectively, form and express their views and influence matters that concern them directly and indirectly. Participation and engagement opportunities must be inclusive, giving adolescents of varying ages, socio-economic background and physical, emotional and cognitive abilities, the chance to take part in shaping decisions and policies that affect their lives … Participation has also been measured by process-driven indicators such as the number of adolescents who take part in specific meetings, organized activities, groups or governance structures".

1.4 DELIMITATIONS/ SCOPE OF THE STUDY

The delimitations or scope of the study relate mostly to the boundaries within which the field of investigation is restricted or confined (Rees, 2016). Accordingly, such confinement or restriction also determines the scientific parameters or reach of the study in order to eventually limit or constrain the extent of "red-herring argumentation" and "*non-sequitur* reasoning" as envisaged by Mouton (2014:120). It is worth noting that the mere presence of a 'delimitation' in any study does not necessarily connote any weakness on the part of its

processes and ultimate outcomes (Rees, 2016). In respect of its conceptual/ disciplinary scope, the study is confined to the field of healthcare service delivery, as opposed to disease management, for instance. Furthermore, the study is geographically confined to the Butha-Buthe area, which is the actual research site/ setting. The researcher also notes that this geographical confinement could potentially project on the study findings' generalisability, given that the Lesotho SRH and HIV linkage project was not confined to the Butha-Buthe area only. However, such a possible effect on generalisability is mitigated by the fact that it is not always possible to attain significant generalisability in a qualitative study's findings (Patton, 2015; Rajasekar, Philominathan & Chinnathambi, 2013).

Linked to the above (geographic scope), the study then adopted a qualitative research approach since the intention was to obtain the actual or first-hand experiences, knowledge, and perceptions of the adolescents and healthcare workers in their own naturalistic environment, and in their own words (Walliman, 2016). It is of significant noting that the delimitation or confinement of a study to specific conceptual, geographic, or methodological boundaries is also advantageous for the logical construction and development of its processes as a whole (Burrel, 2017; Mouton, 2014).

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

According to Matua and Van Der Wal (2015), the aim of a study is a depiction of the overall intention of the researcher in undertaking a particular study, and the reasons attached to the undertaking of such a study. Burrel (2017) and Rajasekar et al. (2013) illuminate that the research aim is usually linked to the investigated research problem, and serves as the seminal point from which the objectives of the study are developed and articulated. In that regard, the aim of the current study is articulated thus:

To evaluate the sexual and reproductive health (SRH) linkage project on friendly health service delivery and utilisation by adolescents in Lesotho.

Implicit in the above-sated aim or purpose of the study is that the evaluation was based particularly on determining the extent of efficacy of healthcare service provision to the targeted adolescent population under the aegis of the Butha-Bothe Government Hospital (BBGH) as the primary provider of the healthcare services.

1.5.1 Objectives of the Study

Whereas the aim or purpose of research are characteristically broad and general in their orientation, the objectives of a research study are fundamental and declarative statements

of intent directed at addressing some aspect/s of the research aim (Atmowardoyo, 2018). Therefore, research objectives should typically be specific, measurable, attainable, relevant, and bound to timeframes (Burrel, 2017; Ferraro, 2015). Similar to the research aim or purpose, the objectives of a research study should also be aligned with the articulated research problem. Therefore, the research study sets out to achieve the following objectives in its resolution of both the investigated problem and actualisation of the research purpose:

- To identify ways in which the Butha-Bothe Government Hospital could organise and offer SRH services to adolescents requiring such services;
- To identify any health factors and challenges influencing access to, and utilisation of SRH services; and
- To explore the adolescents' and healthcare workers' views on possible improvements in the provision and utilisation of adolescent-friendly healthcare services.

1.6 RESEARCH QUESTIONS

The following research questions are not a stand-alone aspect of the research study, but are sequentially and thematically linked to the afore-cited objectives (Clark et al., 2018):

- How can the Butha-Bothe Government Hospital organise and offer SRH services to adolescents requiring such services?
- What are the health factors and challenges influencing access to, and utilisation of SRH services?
- What are the views of adolescents and healthcare workers on possible improvements in the SRH and HIV linkage project for adolescent-friendly services delivery and utilisation?

1.7 CLARIFICATION OF ESSENTIAL CONCEPTS

The clarification of essential concepts is necessary for obviating any lexical, contextual, disciplinary, and practice related usage or application (Babbie, 2018; Patton, 2015). In Section 1.1 (particularly in the last paragraph of page 1 and first paragraph of page 2), the researcher has articulated the foremost criteria or reasons in terms of which the ***essence*** of these terms was determined. The current section proceeds further contextualises these (thematically and logically) identified concepts/ terms in relation to both the research topic and various core aspects of the study as a whole (Polit & Beck, 2017; Walliman, 2016).

1.7.1 Essence and Contextualization of Sexual Reproductive Health

The United Nations Population Fund (UNFPA, 2022: 1) articulates that sexual reproductive health (hereinafter referred to as SRH) is actually "a state of complete physical, mental and social well-being in all matters relating to the reproductive system …. [which enables individuals] … to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so". While it emphasises safety, it is noteworthy that the decision-making capacity is also encapsulated in SRH matters. Meanwhile, Godia, Olenja et al. (2013) further acknowledge that sustainable, effective, and affordable SRH could be advanced through accurate and accessible information obtainable from protracted education, health and other social programmes.

Both the World Health Organisation (WHO, 2017) and the UNFPA (2022) share the common perspective that informed reproductive health choices are achievable through an approach to sexual relationships and sexuality that is devoid of discrimination, coercion, and violence of any form. Such an approach should also be inclusive of individually preferred contraception methods that are acceptable, and do not aggravate any culturally sensitive practices in some communities (Godia et al., 2013; Thongmixay, Essink & Greeuw, 2019). Additionally, a conducive SRH care approach, model or programme should also be inclusive of having access to different good-quality services that encompass family-planning, education and antenatal care (ANC), safe delivery and post-natal care (PNC).

1.7.2 Essence and Contextualization of Adolescence

"Adolescents are not simply old children or young adults" (WHO, 2020a:n.p.). In this study, adolescence is an important factor insofar as it constitutes or presents a framework against which the efficacy of the envisaged youth-friendly SRH and HIV service could be empirically determined from this stakeholder category. Accordingly, adolescents in the context of the current study are viewed as the intended or immediate beneficiaries of the Lesotho SRH and HIV linkage project for adolescent-friendly health services initiated by the Lesotho's Ministry of Health. While there are varying conceptual contestations regarding the age parameters of "youth", there appears to be some significant degree of agreement of the age categorisation of adolescence as a a critical post-childhood, but pre-adulthood phase in human growth and development among those in the 10-19 year old age cohort (Boamah-Kaali, Seyram, Manu, Gyaase et al., 2018; WHO, 2015). From a growth and developmental perspective, the criticality of adolescence is occasioned by the fact that adolescents both undergo and experience extensive and transitory or immature physiological, emotional, and psycho-social

changes (Essack, Toohey & Strode, 2016; Ryan, 2019). It is most noticeable that it is during the transition stage of adolescence that relevant information and knowledge about sexual and reproductive health service play a fundamentally vital role in shaping ideas and attitudes concerning health consciousness, healthy living, and health lifestyles (Gbagbo & Nkrumah, 2019; UNAIDS, 2017).

Reputable international bodies such as the (UNICEF, 2022a; 2022b), UNFPA (2022), and the WHO (2022) are in concurrence that adolescents worldwide have been neglected, which translates into a gross denial of their basic human rights as enshrined in various international human rights charters. Both Section 1.2 and Section 1.3 (in conjunction with Section 2.3 of Chapter 2) have contextualised the various challenges experienced by adolescents in different parts of the world (including Lesotho). As a marginalised social group (due to policymakers' negligence, amongst other causal factors) adolescents' poor access to healthcare services has rendered them ill-informed on salient health issues concerning sexual maturity, which is known to enhance a healthy sexual and reproductive life (Ivanova, Mlahagwa, Tumuhairwe, Bakuli & Nyakato, 2019; Neal et al., 2016). For example, the fact that about three million adolescents aged 15-19 years of age globally undergo unsafe abortions each year is an apt demonstrative example of the essence and indispensability of adolescent-friendly SRH services and programmes (Ivanova et al., 2019; Xiong, Mo, Luo & Huo, 2018). Moreover, improving adolescents' sexual and reproductive health (ASRH) is instrumental in the accomplishment of both the Sustainable Development Goal (SDG) 3 emphasising good health and well-being, the SDG 5 and its emphasis on gender equality; as well as a variety of other SDGs entailed in the SDG Agenda 2030 (UNICEF, 2022a; UNFPA, 2016b).

1.7.3 Essence and Contextualization of Youth Friendly SRH Services and Their Utilisation

The mere reference to "youth-friendly" in this sub-section implies that the envisaged healthcare services should be provided in a manner that enhances adolescent interest, participation and empowerment in a non-threatening environment (WHO, 2016; Zhuang, Li & Li, 2019). In other words, the SRH service should not be antagonistic, and recognise the inviolable rights of adolescents as the same as those accorded to adults because adolescents are naturally not to be construed as lesser human beings (Brindis, 2017; Ogu, Maduka & Alamina, 2018).

In the context of this study, the essence and viability of youth-friendly healthcare service provision is viewed against the background of problems and challenges that dominate all health-related aspects of the adolescents' lives, as acknowledged by Ogu et al. (2018) and the WHO (2022). However, it is also mooted by various scholars' and practitioners' perspectives that viable and relevant policy-initiated adolescent-friendly health services ought to transcend ordinary SRH and HIV topics, but should also address a broad variety of adolescents' growth and developmental requirements that foster active citizenship and long-term health consciousness in their lives as adults (Ajike & Mbegbu, 2016; Swannell, 2019).

For Goicolea, Carson and Sabastian (2018), adolescent health services are considered to be friendly and empowering on account of their geographic location, accessibility, affordability, and acceptability to the targeted population. Moreover, such health services should be rendered by sufficiently qualified and proficiently skilled health personnel at well-equipped facilities for purposes of effectiveness and efficiency. The researcher contends that professionally trained and skilled healthcare personnel are suitably placed to address the gamut of challenges experienced by adolescents as variously mentioned in Sections 1.2 and 1.3 of this study (not repeated here for the avoidance of duplication). However, Akatukwasa, Bajunirwe, Nuwamanya et al. (2019) and Low, Broutet and Turner (2017) affirm that the full range of service rendered at the adolescent-friendly healthcare facilities should be inclusive of: family planning services, life skills, nutritional information, voluntary male medical circumcision (VMMC); as well as education and consultation on general health prevention, human sexuality, reproductive health and treatment of sexually transmitted diseases.

Based on all of the above, it is evident that the adoption, provision, and utilisation of adolescent- and youth-friendly SRH and HIV services is contingent on the availability of policies and systems that advance the empowerment and participation of the very beneficiaries (GoL, 2018; Till et al., 2019). The latter is effectively a paradigm that advances equitable access to health services and information. It is irrefutable that poorly informed adolescents were most vulnerable to risky sexual behaviours (Akatukwasa, Bajunirwe, Nuwamanya et al., 2019; Gebreyesus, Teweldemedhin & Mamo, 2019).

1.7.4 Essence and Contextualization of Evaluation of the SRH and HIV Linkage Project

As indicated variously in Section 1.2 and Section 1.5, the present study draws on a particular pilot project by the government of Lesotho through its Ministry of Health. Accordingly, is

against this background that the present study embarked on evaluating the 2011 SRH and HIV linkage project on friendly health service utilisation by adolescents in Lesotho. In the context of the current study, such evaluation is premised fundamentally on the extent of healthcare service provision to the adolescent population served by the Butha-Bothe Government Hospital (BBGH) as one of the pilot sites for the SRH and HIV linkage project in the country.

For the purpose of this study, therefore, an evaluation of the SRH and HIV project's (in)efficacy or otherwise entails that the intended provision of the intended services should be determined in the context of criteria such as the policy domain; attendant processes and systems; as well as the impact and outcome(s) of the project itself (GoL, 2020; Landau, 2022). To this effect, the study has pursued an empirical, evidence-based approach to evaluation through the involvement of sampled adolescents and healthcare workers for their real-life experiences, perceptions, and knowledge regarding the extent of service provision as initially anticipated at the launch of the SRH and HIV linkage project.

The researcher draws attention to the fact that the usage and application of the term, "linkage" is neither incidental nor peripheral. Rather, it implies the symbiotic indivisibility of both the SRH and HIV project as integral to the adolescent-friendly healthcare services proposed by the Lesotho Ministry of Health in 2011 (AFIDEP, 2011; GoL, 2020; UNFPA, 2016a). The researcher is of the view that the following excerpt actually encapsulates the essence and integrative value of "linkages":

> "In fact, there is growing understanding that countries with high unmet need for SRH services and high HIV prevalence will find it hard to achieve the Millennium Development Goals (MDGs) if they do not ensure universal access to SRH and HIV services" (AFIDEP, 2011).

1.8 RESEARCH DESIGN AND METHODOLOGY

The research design and methodology (discussed in more detail in Chapter 3) basically direct the processes, procedures, strategies, management, and planning of the entire research and its data collection and analysis processes as informed by the scientific perspectives or paradigmatic orientations that have been adopted or embraced by the researcher (Alase, 2017; Grove, 2021). It is on the basis of the research design and methods that researchers would be able to develop a framework on whose basis the particular study's structure could be framed in response to the research problem identified; achieving the aim and objectives of the study; answering the research questions; identifying and framing the

appropriate sampling techniques; as well as the appropriate data collection and analysis methods (De Vaus, 2018).

The study has adopted the constructivist-phenomenological research paradigm, given the primary focus of data collection from a participant-centric perspective (Babbie, 2018; Creswell & Poth, 2018). Informed by its afore-cited philosophical paradigm, the study has then adopted the qualitative research approach to enhance the acquisition of relevant information and data from the affected individuals in their own ecological surroundings, and in their own words. To that effect, semi-structured interviews were utilised to obtain relevant (oral) information from the sampled participants (adolescents and healthcare workers). However, research scholars and professionals have argued that the qualitative research approach (as compared to its quantitative variant) is advantageous for its enablement of the researcher's neutrality since the findings would have been drawn from the participants themselves. On the contrary, it is also argued that the mere physical presence of the researcher on the research site necessarily establishes subjectivity and/ or possible bias and being emotionally influenced by the feelings the participants attach to the real-life experiences in relation to the phenomenon being investigated (Creswell & Poth, 2018).

For its evaluation of the SRH and HIV project's (in)efficacy, the present study focused only on 1 (one) pilot site (Butha-Bothe Government Hospital/ BBGH) from the initial ten (10) that were selected at the launch of the project in 2011. In this regard, the BBGH could be viewed as providing a 'case' or contextual framework for evaluating the probable or most likely systemic hindrance factors affecting healthcare service delivery at the other 9 (nine) piloted healthcare facilities (Alpi & Evans, 2019; Joo & Huber, 2018). However, the study acknowledges that qualitative studies are not necessarily compliant with generalisations (Walliman, 2016; Rajasekar et al., 2013).

Creswell and Creswell (2018) and Yin (2018) inform exegetically that a case refers to the conglomerate of decisions, events, policies, activities, projects, institutions, systems, individuals, or even programmes, that are subject to being studied by one or more approaches as commensurate with the complexities of the phenomenon under review. Therefore, the BBGH serves as single-case or reference point for evaluating and matching possible patterns of congruence in respect of the policy context, systems and processes, impact, and outcomes of the SRH and HIV linkage project.

The research setting is the Butha-Buthe area in Lesotho (see Sub-section 3.3.1), at which 5 (five) professional nurses (healthcare workers) and 21 adolescents were purposively sampled for participation in the study in accordance with the researcher's judgement and understanding of the research milieu or environment and it's dynamics in this area (Hawkins, 2018). It is at this research site that data was collected by means of semi-structured interviews with a total of 26 participants. Both thematic and content analysis were utilised for the processing, organisation, and classification of frequently emerging data sets obtained from the audio-recorded structured interviews and content of relevant legal and health policy documents. It was on the basis of the analysed data that the ultimate findings of the study were developed and finalised (Polit & Beck, 2017; Yin, 2018). The study's applicable ethical considerations and trustworthiness of the findings are discussed in Chapter 3 in tandem with other relevant aspects of the research design and methods.

1.9 SIGNIFICANCE OF THE STUDY

In essence, the significance of the study is underpinned by the extent of its relevance and contribution (Alpi & Evans, 2019). It is characteristic of research studies to make such contributions in the spheres of epistemology, institutions/ organisations, or to society and/or the economy. However, depending on the nature and purpose of the research being conducted, it is not always the case that a single study would necessarily contribute in all the above-mentioned three spheres (Babbie, 2018). Accordingly, the present study is epistemologically significant insofar as it augments to the current body of literature on ***linked*** friendly SHR services for utilisation and access by adolescents as the beneficiary key population in developing countries such as Lesotho. Inordinate literature sources exist in this regard, but focus largely on adolescents as part of the broader society, rather than a distinct category with its own idiosyncratic features, experiences, and challenges (Aventin et al., 2021).

The institutional or organisational significance of a study translates into the extent to which the particular study contributes to the further development and performance of the concerned organisations (Alpi & Evans, 2019). In the case of this study, the Lesotho Ministry of Health is the most directly affected institution insofar as it is the section of government under whose aegis the SRH project was launched for subsequent implementation. Additionally, various healthcare facilities in Lesotho are also directly affected since they are the local healthcare service delivery and implementation centres or agencies of the SRH project, while the Ministry of Health is mostly influential at the policy and funding levels. The empirical findings

of the study and consequent recommendations are of great institutional significance and value in terms of the identified areas in which improvements are required in order to advance the intended goals of the SRH and HIV linkage project.

In the same vein as the institutional or organisational significance of the study, the socio-economic value is premised on the evidence-based recommendations in respect of improvements in the policy and service delivery domains for the purpose of improving the lives of adolescents. It is axiomatic that the 10-19 years old cohort are the future of their societies. Therefore, being imbued with viable SRH education and attitudes is a positive development for adolescents as future adults and active citizens capable of making informed health decisions and choices. A thoroughly health-informed cohort of adolescents implies a reduction in the 'burden of disease' spending by governments (UNFPA, 2016a). Therefore, the national fiscus of the Lesotho government would be able to direct more budgetary allocations in the most dire areas requiring socio-economic development because the adolescent population would be growing more healthier.

1.10 CHAPTER LAYOUT

The entire study is demarcated into five chapters as indicated below:

Chapter One: Overview of the Study

This chapter lays the broader context within which the present study is understood. Accordingly, the chapter introduced the study and its background in order to contextualise the research problem, aim, objectives, and questions. This chapter also presents the delimitations of the study, clarification of essential concepts; as well as layout of all the chapters in the study.

Chapter Two: Theoretical Framework and Literature Review

This chapter largely outlines the theoretical framework and the literature reviewed to address the specific issues related to adolescent sexual reproductive health globally. The specific context of Lesotho's 2011 sexual and reproductive health and HIV linkage project for adolescent-friendly services is also addressed in the chapter.

Chapter Three: Research Design and Methodology

The research design and methodology employed is presented and discussed in this chapter, including the sampling context, data collection and analysis methods; as well as the ethical considerations and trustworthiness criteria of the study as a whole.

Chapter Four: Data Presentation and Analysis

This chapter is considered the ‘heart’ of the study insofar as it presents the actual empirical data obtained through the semi-structured interviews with the sampled 26 participants. The subsequently analysed data constitutes the essential framework against which the findings were finally developed.

Chapter Five: Main Findings, Conclusions, and Recommendations

This chapter presents the main findings, conclusions and recommendations of the study.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 INTRODUCTION

The preceding chapter premised mostly on the provision of a general outline of the fundamental issues of the study and their placement or location in the different chapters of the study. The present chapter, on the other hand, focuses principally on presenting both the theoretical framework and relevant literature reviewed for purposes of contextualisation and clarification of the current study's core or pertinent issues. Whereas the review of literature logically preceded the actual theoretical framework, the latter precedes the review of literature in the present chapter's structure for the purpose of integrating theory to practice, and for the purpose of rendering the research undertaking as a significant contribution to real-life challenges experienced by real (and not imaginary) human beings in their realistic setting at which these challenges are experienced (Ary et al., 2019; Grove, 2021; Mouton, 2014). At the same time, the theoretical framework could not be under-valued, given its contribution to enhancing the scientific value to the study (Atmowardoyo, 2018; Haven & Van Grootel, 2019).

While the theoretical framework is situated and grounded within the parameters of the Theory of Access to Care (TAC), the literature review section in this chapter is layered into two main strata or domains, namely: the macrocosmic context of adolescent sexual reproductive health and youth-friendly healthcare services provision; as well as the microcosmic domain in terms of which the Lesotho SRH and HIV linkage project for adolescent-friendly healthcare service delivery or provision constitutes the foremost contextual reference point. In this regard, the macrocosmic domain comprises five major discussion sections, namely: an overview of adolescents in the context of HIV/ AIDS; adolescents in the context of sexual reproductive health; factors and challenges affecting adolescents' access to healthcare service provision and utilisation; components or characterisation of viable adolescent SRH service provision and utilisation; as well as an overview of the Sub-Saharan context of adolescents healthcare service provision and utilisation in relation to HIV/ AIDS and sexual reproductive health.

On the other hand, the more Lesotho-focused microcosmic section entails specific issues for discussion in tandem with the research topic, that is: HIV/ AIDS prevalence in Lesotho; the legal and policy domains of HIV/AIDS and sexual reproductive health; as well as the evaluation parameters of the SRH/ HIV linkage project itself.

2.2 THEORETICAL FRAMEWORK

In research, a theoretical framework is situated within both the disciplinary/ scientific and philosophical parameters of a study in relation to the researcher's preferred or identified theory for the purpose of resolving the research problem and answering the crucial research questions (Cho, 2018; Matua & Van Der Wal, 2015). Theories themselves are foundational or seminal interconnected concepts or principles that serve as building blocks for explaining (providing clearer understanding) or predicting the manifestation and prevalence of the phenomena under investigation (Abend, 2013). According to Nowell, Norris, White and Moules (2017) and Ryvicker (2018), theories also represent systematically connected abstract ideas and philosophical principles that underpin some assumptions to depict some (assumed) realities concerning nature (environment), knowledge or human beings.

In addition, the assumptions themselves could exist within the realms of *epistemology* (concerned with the nature or reality about knowledge); *ontology* (concerned with the nature of reality); *axiology* (extent of ethical application in the research process); *rhetoric* (about the extent of written or oral persuasiveness); or *methodology* (about techniques or strategies to acquire relevant knowledge) (Nowell et al., 2017). Drawing inspiration from theory of access to health care, the framework is significant as it redirects attention from the healthcare service users to the healthcare organisation, public health policies, and the community, making explicit the areas where the responsibility for enhancing access to healthcare lies. In this study the focus was directed on how SRH services are offered to adolescents, and also assessed if the services are meeting the needs of adolescents.

The study revealed that, services were not user-friendly as the health care services provision focused more on pregnant, lactating adolescent' mothers than boys and girls who have no children. It is the responsibility of health care worker to make sure there is improved and integrated service delivery to meet need of adolescents. The study found out there stock-out of medication and adolescents had to buy from pharmacy retailers. The study by Baroudi (2023) support this notion and also highlight the importance of providing youth-friendly health services that are integrated and are affordable for improved health outcomes.

Furthermore, approaching access as a process allows for a comprehensive interpretation of the factors related to healthcare access and facilitates more direct connections to policy implications(Wani, Rashid, Nabi & Dar, 2019).This is in contrast to the common risk-based

approach, which only identifies populations at risk without offering significant guidance for policy and practice considerations. The framework is non-linear, as access is influenced by previous encounters and the degree of trust in the healthcare system. These factors consequently impact future access to healthcare. The framework with its steps is used to study the various barriers to accessing SRH services among adolescents in Lesotho.

Therefore, a theoretical framework refers the particularisation or centralisation of a specific theory or theories within the disciplinary parameters of a specific state of affairs or phenomenon identified by the researcher for further exegetic examination or investigation (Abend, 2013; Kendall & Halliday, 2014). Additionally, a theoretical framework is a paradigm-induced reconstruction of interconnected (abstract) ideas, assumptions, or philosophical principles that are viewed as relevant for explaining why the research problem under study exists. In this study, the theoretical framework was helpful insofar as identifying and contextualising the foundational tenets or principles relating to the Theory of Access to Care as well as the conceptual relevance or applicability of the self-same theory and its attendant principles (Kendall & Halliday, 2014; Saurman, 2015) in respect of adolescent healthcare service provision, including access and utilisation factors (Wani, et.al, 2019).

2.2.1 The Theory of Access to Care (TAC)

Historically, the Theory of Access to care (TAC) originates from the contributions of Penchansky and Thomas to the field of healthcare service delivery to key populations (Myers & Hansen, 2020; Saurman, 2015). This theory is most appropriate in the present study insofar as it assisted in exploring the context of SRH service provision for available and appropriately rendered to adolescents as the intended or targeted group .Access to care in is highly dependent on a range of contextual factors including geography, population distribution, population needs and capacity, health system capacity, resourcing, and policy. The study found out that the context of SRH service provision does not adequately address the needs of adolescents. This is influence by geographical factors. Adolescents have to travel long distances to the facilities as they cannot afford bus fare. Also, in some areas there is no access to proper road, as thus, there is lack of public transport.

Of importance to the TAC is the centrality of the concept or principle of access to services as entailed in the seminal or foundational tenets of ‘the 5 (five) "A”s’, namely: affordability, availability, accessibility, accommodation, and acceptability (Homer, Castro-Lopes, Nove et al., 2018).

The ‘five ‘A’s’ are highlighted in the ensuing subsection. The above-cited ‘five “A”s’ are layered into independent, but complementary dimensions that have a significant value in accessing health services. The degree of complementarity of the “five A’s” is also a determinant of the healthcare service’s extent of utilisation and satisfaction by the intended populations (Brindis, 2017; Brindis & Decker, 2018).

2.2.1.1 The TAC’s Seminal/ Foundational Tenets and Relevance/ Applicability to the Current Study

It is the view of Myers and Hansen (2020), Homer, Castro-Lopes, Nove et al. (2018) and Saurman (2015) that the TAC is critically and profoundly instrumental in healthcare policy development. In that regard, the identification and contextualisation of the below-cited “five ‘A’s” is viewed as justifying their relevance and applicability in the current study.

2.2.1.1.1 Affordability

Affordability is established on account of the service user’s willingness and ability to comply with the service provider’s charges in relation to the service being offered (Lee, 2010). It is on the basis of a service’s affordability that accessing such service could become either prohibitive (i.e., difficult to afford) or affordable (i.e., easily paid for).The research found out that, SRH services are offered free in the hospital however, the issue that impede on access is transport fare. In addition, SRH services are not integrated, if adolescent need other services such as normal consultations they needed to pay a sum of M15.00 which at times they cannot afford it. For Adan and Githae (2018), the notion of affordability is more expanded and encompasses aspects such as the distance between the site at which the services are provided and the service users’ location or geographic origin. For example, adolescents residing in the urban areas would be more likely to access these SRH services, as opposed to their more socio-economically depressed rural counterparts. Ivanova et al. (2019) are in concurrence with Adan and Githae (2018), and further that distance could be an inhibitive factor to adolescents’ capacity to access the existing services due to direct and/ or associated (indirect) cost of the services. The study revealed that, adolescents arrive early in the morning and are served after a long time and have to spend money to buy food. This implies that they have incurred indirect cost which could negatively affect access.

2.2.1.1.2 Availability

Availability relates to the extent to of the (healthcare) service provider's capacity to meet, uphold, and sustain the users' clients and interest with the support of the required financial, human, and infrastructural (including physical and technological) resources (Denno et al., 2015; Lee, 2022). Accordingly, healthcare facilities that are acutely resource-deficient, were more likely to project a dissatisfactory and unacceptable image to the service users. The study found out that SRH services are available at the hospital however, they are not available for every adolescent that may need them such as adolescent boys and girls who do not have children. Most services that are available are family planning services, ANC, PNC, Under 5 clinic for infant. in addition the services are not comprehensive, adolescents have to go to other department to access other services where thy have to queue with adults Homer et al. (2018) and Myers and Hansen (2020) emphasise categorically that acceptability should also be construed from both the perspectives and perceptions of the users (i.e., adolescents), and not only those of the (healthcare) service provider in order to achieve and improve adolescent-friendly service provision. Most importantly, the subject of acceptability of services was also cited as a challenge amongst other challenges. When the SRH project was introduced in Lesotho, it was meant to be available to its beneficiaries (i.e. adolescents and youth generally), lest they avoid the use of the services itself.

2.2.1.1.3 Accessibility

As noted earlier (see Section 2.2.1), the aspect of accessibility in the TAC is interstitial (i.e., pivotal) to the other "4 (four) A's", namely: the affordability, availability, accommodation, and acceptability factors. Accessibility also constitutes a primary consideration in the sphere of healthcare policy since it (access) further determines the extent of the healthcare service's relevance and utilisation (Gebreyesus et al., 2019; Ngilangwa et al., 2018). According to Saurman (2015), access to health services is also a determinant of the extent of easy physical reach of the service in relation to the provider's geographic location. The hospital is located in Butha-Buthe town and accessibility of services among adolescents who reside in hard reach areas is not easy. There are no access road and lack of public roads as a result some adolescents are not able to access service. Thus, accessibility of services is concerned with enabling a patient in need of services to receive the appropriate form of care, from an appropriately qualified provider, at the convenient time to the service user, and in a secure, safe and conducive place. Therefore, the services provided are directed towards addressing

and appropriately fulfilling the needs of the individual within his/ her environment or context (Gebreyesus et al., 2019; Saurman, 2015).

Levesque, Harris and Russell (2013) emphasise further that accessibility is the definitive means by which patients or communities have the opportunity to utilise services that are appropriate to their health needs. Therefore, it is on the basis of the accessibility of services that influential factors concerning the initial contact or utilisation of such services could be effectively designated (Levesque et al., 2013). It is also mooted that other accessibility factors that influence accessibility to health care services should be considered. The rationale is that the willingness, desire, or intent of the client or patient to seek care, their knowledge and attitudes about the health system; as well as their level of need also ought to be taken into serious account (Nditunze, Makuza, Amoroso et al., 2015; Ryvicker, 2018).

2.2.1.1.4 Accommodation

Accommodation is often reflective of the extent of the healthcare service provider's organisation and operation of services such that the client's preferences and limitations are considered and catered for (Amoroso et al., 2015; Denno et al., 2015). Accordingly, a healthcare system and its services is viewed as accommodating insofar as it does not accentuate the client's or user's limiting and inhibitive factors (e.g., distance to health facility and associated travel costs), to the detriment of service delivery and trust by the key populations or intended beneficiaries (Nditunze, Makuza, Amoroso et al., 2015). It should be noted that an accommodating healthcare service does not necessarily imply an orchestrated exclusion of certain population categories, nor a compromisation of the quality and standards of care. Rather, it is an expression of flexibility and inclusivity, and an assurance that the service provider is willing to 'go an extra mile' to bring the required service to the user who requires it (Lee, 2022; Homer et al., 2018).

Examples of an accommodating health system include (but not limited to): flexible and/ or extended operating hours (considering staff availability); telephone communications for 24-hour contact and required health information; permissibility of receiving care without rigidity of prior appointments; as well as due recognition of age, gender, cultural, and socio-economic background of the user/ client and other relevant. According to Akatukwasa, Bajunirwe, Nuwamanya et al. (2019) and Fekadu, Yitayal, Geta et al. (2019), other barriers to accommodation include adolescents' understandable aversion to being served by unfriendly healthcare workers and providers; and sharing the same facilities with adults. Also,

the healthcare staff should be professional enough to realise the sacrosanct importance of the confidentiality and privacy of their patients' information and other pertinent health-related information. Any failure in this regard could result in severe legal outcomes for the institution and/ or personnel providing such services (Abbiate & Ebenezer, 2016; Jonas, Crutzen, Krumeich & Roman, 2018).

2.2.1.1.5 Acceptability

Essentially, the aspect of acceptability relates to the extent of both the client's and service provider's comfortability and satisfaction with each other in relation to attributes such as the expected level and standard or quality of the service (Goicolea et al., 2018; James, Petro, Imrie et al., 2018). Other relevant attributes encompass (but not limited to) the gender, age, ethnicity, social class, educational background of both the client and the provider; as well as the coverage type and diagnosis of the client. In the view of the researcher' the acceptability of the health service could be equated to the accommodation factor as elucidated in Sub-section 2.2.1.1.5; given also that all five TAC tenets or principles are symbiotically linked to each other as stated earlier in Section 2.2.1.

Therefore, the greater the mutual acceptability of the service, the most likely and greater the impact. Largely as a factor of their developmental stages (characterised by transient physical, psychological, and emotional state), adolescents are more prone to believing that they are healthy and 'immune' from illness (Ajike & Mbegbu, 2016; UNAIDS, 2017). In that regard, persuasive (rather than confrontational) approaches are required to enhance a semblance of attractability of health services. Therefore, it is absolutely crucial for healthcare service providers to connect the adolescents' perceived beliefs and willingness or intent to seek care. Such connection could help in exploring their individual reasons, knowledge of, and attitudes towards the healthcare system, and level of need in order to significantly improve both service utilisation and access (UNFPA, 2016a; UNICEF, 2022b).

In concluding this sub-section, it is worth stating that the TAC was deemed relevant and applicable to this study, particularly in view of the plethora of adolescents' challenges and needs (see Section 1.2 and Section 2.2) that acutely warrant their access to, and utilisation of pertinent healthcare (i.e., SRH and HIV) related information to counter the problems they experience daily at home, school, or in their communities. Additionally, the theory of health care utilisation and access to care is pertinent to this research insofar as providing the

scholarly and methodological tools required to understand factors which influence access and usage of sexual reproductive health amongst adolescents.

The next section is entirely focused on the reviewed literature in respect of both the macrocosmic and microcosmic aspects of the research topic as variously stated in both Section 1.2 of Chapter 1, and Section 2.1 of the present chapter.

2.3 A MACROCOSMIC CONTEXT AND PERSPECTIVE OF ADOLESCENT SEXUAL REPRODUCTIVE HEALTH AND YOUTH-FRIENDLY HEALTHCARE SERVICES PROVISION

In essence, the macrocosmic context (as opposed to the microcosmic Lesotho-focused perspective, which constitutes the latter part of discussions in this chapter) of the reviewed literature is a depiction of the conceptually and geographically broader scope or context of sexual reproductive health and youth-friendly healthcare services provision. It is the researcher's concerted view that such an orientation of discussions in this section of the current chapter also provides a synergistic and seamless connection between the state of adolescence and its various contextual factors. Table 2.1 below is reflective of the researcher's attempt to show a 'quantified' overview of the state of these adolescence contextual factors as they pertain to the present research study. It should be stated, however, that the 'unquantifiable' issues are also discussed in this chapter, such as adolescents' informational needs and barriers.

Table 2.1: Main adolescent issues/ challenges and their manifestation worldwide: 2020/2021

Specific Issue	Degree/ Extent of Manifestation
Disease-related	
HIV/ AIDS & STIs	2.8 million adolescents are HIV-infected, 88% are in Sub-Saharan Africa; 300,000 new HIV infections annually & 37,000 AIDS-related deaths; 340 million new annual STIs among the 15-24 years age group
Risk Factors Attributed to Maltreatment and Abuse	
Gender inequality	almost 25% of girls aged 15-19 years are neither employed nor in education or training, compared to 10% of boys in same age cohort; 129 million girls are completely out of school, including 32 million of primary school age, 30 million of lower-secondary school age, and 67 million of upper-secondary school age.
Gender-based violence	243 million women and girls sexually abused prior to advent of Covid-19
Intimate partner violence/ Violence against women and children (VAWC)	38% of women and adolescents murdered globally were by their male intimate partners;
	33% of women and girls experiencing physical, psychological, emotional or sexual violence by either person known to them or intimate partner
Forced marriages or unions	20% before the age of 18 years in developed countries; 10% already married before age of 15 years; 36% in developing countries by age of 18 years;

Specific Issue	Degree/ Extent of Manifestation
	over 100 million girls worldwide expected to be forcefully married before the age of 18 years by 2030.
Pregnancies	777,000 girls under 15 years of age in least developed countries giving birth annually; an estimated 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million of them give birth
Abortion/ Termination of pregnancy	73 million induced abortions annually occur globally; 61%) of all unintended pregnancies, and 29% of all pregnancies end in induced abortion
Female genital mutilation (FGM)	over 4 million girls worldwide at risk of undergoing FGM annually; FGM performed on about 200 million girls and women in 31 countries in three continents, more than half found in Indonesia, Egypt, and Ethiopia.
Child labour	160 million worldwide, an increase of 8.4 million children in the last four years and millions more at risk owing to impacts of COVID-19
Child soldiering	more than 93,000 children recruited and used in armed conflicts globally

Source: Compiled by researcher from WHO (2020; 2022); UNICEF (2022a); UNAIDS (2021); UNFPA (2022)

Irrefutably, the statistical information in Table 2.1 portrays a dire situation for the 1.2 billion adolescent population worldwide. UNICEF (2022a adds further that such a state of affairs is compounded by the fact that 90% of adolescents are found in low- and middle-income countries, and 125 million are in areas afflicted by armed conflict. Moreover, 25% of adolescents from the poorest social strata have never experienced formal schooling, while more than 200 million secondary school age adolescents are out of school (UNICEF, 2022a). The next section presents an overview of adolescence in the context of HIV and AIDS, notwithstanding that there are still many other contextual factors attendant to the phenomenon of adolescence. However other critical factors and relevant issues are highlighted in varying degrees of detail in Section 2.3.1 to Section 2.3.4.

2.3.1 Overview of Adolescents in the Context of HIV/ AIDS

By 2021, about 40.1 million people globally (33.6 million-48.6million) had died as a result of illnesses associated directly or indirectly to HIV and AIDS-related (UNAIDS, 2021). Moreover, about 84.2 million people worldwide (64.0 million-113.0 million) people have been HIV-infected since the beginning of this (HIV) epidemic. Most regrettably, the WHO (2022d) acknowledges that adolescents were the only age cohort experiencing increased AIDS-related deaths, amidst the synoptically presented context cited below in addition to the information in Table 1:

- nearly 2.8 million children and adolescents live with HIV, 88% of them are in Sub-Saharan Africa;

- about 85% of pregnant women were living with HIV, while only 54% of the HIV-infected children and adolescents received treatment;
- in 2020, about 300,000 children (one in every two minutes) were newly HIV-infected;
- in 2020, about 120,000 children and adolescents (i.e., one in every five minutes) died from causes connected to HIV/ AIDS.

According to Jubilee, Champango, Pule and Machinda (2019), the World Health Organisation (2016), and UNAIDS (2021), adolescents are susceptible to HIV/AIDS and sexually transmitted infections largely because they are information-deficient. From the perspective the researcher, the lack of appropriate information and relevant knowledge constitute the most critical aspects linked to challenges and risk factors confronting adolescents globally. To this effect, Section 2.3.1 focuses specifically on these information-induced risks. The next Sub-section (2.3.1.1) focuses on HIV/AIDS-related education as a response to the noted information deficiency.

2.3.1.1 Education on HIV/ AIDS and Voluntary HIV Testing Services (VHTS)

Education on HIV/ AIDS and voluntary HIV testing services are viewed as catalysts for the prevention and treatment of sexually transmitted infections (UNAIDS, 2019; Van Dyk, Tlou, & Van Dyk, 2017). According to Morris and Rushwan (2015) and Lowe et al. (2019), increased HIV is more prevalent amongst people with STIs. The latter is induced by the fact that sexually transmitted infections (STIs) cause and increase the risks of HIV infection, since any sore or breaks in the skin from an STI infection could potentially allow HIV to enter the body easily (Fatusi, 2016; UNAIDS, 2019; Van Dyk et al., 2017).

Globally, approximately 340 million new sexually transmitted infections are diagnosed amongst young people between the ages of 15 and 24, who constitute the highest rates of STIs (UNAIDS, 2019; WHO, 2020a). Sexually transmitted infections among adolescents are more common with a higher rate than among older women, thereby likely to cause higher miscarriage rates for adolescent mothers. In addition, at least one in five females youngsters between the ages of 15 and 19 years who had sexual experience also had STIs symptoms. Such a situation has become a serious concern, especially amongst adolescent girls as they can lead to pelvic inflammatory disease, ectopic pregnancy, premature membrane rupture, infertility, and other complications.

In tandem with all reputable global conventions and norms (e.g., International) Convention on the Rights of the Child), any individual (including children and adolescents) are entitled to proper education and detailed information about their HIV and AIDS status, including the right to unfettered access to information regarding prevention (UNAIDS, 2021; UNICEF, 2022b). Therefore, public institutions (i.e., schools, colleges, universities) and the non-governmental sector ought to be involved in actively in HIV and AIDS education initiatives and focus particularly on core aspects such as HIV/AIDS prevention, treatment and management; as well as the elimination of discrimination against persons living with HIV and AIDS (Lowe, Mudzviti & Mandir, 2019; Ryvicker, 2018).

It is of critical essence for individuals to know their HIV status, in a similar manner as accessing an HIV test is a right (Bruser, 2020; Mchenga & Dieter, 2019). The overall impact of the HIV testing services is to identify people living with HIV (PLHIV) on time through the provision of quality testing services for all, including adults, children, adolescents, couples and families (Jubilee et al., 2019).Accordingly, HIV testing should be performed freely and confidentially while pre- and post-test counselling is recommended for anyone utilising any healthcare facilities. However, it should be emphasised that individuals (including adolescents) have the right to object, and should neither be coaxed nor coerced to undergo such HIV testing. In the context of HIV testing, confidentiality implies that:

- HIV-positive patients' test results ought to be treated with the most possible optimum level of non-disclosure;
- Other healthcare and legal practitioners are also obliged not to reveal any person's HIV status without the written permission of the concerned person or their next-of-kin, unless such disclosure is indicated clinically indicated;
- For the treatment and care to be in the best interests of the patient, the need for disclosure of clinical data (including HIV and related test results), to healthcare practitioners directly involved in the care of the patient, should first be discussed with the patient; and
- The HIV test results and their report by a laboratory, should be considered as confidential information to which unauthorised persons are not privy. A breach of confidentiality is more likely to occur in the ward, hospital or healthcare practitioner's reception area than in the laboratory. It is therefore essential that healthcare institutions, pathologies and healthcare practitioners formulate clear policies concerning confidentiality and communication of such laboratory results.

According to UNAIDS (2019) and WHO (2017b), it is also essential to effectively link HIV testing and linkage (supported by confidentiality), enrolment of HIV positive people to antiretroviral therapy (ART) and Tuberculosis (TB) screening, to appropriate prevention, care and treatment and support services. Moreover, persons (including adolescents) who have tested HIV-positive should be allowed unfettered access to, and utilisation of supportive healthcare services. Accordingly, national governments and institutions are encouraged to develop and provide conducive policy environments for free, affordable, and accessible HIV testing services to all persons including the adolescent cohort (Van Dyk et al., 2017).

2.3.2 Overview of Adolescents in the Context of Sexual Reproductive Health

Both the characterisation and essentialisation of "adolescents" and "sexual reproductive health" in this section of the chapter is perennial from, and interstitial to Sub-sections 1.7.1 and 1.7.2 of Chapter 1. While, both these concepts constitute critical variables of the research topic itself, they have also assisted in shaping the iterative literature review process.

During their developmental stages from conception to adulthood, adolescents undergo different stages of growth and development, each of which is characterised by different and unique physiological, emotional, cognitive, and psychological processes towards adulthood and maturity (Kapur, 2015; Makadma, 2017). It is noteworthy that WHO (2020:n.p.) poignantly alludes: "Adolescents are not simply old children or young adults". The criticality of the latter assertion lies in the fact that adolescents are characterised as actual/ real human beings, and not merely a transitory or insignificant developmental phase in the process of being human. Accordingly, the researcher fully concurs with Ryvicker (2019), who emphasise that the adolescents' transition to adulthood is classified ***not only*** through body changes, but also by ***personal traits*** such as an increased independence from parents, individual identity, the building of friendships, and experience of sexual interest (Aventin et al., 2021; Bruser, 2010).

The complexity and transitory nature of the adolescent stage further presents one of the most dynamic, broad, and influential phases of human development and changes from a biological and physical perspectives (Iqbal et al., 2017). This is a stage underpinned by risk-taking behaviour, which is tantamount to a propellant for adolescents in their adventurous self-initiated or independent discovery of themselves and their surroundings. The period of adolescence is universally recognised for health risks as well, mainly associated with sex and the reproductive process (Homer et al., 2018; Rees, 2016). During adolescence boys

and girls (age 10-19 years) take chances, learn new skills, and initiate novel ways of interacting with their ecological surroundings. Most importantly, they begin to experience unfamiliar emotions, venturing beyond their own families to develop strong peer connections (UNFPA, 2016b). Furthermore, they become creative to find ways of being spectacular and standing out and belonging, in order to establish themselves and be recognised in society as having made a difference in their own world.

The adolescents' adventurism can also lead to both regrettable and disastrous consequences in the absence of proper guidance, adequate support, empowering information, as well as appropriate channels, mechanisms, or avenues to overcome their challenges (Rees, 2016; WHO, 2017a). The adolescents' risk-taking behaviour and sense of adventure could also have positive outcomes such as learning new skills and developing some experience resulting in future life, which sometimes renders them vulnerable (Alemayehu, Addissie, Ayele, Tiroro & Woldeyohannes, 2019; Zinn, 2019). This is also confirmed by Busso, Volmert and Kendall-Taylor (2018), who states that adolescence is both a moment of opportunity and a time of vulnerability and risk, particularly those (risks and vulnerabilities) associated with poor sexual reproductive health outcomes.

Alemayehu, Addissie, Ayele et al. (2019) advice that such poor outcomes could produce deleterious health problems including early marriages, unwanted pregnancies, unsafe abortions, STIs and HIV. The World Health Organisation (2016; 2017; 2020) and Zinn (2019), categorically emphasise that adolescents' often adventurous propensity and risk-taking borders largely on poor guidance and gross information deficit, leading impetuously to acts such as initiating unsafe sexual practices and activities while lacking sufficient protection knowledge, information, and skills; all of which heightens the risk of unsafe abortions, unwanted pregnancies, and sexually transmitted infections, including HIV/AIDS.

Adolescents constitute a cohort of 1.2 billion of the overall world population, and are the largest social category/ cohort, and the most urbanised and educated (UNFPA, 2022; UNICEF, 2020). However, they continue to experience a range of challenges, some of which are represented in Table 2.1 and the ensuing Section 2.3.3 in varying levels of detail. Their experiences and ignored hopes have also stifled their self-realisation and "full range of rights" (UNFPA, 2022: n.p.). Regrettably, policymakers have not made significant radical and concomitant decisions to change the current trajectory.

2.3.3 Risk Factors/ Challenges Affecting Adolescents' Access to Healthcare Service Provision and Utilisation

Having addressed the state of adolescence in the preceding section, the current section essentially outlines the risk factors and challenges affecting adolescents as critical contextual factors and determinants of the extent of healthcare service delivery to this important age group. Additionally, the adolescents' informational needs are outlined in this section in the context of ASRH service provision. To this effect, Tran, Yameogo and Gaffield (2018) and Wani et al. (2019) actually confirm that the capacity to address and resolve risk factors and the informational needs and barriers of the adolescents is also a measurement of the healthcare system's viability and stability.

2.3.3.1 Accessibility to Health Services

The criticality of access to healthcare services (particularly for adolescents) was accentuated as a valuable component of the study's theoretical framework in Section 2.2 of the present chapter. In essence, the concept of "access" relates to the availability and adequacy of healthcare services, such that the utilisation of such services is enhanced (Gebreyesus et al., 2019; Odo et al., 2018; Saurman, 2015). In this regard, the affordability, physical accessibility, and acceptability of these services constitute a mechanism to monitor the extent of their utilisation of services by the people for whom the services are intended. Abaerei et al. (2017) and Ngilangwa et al. (2018) report that access to services enables the achievement of the set goals of a health service policy and resolving barriers in consideration of the context, health needs, as well as the physical and cultural settings of diverse populations.

Other barriers include poor access to the existing services, discrimination and denial stemming from negative attitudes towards female sexuality and poor-quality services. For example, parents tend to refuse having adolescents' access certain services because of cultural practices. Some of the reasons given for discouraging these adolescents include: young age for using family planning for fear of delayed childbearing on the part of such young women. Evidence by Gebrejesus et al. (2019) suggests that 49% of adolescents residing in rural areas report problems in accessing healthcare, as compared to their urban counterparts. In the self-same study by Gebrejesus et al. (2019),only 29% of the urban-based adolescents have reported their problems related to access, while about 70% of the adolescents without any education have reported at least one difficulty in accessing health care because of financial problems.

From the perspective of the researcher, and in the context of the current study, both the extent and level of adolescents' access to healthcare services, are crucial factors for determining the adolescents' (as key populations or service user) health education in general; and SRH and HIV/ AIDS in particular. It is in this regard that the next section highlights informational deficit and knowledge deficiency as vital contextual factors for advancing adolescents' health education and knowledge. It is worth noting that SRH education accrues from the stipulated SRH rights in the 1994 International Conference on Population and Development (ICPD) programme of action (Pradnyani, Putra & Astiti, 2019).

2.3.3.2 Information Deficit and Knowledge Deficiency

From the researcher's viewpoint, both "information deficit" and "knowledge deficiency" underpin the salience and extent of relevant information and appropriate knowledge as enabling instruments for understanding of sexual reproductive health issues by adolescents. Such understanding, therefore, is also an enabler and empowerment tool against any lack of knowledge that would have been obtained from the home, school, or the community/ society. While Table 2.1 has portrayed general contextual factors, the current sub-section focuses largely on those factors that have a direct link to information and knowledge concerning adolescent sexual reproductive health and attendant services. However, the role and effects of the indirectly linked factors (e.g., child labour and child soldiering) is not underestimated, since both the direct (e.g., contraception) and indirect factors are symbiotically related.

Owing largely to their transitory growth and development stage, adolescents were likely to make uninformed healthcare decision due to lack of appropriate knowledge, skills and information (WHO, 2017b). Therefore, increased healthcare knowledge is fundamental to responsible preventative behaviour, inculcation of informed decisions, and adoption of positive lifestyle and growth attitudes by adolescents (Pharr, Enojoh & Mavegum, 2017). In many instances, it was found that unsupportive environments and guidance were primary contributory factors in adolescents receiving misleading and inaccurate information concerning prevention, transmission, use and management of diseases (WHO, 2017). Such a situation further denies adolescents the opportunity for, and exposure to valuable information and knowledge on topics such as: puberty; fertility; existing contraceptive methods; HIV and STIs; sex education and information; delay of early pregnancies; as well

as behavioural change communication (BCC) strategies (Artz, Burton, Ward et al., 2016; Binu, Marama, Gerbaba & Sinaga (2018).

Incorrect and inadequate SRH information could render adolescents less likely to protect themselves against risks such as sexual transmissions and partial or complete non-utilisation of SRH services and facilities. Notwithstanding its capacity to provide adolescent girls and boys increased opportunities to make informed decision in life, SRH education is still limited in some parts of the world, especially in tradition-steeped communities (Brindis & Decker, 2018; Vongxay, Albers, Thongmixay et al., 2019). As such, their hesitancy to seek SRH health services compounds the opportunity for adolescents to claim and protect their sexuality-related rights in order to obviate any violations against themselves.

On the other hand, it is suggested that the information deficit and knowledge deficiency experienced by adolescents could be ameliorated through the incorporation into life skills education at schools (Ayalew et al., 2019; Swannell, 2019; Woo, Soon, Thomas & Kaneshiro, 2011). However, the teacher's discretion regarding the provision of SRH education could result in the teacher failing to provide comprehensive education appropriately and perpetuate gaps and ignorance amongst adolescents (Woo et al., 2011). For Vongxay et al. (2019), the significance of identifying barriers that hinders sexual and reproductive health education lies in the fact that it could allow researchers to implement changes and facilitate interventions meant for providing comprehensive sex and sexuality education for adolescents as the primary target group or key population.

2.3.3.3 Specific Factors Linked to Adolescents' SRH Education

The following sub-sections focus on some specific factors linked to adolescents' SRH education, which is itself a factor of the information deficit and knowledge deficiency. While the researcher acknowledges the prevalence of other related specific factors, the following discussions mostly outline (to varying degrees) those that are deemed to be relevant in the present study. Therefore, adolescents' knowledge of these below-cited issues is beneficial to the advancement of both their health and human rights (Janet, Onyango & Cheptoo, 2018; UNFPA, 2016a). It should also be mentioned that these issues, which also engulf adolescents and pose an existential threat (considering their demographic presence as constituting 1.2 billion individuals in the entire world), are also reflective of the systemic, institutional, personal, socio-cultural, and behavioural contexts within which adolescents are expected to live in contemporary societies (Ajayi & Somefun, 2019; Janet et al., 2018).

2.3.3.3.1 Gender inequality/ discrimination and forced marriages

It is important for adolescent boys in particular, to understand the problem of gender inequality, the stereotypical and chauvinistic notion of gender inequality based on the archaic view of male 'superiority', and female 'inferiority' (Slater, Estrada, Suarez et al., 2018). Gender inequality or discrimination in the adolescent sphere is exemplified by the fact that in 2021, about 25% of girls (in the population of 1.2 billion girls and boys) between 15 and 19 years of age globally were neither employed nor in education or training, as opposed to only 10% of boys (UNFPA, 2022). In the current era, developments in globalisation, information and communication technologies, and mass democratisation of societies globally are rendering gender inequality a retrogressive force in the promotion of a culture of human rights (Abaerei et al., 2017). In many societies worldwide, adolescent girls were still expected to uphold certain discriminatory gender norms that render them secondary and domesticated to serve men. For instance, girls are groomed in society to display modesty and politeness, whereas boys are 'entitled' to be independent, brave, and typically masculine in their physicality (Artz et al., 2016; UNICEF/ ILO, 2021).

According to the researcher, the problem of gender inequality among adolescents further perpetuates the highly erroneous view of such inequality as naturally occurring. As such, boys may grow with the 'knowledge' that they are 'naturally' 'better' and 'superior' to girls and later become abusive adults involved in sexual abuse and general violence against women and children (Slater et al., 2018). It is against such a background that forced marriages in many countries are falsely projected as the natural entitlement of boys or men who grew up in socio-cultural environment where practices that promote the commodification and enslavement of women and girls as normal. Hence, 20% of girls in developed countries are in forced marriages before the age of 18 years; 10% already married before age of 15 years; 36% in developing countries by age of 18 years (WHO, 2022b). There is also the projection that over 100 million girls worldwide are expected to be forcefully married before the age of 18 years by 2030 (see Table 2.1).

2.3.3.3.2 Menstruation and female genital mutilation (FGM)

Despite increased awareness of the SRH needs and interests of adolescents, menstruation still remains as one of the foremost issues requiring improvement in the healthcare education of adolescents, given that menstruation is still viewed as taboo in many socio-cultural settings (WHO, 2020). The on-set of the menstrual cycle among girl adolescents requires

that adequate support and guidance should be provided, especially that adolescents are generally the only age cohort among whom HIV-related deaths and levels of other sexually transmitted infections continue to rise (WHO, 2022b). The menstrual cycle is also a consideration on whose basis the importance and need for family planning services and contraception could be made (Ali, Farron, Ramachandran Dilip & Folz, 2018).

Female genital mutilation (FMG) is one of the myriad of SRH contextual factors and considerable challenges of reproductive health and sexual rights facing adolescents. Female genital mutilation itself refers to all procedures relating to the partial or complete removal of the female external genitalia or any other harm to the female genital organs for non-medical reasons (Akatukwasa, Bajunirwe, Nuwamanya et al., 2019; WHO, 2020). More than four (4) million adolescent girls around the world are facing the risk of undergoing female genital mutilation annually (WHO, 2020). Moreover, the FMG practice is performed on about 200 million girls and women in 31 countries in three continents, more than half of whom are found in Indonesia, Egypt, and Ethiopia. It is instructive that these three countries are not in the list of developed economies in the world.

2.3.3.3.3 `Sexual abuse, sexual exploitation, and sexual harassment

Inordinate numbers of adolescent girls globally have experienced either sexual abuse, exploitation, or harassment, which is reflective of the general violence meted mostly by males (including intimate partners or next-of-kin) against females (Kusheta, Bancha, Habtu, Helamo & Yohannes, 2019; WHO, 2017; 2020; 2022b). According to WHO (2022b), the terms, sexual abuse, exploitation, and harassment are not synonymous, but are also mutually reinforce and complement each other. In that regard, sexual exploitation is viewed as “any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including threatening or profiting monetarily, socially or politically from the sexual exploitation of another” (WHO, 2022b: n.p.). On the other hand, sexual abuse is viewed as “the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. Sexual exploitation and abuse includes sexual relations with a child (18-years-old or younger), in any context (WHO, 2022b: n.p.).

Meanwhile, sexual harassment relates specifically to “prohibited conduct in the work context and can be committed against … staff and … personnel [and] … primarily describes prohibited behaviour against another … staff or related personnel … and involves any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture

of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment" WHO, 2022b: n.p.).

According to the United Nations Women/ UNW (2020) and WHO (2022), all forms of sexually perpetrated violence against women and children (including sexual abuse, exploitation, and harassment) have been a perennial feature of harmful male-female inter-personal relations. For instance, 243 million women and girls aged 15-49 years were sexually abused even *prior to* the advent of the Covid-19 global pandemic, which also affects their sexual and reproductive health and mental health. Moreover, approximately 38% of women were murdered "by a male intimate partner" (WHO 2017:1). In addition, approximately 35% of women worldwide have encountered physical, sexual, and psychological violence from either intimate or non-intimate partners, while nearly 30% have suffered physical and/or sexual violence in their lifetime. The WHO (2020:1) reported alarmingly that "up to 1 billion children aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect" globally between 2019 and 2020.

It is evident that the general treatment of females by males necessitates protracted interventions should be undertaken at home, school, and in the community to ensure that young girls grow with full understanding of their reproductive health rights in largely untransformed environments.

2.3.3.3.4 Teenage pregnancy

Unmet needs for family planning especially for spacing are high among adolescents, given that their first sexual debut is reported to have start at the age of 17 years. In 2020, about 73 million induced abortions occurred globally, while 61% of all unintended pregnancies, and 29% of all pregnancies end in induced abortion (WHO, 2022a). Evidently, such a state of affairs warrants that teenage pregnancy and its associated topics (e.g., contraception and abortion) should be part of the continuous healthcare education for adolescents, many of whom could have been deprived of reproductive health services related to childbearing and pregnancy due to, amongst others, the absence of parent-child dialogue about sex and sexuality (Guthold, Moller, Azzopardi, et al., 2019). Some of the challenges encountered by adolescents include: inadequate sexual and reproductive health (SRH) information arising from lack of access to sexual and reproductive health (SRH) education; as well as poor

quality of sexual and reproductive health (SRH) services where concerns about privacy and confidentiality are related to health care provider and health facility infrastructure (Boah, Bordotsiah & Kuurdong, 2019).

According to Pandey, Seale, and Razee (2019), the socio-cultural norms within their communities; the care and support they receive; the accessibility of services; are all factors that guide the extent to which they can influence decisions that affect them all make a difference. Given the almost negligible attention to SRH, particularly in poor and developing, most of the adolescent pregnancies are caused by the unmet need for contraception and adolescents' minimal or no voice in decision making regarding their SRH matters (Pandey & Razee, 2019). Early pregnancy and childbirth can result in pregnancy related complications, which have become the leading cause of maternal death among adolescent females and child morbidity (Kusheta et al., 209; WHO, 2020). Furthermore, adolescent pregnancy is linked to other health risks such as: anaemia, sexually transmitted infections, unsafe abortion, postpartum haemorrhage, and mental disorders. Regrettably, pregnant adolescents also experience negative social pressures and compels them to exit school, which – in addition to gender inequality - further reduces their employability and increased long-term economic ramifications.

Early or unplanned adolescent pregnancies have resulted in other problems, such as induced illegal abortion, maternal and child morbidity and mortality; as well as new infections such as HIV and STIs. These are believed to be resulting from poor access to, and utilisation of adolescent-friendly reproductive health services (Binu et al., 2018). For example, an inconsistent use of condoms, more especially with many sexual partners has been reported common. According to Maradei and Santos (2015), unprotected sex is more frequent in rape cases, which also has elevated the risk of infectious diseases such as HIV, STIs and hepatitis B infections to both female and male adolescents. The age-group of 15 to 24 is an attestation of almost 50% of all newly acquired sexually transmitted diseases (STIs) worldwide (Francis et al., 2018). The current body of scientific literature records (STIs) perpetuate transmission of the virus. This is done by breaching protective mucosal barriers and causing vaginal bleeding, further increasing the chances of being infected (Van Dyk, et al., 2017). Amongst other challenges faced by female adolescents, is a high death rate, with numbers being reported at all hospitals showing over 14-year olds at the estimated rate of 16.7%, and resulting from abortion (Boah et al., 2019).

2.3.4 Characterisation of Viable Adolescent-friendly SRH Service Provision and Utilisation

Many adolescents requiring sexual and reproductive health services such as appropriate information, contraception and treatment for sexually transmitted infections, have found these either unavailable, or that they are provided in a manner that makes adolescents feel unwelcome and embarrassed (Abbiate & Ebenezer, 2016). The latter assertion demonstrates that the nature of conditions for SRH service provision necessarily presage the extent of access and utilisation of such services. It is in this regard that the World Health Organisation promotes and advocates for *Adolescent-Friendly Health Services* at appropriately suited healthcare centres or facilities in order to address the sensitivities associated with the growth and developmental needs of adolescents; while also increasing the 'attractability' and utilisation of such services. From the researcher's viewpoint, the appropriateness and viability of the *Adolescent-Friendly Health Services* centres is contingent on the prevalence of enabling environment, supported by a conducive policy-driven delivery framework; as well as adequate human, financial, and infrastructural resourcing (Gebreyesus et al., 2019; Van Dyk et al., 2017).

2.3.4.1 Financial and infrastructural resources in healthcare centres

A financially viable healthcare system at the national level is most likely to deliver effectively on its mandate to the populace, with undue considerations of the burden of disease (Van Dyk et al., 2017). Conversely, a poorly financed healthcare system is bound to fail in its endeavour to provide relevant and appropriate health services to all its clients or users. In fact, poorly funded and managed healthcare centres (provincial, district or local; primary or tertiary) were most likely to even sustain the human and infrastructural resources. Having noted that the plight of adolescents has tended to be neglected generally (WHO, 2020; 2022b), it is axiomatic that the provision of healthcare services due to them is also likely to be scantily addressed.

The viable utilisation of healthcare centres providing adolescent-friendly SRH services is also contingent on innovated infrastructure, buildings and equipment, with providers who are willing to serve young people and fulfil their confidentiality and privacy requirements in separate ergonomically friendly buildings to prevent services and products being mixed with those of adults (Akatukwasa, Bajunirwe, Nuwamanya et al., 2019). Any healthcare facility that is regularly known for stock-outs of family planning commodities, crowded waiting

rooms, limited hours and lack of walk-in appointments, may prevent providers from delivering SRH services to all clients, including adolescents, thus discouraging them from seeking SRH care at such a facility (Nditunze, Makuza, Amoroso et al., 2015). Consequently, adolescents in particular, may lose trust in the healthcare system as a whole.

2.3.4.2 Human resources

Relevant information and appropriate knowledge on sexual reproductive health education and rights has been endorsed by the 1994 International Conference on Population and Development (ICPD) programme of action. On this basis, adequately trained and skilled healthcare professionals at healthcare institutions remain obliged to provide adolescents with comprehensive knowledge about SRH issues, including reproductive health (WHO, 2017; 2020). This will empower them to make informed decisions and be even more responsible for their lives. Education about sex and sexuality, pregnancy and contraceptives should begin at the primary level when learners are still ten years of age, and certainly not later than 12 years of age. The study by Pound, Denford and Shucksmith (2017) has revealed that adolescents who were educated on SRH at the later years of adolescent development would fail to comprehend such information.

Notwithstanding the salience of SRH education at appropriately funded and equipped facilities, Koto and Maharaj (2016) acknowledge that the scarcity of appropriately qualified and trained SRH healthcare personnel or professionals constitutes one of the most disconcerting factors in the healthcare sector. This could potentially become a serious impediment to realisation of the United Nations' Sustainable Development goals (SDG), in particular, the SDGs 1, 3, 5, 6 and 8 focusing on eradicating poverty, gender inequality, maternal health and the mitigation of new HIV infections (United Nations, 2014). The shortage of sufficiently trained and appropriately skilled SRH healthcare workers is exacerbated by several factors, including: unsatisfactory working conditions and salaries; unsafe and inadequately resourced workplaces; low morale among staff; poor nursing leadership; heavy workloads; as well as limited opportunities for career progression (Manyisa & van Aswegen, 2017). Consequently, low-income countries in particular, have experienced high brain-drain trends in terms of which trained personnel in various medical and healthcare fields/ sectors have migrated to overseas country in search of better-paying jobs (Koto & Maharaj, 2016; Manyisa & van Aswegen, 2017).

2.3.4.2.1 Some observations concerning SRH personnel

According to Abbiate and Ebenezer (2016) and Bindu et al. (2018) argue that the provision of SRH services to women by unskilled or untrained healthcare providers has posed some serious challenges in most African countries, where women and girls experience maltreatment and abuse when accessing services. Largely as a factor of unsavoury working conditions such as work overload, healthcare professionals regularly experience frustration and anger; as well as emotional and occupational stress emanating from organisational factors such as unsupportive emotional environments, absence of supervised mentoring, role ambiguity because of role expansion, role discomfort inadequate training, and lack of staff, heavy patient-client workload, poor salary and isolation. Given such a scenario, Ayalew et al. (2019) have suggested that SRH education should be provided also outside of the formal schooling environments so as to facilitate decision-making and build adolescents' confidence and interest in controlling their own lives. The above-cited authors also propose that teenagers should be included in programme design and the implementation of services intended to improving their health. In that regard, their awareness and creativity can result in the development of accurate friendly services and key programmes.

2.3.4.3 Overview of expected SRH services

In the context of the current research study, the expected SRH services provided at adolescent-friendly healthcare centres include: communication/ teaching relevant healthcare information and knowledge; family planning services; as well as antenatal and postnatal services

2.3.4.3.1 Communication/ teaching relevant healthcare information and knowledge

Evidently, the communication/ teaching of relevant healthcare information and knowledge is typically provided by trained personnel. (WHO, 2017). However, in the new digital era, bringing in new learning opportunities and unlimited access to technologies and innovations has empowered adolescents insofar as learning more about their sexual conduct and lives (Leung, Shek, Leung & Shek, 2019). Accordingly, school-based sex and relationship education (SRE) is viewed as crucial for steering these changes, safeguarding adolescents and assisting them to contest child sexual abuse and exploitation (Leung et al., 2019). While the digital age has revolutionised the manner in which information is freely obtainable, adolescents should also be equipped with knowledge and skills to safeguard themselves against predatory practices such as pornographic materials and recruitment of sex slaves

(human trafficking) by agencies masquerading as philanthropic social welfare organisations involved in SRH and other humanitarian concerns (UNFPA, 2022).

2.3.4.3.2 Family planning services

Family planning entails the decisions on the number of children chosen to establish a family in respect of timing of pregnancies and birth spacing (Wani et al, 2019). The suggested interval before attempting the next pregnancy is at least 24 months to reduce risks to the mother and the new-born. Such risks involve early pregnancy and premature and low-birth weight babies (Jayaweera, Ngui, Hall & Gerdts, 2018). Also noted is that women have increased chances of becoming pregnant as soon as they engage in sexual activities, approximately six weeks after delivery. In that regard, Tran et al. (2018) suggest the use of family planning methods to prevent unwanted pregnancy, more especially with the use of a condom for preventing STIs and HIV. One of the most useful techniques in helping women and their partners to control their reproductive health is through counselling on family planning methods; especially during late pregnancy and the postpartum period (Van Enk, Kasyaba, Bosco Kanani, Tumwesigye & Cachan, 2017). The benefits of beginning family planning as early as six weeks after delivery are recommended (Tran et al., 2018). In addition, counselling on family planning could help couples to choose the best contraceptive methods for them. Furthermore, health care providers should give adequate information about the available contraceptives, their benefits and side effects (Ali et al., 2018; Van Enk et al., 2017).

Women who have just given birth and are breast feeding, are discouraged from using certain contraceptives because of their side-effects and the potential to reduce milk production (Tepper, Phillips, Kapp, Gaffield & Curtis, 2016). Hence, their increased weight. In such instances, precautionary measures should be addressed, such as checking readiness and willingness to start the use of contraceptives. The study by Gbagbo and Nkrumah (2019) has revealed that access to quality care during family planning services in particular, reduces unwanted and unplanned births. Therefore, while different methods of contraceptives are available to adolescents and older women, some (especially long-term contraceptives) have been inappropriately used by adolescents. However, De Vargas, Coll, Ewerling et al. (2019), have shown that a long-term use of contraceptives causes infertile and/or delayed conception and decreased libido. Illustrated in Table 2.2 (overleaf) are different types of contraceptives.

Table 2.2: Different family planning methods used to prevent pregnancy

Method	Breastfeeding	Non-breastfeeding	Effectiveness
LAM (Breastfeeding)	Start immediately after childbirth; can use if exclusively breastfeeding day and night for up to 6 months or until periods return	N/A	Very effective with correct use, few side effects
IUCD	Insert within 2 days of childbirth, or from 4 weeks after childbirth	Insert within 2 days of childbirth, or from 4 weeks after childbirth	Insert within 2 days of childbirth, or from 4 weeks after childbirth
Female Sterilization	Perform within 7 days, or from 6 weeks after childbirth	Perform within 7 days, or from 6 weeks after childbirth	Always very effective, permanent method, fewer side-effects
Combined pill (estrogen-progestogen)	From 6 months after childbirth	From 3 weeks after childbirth	Very effective with careful use, may have side-effects
Monthly injection (combined)	From 6 months after childbirth	From 3 weeks after childbirth	Very effective with careful use, may have side-effects
Implants	From 6 weeks after childbirth	From immediately after childbirth	Always very effective, long term method but may have the side-effect
Condoms	From immediately after childbirth	From immediately after childbirth	Effective with careful use
Diaphragm	From 6 to 12 weeks after childbirth depending on when the uterus and cervix return to normal	From 6 to 12 weeks after childbirth depending on when the uterus and cervix return to normal	Effective with careful use

2.3.4.3.3 Antenatal services

It is recommended that pregnant adolescents should have regular antenatal check-ups or consultations with doctors, nurses, or midwives during pregnancy in order to receive the required services necessary to their health and their new-borns (Mchenga, Burger & Fintel, 2019). Antenatal care helps a pregnant woman to prepare for delivery in terms of understanding warning signs during pregnancy and childbirth. These consultations are also helpful in obtaining relevant information and advice concerning birth spacing, breastfeeding and support for health care and diet (Wudineh, Nigusie, Gesese et al., 2018). During ANC consultations, adolescent mothers are also treated for hypertension to prevent eclampsia, immunisation against tetanus, HIV testing and medication to prevent mother-to-child transmission of HIV. They are also provided with micro-nutrient supplements to boost their immune systems and improve child development. Mchenga et al. (2019) recommends that a pregnant woman should have a minimum of four scheduled antenatal care visits. However, it is estimated that only half of all pregnant adolescents globally comply with this

recommended number of ANC visits in a first trimester (Fekadu, Yitayal, Alemayehu et al., 2019).

Also, only about 86% of pregnant adolescent girls worldwide access antenatal care with experienced health personnel at least once, while only 62% have received at least four antenatal visits (WHO, 2020). In Sub-Saharan Africa, fewer women have received at least four antenatal visits despite the increased rates of mortality (Lattof, Tunçalp, Moran et al., 2019). In Lesotho, there is provision for 'mother-baby packs' (package of medication (prophylaxis) and B complex supplements, and Fefol) for use during and after pregnancy by all mothers, including Nevirapine for an infant born from an HIV-positive mother. The mother-baby package was adapted from the Minimum PMTCT Package (MPP) and introduced in Lesotho in 2007 by the Ministry of Health.

A continuum of maternal during pregnancy and childbirth and the postpartum period is fundamental for maternal and neonatal health (De Vargas, Coll, Ewerling et al., 2019; Van Enk et al., 2017). All adolescents ought to have easy access to quality services that are provided by qualified healthcare providers regardless of the adolescents' social and economic status (Iqbal et al., 2017). Adolescent mothers are a vulnerable group since their bodies are not fully developed to carry full term pregnancy and delivery complications. Therefore, it is crucial to encourage such young women to attend antenatal clinics and be taught on care during pregnancy, delivery and after childbirth (De Vargas, Coll, Ewerling et al., 2019).

However, Perez, Patterson, Hinshaw and Enscobar (2018) caution that, receiving antenatal care during pregnancy does not necessarily constitute the totality of effective maternal health improvement interventions. Rather, ANC mainly increases the opportunity of receiving effective maternal health interventions during antenatal visits. Additionally, such interventions are associated with some complications, as is the case with any other medication (Perez et al., 2018). Regardless, the delayed use of antenatal care from clinics could exacerbate some of the challenges facing adolescents during pregnancy and delivery.

2.3.4.3.4 Post-natal care (PNC)

Both antenatal and postnatal care are not only important for the health of both the mother and child, but also provide appropriate information and counselling on family planning in order to assist adolescents prevent or delay a second (unplanned or unwanted) pregnancy

(Wudineh, Nigusie, Gesese et al., 2018). After birth of the newly-born child, both mother and child should be examined within 24 hours by a qualified health worker who will also discuss a schedule for the next visits and immunisation for the baby with the mother and family. However, Amouzou, Mehra, Carvajal-Aguirre and Khan (2017) recommend that trained health workers should visit mothers and their babies at home, preferably within the first week after birth. However, the mother should visit the facility within the scheduled dates in the event that the facility does not conduct home visits (Amouzou et al., 2017).

In the context of Lesotho, the postnatal care visits were found to be very essential, particularly for the post-natal examination on both the mother and the new-born baby. Mchenga et al. (2019) support the view that such an examination should be conducted within an hour after birth and within 48 hours before discharge. The mother should also visit the healthcare facility after 7 (seven) days, 6 (six) weeks, 10 weeks and 14 weeks. Such a schedule of post-natal visits is intended primarily to provide guidance on timely breastfeeding, and also address any difficulties with attachment and positioning of the baby (Mchenga et al., 2019).

The PNC visits are also a platform for discussing sexuality issues (Zhuang et al., 2019). Accordingly, the mother visits the health facility alone for private discussions with a qualified healthcare worker on matters such as resumption of sexual activities with a partner after childbirth (Phakisi, 2018). It is also important to recognise the different cultural and religious practices in this regard, such as periods for abstinence after childbirth. For example, for some women, any discussions relating to sexual relations and activities with partners is viewed as taboo, which renders women somewhat embarrassed if asked about such. In some cases, the partner may have had sexual intercourse outside of the relationship, which accentuates the possibility of the other partner contracting STIs (UNAIDS, 2017; Zhuang et al., 2019).

2.3.5 Overview of the Sub-Saharan African Context of Adolescent SRH/ HIV Healthcare Service Provision and Utilisation

The current section presents an overview of the Sub-Saharan context of adolescents healthcare service provision and utilisation in the context of HIV/ AIDS and sexual reproductive health. According to UNICEF (2020), the Sub-Saharan African region is the epicentre of HIV and AIDS prevalence and infection among children and adolescents, compared to other parts of the world. Although different factors account for some statistical variability, it is reported that approximately 2.8 million HIV-infected children and adolescents

in 2021 were found in the Sub-Saharan African region alone (UNICEF, 2020). An additional number of 16.6 million children in child labour has compounded the HIV and AIDS situation over the past four years due to structural factors such as: extreme poverty, population growth, recurrent socio-economic instability or crises, vacuous social protection mechanisms; as well poor regional cooperation (UNICEF, 2022a; WHO, 2015). As such, children, their mothers, and adolescents ought to be tested regularly for HIV and treated in order to disrupt the cycle of new infections and resultant deaths. Despite the somewhat disturbing scenario, UNICEF (2022a) projects that the Sub-Saharan Africa's adolescent population is increasing, and anticipated to reach about 500 million by 2050 – a factor that portends powerful and meaningful change.

2.3.5.1 Factors Affecting Access and Utilisation of SRH Services

Despite many collective efforts, most Sub-Saharan African countries are experiencing challenges pertaining to provision of SRH services to adolescents (Ngilangwa et al., 2018; UNFPA, 2016a). Lack knowledge and negative attitudes towards SRH services have hindered and stifled adolescents' utilisation of the existing SRH services (Ayalew et al., 2019). Sexuality information provided to adolescents by families and peers was reported to be insufficient or ineffective. Banke-Thomas, Banke-Thomas and Ameh (2017) report further that one of the reasons for poor access and utilisation of SRH services was the lack of finances to pay for transport and consultation fees at the appropriate SRH centres.

Sexual and reproductive health and universal coverage in health are directly related to the United Nations' Sustainable Development Goals 1, 3, 5, 6 and 8. These SDGs highlight the need to eradicate poverty, gender equality, maternal health and mitigate new HIV infections (United Nations, 2014; WHO, 2016). For the Southern African Development (SADC) region, these challenges have been broadly recognised through the Maputo Plan of Action to Link SRH and HIV for the improvement of health outcomes (AFIDEP, (2011; Aventin et al., 2021. In most SADC countries, rural women in particular have a low income, a low educational level and lower levels of contraceptive use, and were also found to have little knowledge about HIV and STIs (GoL, 2020). In such contexts, it is recommended that traditional and community leaders should play a major role in the provision of education concerning the promotion and protection of the rights of infected and affected persons (Binu et al., 2018; Manyisa & van Aswegen, 2017).

In the South African context, these leaders are even more compelled to work in conjunction with the Department of Health and the Department of Basic Education authorities regarding

‘taboo’ issues such as traditional male circumcision (TMC); medical male circumcision (MMC); initiation; virginity testing; as well as other tradition-centred issues for the purpose of eliminating HIV prevalence and stigmatisation; as well as perpetuated myths and ignorance regarding HIV and AIDS (Koto & Maharaj, 2016).

2.3.5.2 Minimum Standards for Integrating HIV and SRH in the SADC Region

The integration/ linkage of SRH and HIV into continuum of care is crucial for achieving SDG indicators (Hopkins & Collins, 2017). This can be achieved through commitment, collaboration, and accountability by governments in respect of developing Minimum Standards. These are within the SADC mandate of promoting and harmonising policies and strategies for the benefit of citizens to access improved SRH services. Lesotho as an SADC Member State, is also committed to address the SRH and HIV challenges, particularly by incorporating the two thematic areas: SRH and HIV

The Minimum Standards for HIV and SRH Integration are aligned to SRH and HIV-related strategies, policies and guidelines, which includes development of regional policies and plans that recognise the overall impact of HIV and close collaboration with different stakeholders to combat HIV and AIDS (Hopkins & Collins, 2017). Accordingly, policy development will guide the implementation of strategies towards improving maternal death, child morbidity and mortality and reducing unwanted pregnancies, HIV infections and STIs amongst adolescents (UNAIDS, 2016; WHO, 2020c).

2.3.5.3 The Sexual and Reproductive Health Strategy for the SADC Region

The SRH Strategy for provides a framework for developing reproductive health policies (SADC, 2008). The strategy recognises the different socio-economic status of the member states It guides the development of interventions by the SADC member states, the secretariat, donors and other stakeholders in the region. (SADC, 2008). The objective of the strategic plan is to strengthen the capacity of SADC member states to provide integrated SRH services, thereby harmonising guidelines and protocols. The strategy further improves cooperation and complementarity of strategies and programmes on SRH at national and regional levels, thus learning and sharing opportunities, and providing evidence-based policies and programmes on SRH (UNFPA, 2016b).

2.4 THE LESOTHO CONTEXT OF ADOLESCENT SRH AND HIV HEALTHCARE PROVISION

As indicated in Section 2.1, the current section provides the Lesotho context of adolescent SRH and HIV healthcare provision. Accordingly, the following are highlighted: HIV prevalence; the SRH context of adolescent healthcare provision; the legal and policy frameworks of HIV and SRH; as well as the critical aspects of the SRH linkage project.

2.4.1 HIV/ AIDS Prevalence and Its Implications

Lesotho has one of the highest HIV prevalence rates in the world, which is attributable to gender-based violence, cultural practices, and serodiscordancy (an intimate partner relationship in which one of the parties is HIV-positive and the other is not) (UNICEF, 2022a). As recent as 2020, the population of Lesotho was 2.142 million (a third of which is aged 10-24 years). This number represents 0.03% of the entire world's population. Additionally, the life expectancy is 55.65 years, while the infant mortality rate is 50.5 infant deaths per 1,000 live births (UNICEF, 2020). These statistical figures are important, because they also help in understanding of the SRH contextual factors as they pertain to the study for the period under review.

In 2020, Lesotho's population consisted of 674,092 people in urban areas, and 280,000 people (of all ages) living with HIV (UNAIDS, 2021). The adult HIV prevalence rate was 21.1%, while 7,700 new HIV infections were recorded and 4,700 AIDS-related deaths occurred. Meanwhile, 230,000 people were on ART and 94% of the HIV-infected people knew their status; and 97% had suppressed viral loads. According to UNICEF (2020), 28 adolescent girls (10-19 years) and 7 (seven) adolescent boys in the same age cohort were newly infected with HIV every week. Furthermore,19% of females had given birth by the age of 18 years, and 24% of women had experienced sexual and gender-based violence; while 24% of women aged15-59 years had experienced the same scourge. It has also been reported that adolescents living in remote areas were more involved in childbearing than their urban peers, with 23% of rural adolescents giving birth or pregnant; compared with 12% of their urban Counterparts.

2.4.1.1 HIV testing services (HTS) in Lesotho

Lesotho is the first Sub-Saharan African country to launch an HIV testing and treatment policy (GoL, 2016). At the time rate of occurrence amomngst various demographic sectors was as follows: sex workers (79.1%); factory workers (42.7%); prison inmates (31%);

pregnant women (25.9%); young women (10.2%); and young men (5.9%). It is evident that young men and young women respectively had the least number of HIV-infections. Despite the UNIAIDs' strategy to improve testing services, there has been reported delays in testing for HIV due to social pressures and 'fear of the unknown' (GoL, 2016). Nonetheless, Lesotho has rolled out HTS services to all its public health facilities in 10 districts, with more than 80% of people testing at the designated health facilities and the remainder at community facilities. Over the years, the number of people who test has increased from 274,240 in 2011 to 916,649 in 2016 (GoL, 2016). The increase was associated with existing multiple entry points for testing services within public health facilities (DHS, 2014).

2.4.2 The SRH Context of Adolescent Healthcare Service Provision

This section largely focuses on the extent or magnitude of SRH-related problems and implications (i.e., measures/ steps related to service delivery to resolve such problems. Amongst the population of 2.2 million in Lesotho 21.8% were adolescents in Lesotho constitute (GoL, 2020). Teenagers in the lowest wealth quintile were about five times as likely to have given birth to their first child by the age 19 years, than those in the highest quintile (28% versus 6%). For instance, teenage pregnancy was high in the rural district of Butha-Buthe with 25%, compared to Maseru district with 14% respectively. However, childbearing amongst adolescents has been found to be less common amongst adolescent women in the wealthiest households (GoL, 2020).

According to the DHS (2014), about 27% of the adolescents have not accessed SRH due to financial constraints. However, in Lesotho, such services have been rendered freely at all the government and CHAL health centres, except for delivery services. Despite this, some services are provided at standardised consultation fees of R15.00 across the country in most government and CHAL hospitals (GoL, 2017; 2020). The free services include antenatal care services, family planning, HIV testing services, post-natal care, counselling, and psychosocial support. However, financial problems have been experienced, with adolescents suffering to access services at private hospitals and clinics.

Other challenges experienced by adolescents include travelling costs, limited transport and distant health facilities (such as the mountainous terrain inaccessible by public transport) across the country (Binu et al., 2018). In addition, working hours have also been a concern. The health facilities open at 8.00 am or as late as 9.00 am, and close around 4.30pm, at which time adolescents have already left for school, or are on the way from school. This has

impacted negatively on the lives of adolescents in Lesotho, most of whom cannot access services during the week.

Moreover, adolescents' access to SRH information and communication is limited because of the cultural belief that discussing sex and sexuality leads to increased premarital sex or encourages promiscuity (Denno et al.(2015). Similarly, healthcare providers arbitrarily apply their own standards to determine when adolescents are old enough to access SRH services which limits their access to SRH information and services. The services and interventions should be implemented expeditiously, given that the rate of maternal mortality in Lesotho is increasing, reported to be the highest in the SADC region, with approximately 543 deaths per 100,000 live births in 2017 (the most recent and available year) (World Bank, 2022). An increase in the death rate was 419 deaths per 100, 000 live births and 762 per 100,000 in 2000 and 2004 respectively (DHS, 2014; Thongmixay et al., 2019).

The tremendous increase in teenage pregnancy has been aggravated by incidents of rape or incest (Crawford-Jakubiak, Alderman & Leventhal, 2017). In addition, 8% of adolescent Lesotho girls (aged 15-19) have engaged in sexual activity with older men. Studies have observed women or girls as silent about such male-dominated malfeasance in terms of which older men engage in (un)safe sex with adolescents. At the same time, only 10.7% of the adolescents have ever tested for HIV/AIDS amongst those having experienced sexual intercourse (Artz et al., 2016). This implies a high number of adolescents with unknown HIV status, resulting in a delayed target of reaching the 90 90 90 UNAIDS goal of 90% of people tested for HIV. Accordingly, 90% of those testing HIV positive should be on Highly Active Antiretroviral Treatment (HAART) (UNAIDS, 2021). According to the Lesotho Times (2015), rape was one of the traumatic incidents reported, with 90% of prison inmates being incarcerated as rape convicts (The Post, 3 May 2019). Also observed is that rape has been considered a private matter amongst Basotho, usually with victims being urged to be silent, or that they would be killed by the perpetrator. In addition, the rape problem has cut across both males and females. Research has reported males, regardless of their age, as 'resiliently' shying away from reporting rape, as a result there are few statistics (stats) on rape cases involving male victims.

2.4.2.1 Male Medical Circumcision (MMC) and Voluntary Male Medical Circumcision (VMMC)

According to research by Gilbertson, Ongili and Ondongo (2019), male medical circumcision (MMC) has the potential to reduce HIV infection from HIV positive females to HIV negative males by over 60%. Based on existing evidence, Lesotho has implemented the VMMC project as part of the HIV prevention strategy against the country's tradition of circumcising boys to mark their passage into manhood (Gilbertson et al., 2019). However, it is known that traditional circumcisions do not necessarily fulfil the mandatory standards of a complete removal of the foreskin, which heightens at the initiates' risk of acquiring HIV infection. Despite this, significant progress has been made. Lesotho's prevention strategy includes a target to circumcise 80% of all men aged 15-49 by 2020 (UNIAIDS, 2020).

Voluntary male medical circumcision (VMMC) is also a key strategy for primary prevention of HIV infection in Lesotho (Kapumba & King, 2019). Voluntary male medical circumcision itself is the removal of the male foreskin. In combination with other HIV-risk reduction interventions in regions or countries with increased HIV epidemic and low-prevalence of circumcision, VMMC can be offered to male teenagers and men (Kapumba & King, 2019). The President's Emergency Plan for AIDS Relief (PEPFAR) based in Lesotho, has been working with the Lesotho government to scale up VMMC coverage to 80% amongst males in the 15 to 29 years age cohort in Lesotho's five districts with the highest unmet need for circumcision and HIV disease burden (UNAIDS, 2016).

At the time of conducting the study, the programme targets adolescent boys and men aged 15-39 years. The percentage of men aged 15-59 years that were medically circumcised increased from 17.7% to 28% in 2009 and 2014 respectively (DHS, 2014). Based on the current trends, the country is unlikely to achieve the intended goal of more than 317,000 voluntary medical circumcisions because of poor progress. An HIV test provides an entry point to conduct VMMC. For this reason, the WHO (2019) has recommended that all people undertaking VMMC should first know their HIV status in order to assist in the provision of proper treatment and care.

2.4.3 The Legal Context/ Domain of SRH/HIV Healthcare Service Provision

This section synoptically reviews the legal and policy contexts pertaining to SRH and HIV in Lesotho, particularly as they apply to the research topic. The researcher draws attention to the fact that the relevant (international and local) legal prescripts and policy documents are

synoptically referred to in the context of the subject matter under investigation, rather than in an exegetic jurisprudential perspective. Also of note is the fact that both legal prescripts and policies are outlined chronologicalyy - rather than separately - in order to allocate a degree of seamlessness between legal processes and policies as complementary.

2.4.3.1 Alma Mata Declaration

Lesotho is a signatory to international conventions, treaties, and declarations. As such, the country was committed and mandated to provide progress reports on Sustainable Development Goals (SDGs) targets (WHO, 2015). Based on the performance indicators, Lesotho has failed to achieve reduction of the core indicators, including child mortality, maternal health, and combating AIDS and tuberculosis (WHO, 2015).

Following the 1978 Alma Ata Declaration and the Ouagadougou Declaration, the Government of Lesotho attempted to provide affordable quality care services to all Basotho (GoL, 2012). Therefore, there was a need to improve and strengthen health systems (Rifkin, 2018). As stipulated in the Constitution of Lesotho, all Basotho shall have equal access to essential quality services. More focus shall be on resource distribution. Through decentralisation, services were made available to all people Lesotho. Special attention shall be to the hard to reach and underserved communities in the country, considering special socio-cultural environments. As such, the important health package shall be free or highly subsidised (GoL, 2012).

2.4.3.2 Amalgamation of Applicable Legal Prescripts and Policy Frameworks in Lesotho

Table 2.3 (overleaf) is an encapsulation of the most relevant legal prescripts and policy imperatives in respect of the current study and its objectives. It is the well-considered view of the researcher that, the tabular presentation has enabled the elimination of excessive detailing of information that is either secondary or peripheral to the particular policies themselves.

Table 2.3: The Lesotho legal and policy frameworks concerning SRH and HIV

Main Stakeholders, Legal Prescripts, and Policies	Main Function/ Purpose/ Activity
Gender and Development Policy, **2003**	Ensures equality of all opportunities among women, men, girls and boys so that development efforts have an equal impact on all gender. The policy commits the government of Lesotho to ensuring the provision of accessible and affordable SRH care, including FP information and services, maternal and obstetric care and prevention of STIs/HIV/AIDS, and addressing gender-based violence.
National AIDS Commission (NAC), established in **2005** in the Office of the Prime Minister by an Act of Parliament of the Government of Lesotho	Coordinating body responsible for the development and coordination of national policies, strategies and programmes for combating HIV and AIDS
Ministry of Health and Social Welfare (MOHSW)	Provides the medical response to HIV/AIDS, specifically implementing interventions through the healthcare system in Lesotho; The MOHSW plans for, rehabilitates and maintains CHAL health facilities
Christian Health Association of Lesotho (CHAL)	the biggest non-state provider of healthcare services, accounting for 38% of healthcare facilities countrywide (MOHSW 2011a). CHAL has a Memorandum of Understanding with the MOHSW to provide healthcare services and as such the government reimburses its expenditures.
Lesotho HIV and AIDS Policy, 2006 and National HIV and AIDS Strategic Plan, **2006-2011**	Both lay out the country's multi-sectoral approach to fighting HIV/AIDS and commit to mainstreaming HIV into all government sectors. Both commit to various aspects of SRH and HIV linkages approach including PMTCT of HIV; management
Lesotho National Adolescent Health Policy, **2006**	The policy commits to adopting a 'multi-sectoral, multi-disciplinary and holistic approach' in addressing adolescent health issues. Also promote responsible behaviour among adolescents regarding contraception, safe sex and prevention of STIs, HIV and AIDS, address domestic and sexual violence.
Lesotho National Reproductive Health Policy, **2008**	Explicitly commits to ensuring the integration of HIV/AIDS into SRH. The policy's SRH essential package to be offered at all levels of the healthcare system
The National Reproductive Health Policy of 2009 recognises	the individual's fundamental human right to choose on how many children a person wants and guarantees access to quality services (FP). Furthermore, this policy recognises positive health and socioeconomic impact of family planning on improved quality of life of individuals and couples (GoL, 2017).
Health Sector Policy on Comprehensive HIV Prevention, **2010**	Developed by the MOHSW, aims to integrate HIV prevention activities into all activities of the Lesotho healthcare system. The policy commits to linking and integrating of HIV/AIDS with poverty education strategies including a broader focus on SRH, comprehensive and appropriate sexual education for young people, life skills, school-

Main Stakeholders, Legal Prescripts, and Policies	Main Function/ Purpose/ Activity
	based education and linkages with existing programmes in all sectors. To implement the policy
Lesotho Health Policy, **2011**	In 2011, the Government of Lesotho developed the health policy for the singular purpose of guiding the execution of interventions in the health sector
Adolescent Health-Quality Standards, 2**012**	Having acquired funding and support from the WHO, UNFPA and UNICEF respectively, the Government of Lesotho embarked on developing the minimum Quality Standards for adolescents' friendly Health Services (GoL, 2017). The national quality standards for adolescents' friendly health services in Lesotho is informed by the findings of the situational analysis conducted in 2012. The aim of developing these standards was to ensure the maximum and quality provision of health services for adolescents in Lesotho. The document was designed to guide the Ministry of Health and its partners on ensuring quality standards for adolescent-friendly health services in Lesotho.
National HIV and ART Guidelines, 2016	In 2016, the government of Lesotho introduced new guidelines to be integrated in continuum of care for patients living with HIV and AIDS. These guidelines are focused on HIV prevention, diagnosis, linkage, treatment and retention to care. Special attention has been given to precise matters concerning adults, adolescents, pregnant women and children. The procedures are linked to the following HIV-related official papers and HIV testing services: prevention of mother-to-child transmission of HIV; home-based care; nutrition and HIV; male medical circumcision; TB; behaviour-change communication strategies; infection prevention and control; HIV post-exposure prophylaxis; programme monitoring and evaluation; and sexually transmitted infections guidelines. The national ART Guidelines were updated on the need to offer patients living with HIV (PLWH) the best care to reduce prevalence of death and HIV related sickness.

Extrapolated from Table 2.3 is the fact that the cited healthcare legal prescripts and policy frameworks demonstrate a continuum and linkage process in terms of which an attempt was continuously made to prevent a dislocated healthcare system. Also, a people-centred approach is evident, rather than a bureaucratically steeped orientation that ultimately reflects more of policy rhetoric than focused implementation (GoL, 2017).

Table 2.4 below encapsulates the various service standards, their levels, and core focus areas (attributes/ characteristics). These services provided were based on eight quality standards proposed for making primary health-care institutions friendly to adolescents in terms of minimum quality of standards.

Table 2.4: Standards level and their attributes/ characteristics

Standard and Level	Attributes/ Characteristics
Standard 1	Adolescent and young people have right to access existing friendly services including those who request an abortion; those with physical and mental retardation; minority groups including minority groups and adolescents.
Standard 2	Adolescents have access to information and services during convenient hours despite their financial constraints - unable to pay consultation fees.
Standard 3	They should accept the health services provided to adolescents due to constant friendly attitudes of health care providers, reasonable waiting time, confidentiality and privacy.
Standard 4	The provision of relevant services is rendered to adolescents by trained and skilled health professionals with comprehensive knowledge on sexual and reproductive health comprising issues of sexuality, prevention, treatment and care of STIs, mental health domestic and sexual violence.
Standard 5	The provision of appropriate medication by trained personnel. Essential equipment at the service delivery point should be available during service provision for efficient delivery of friendly services.
Standard 6	The service provided to adolescents should be acknowledged and supported by parents and community members include churches and schools, with adolescent having to be knowledgeable about services offered to them in and outside the facility.
Standard 7	Active involvement of adolescents in a project planning, execution, monitoring and evaluation of services rendered to them.
Standard 8	Quality assurance mechanisms, financial support and provision of services to adolescents.

The main strategy to expand the quality and coverage of adolescents - friendly services, include scaled up of services to schools setting, health posts and mobile clinics (UNFPA, 2016a). Through integrated and scaled-up services and/or interventions, outside the hospital, adolescents would be able to acquire necessary knowledge and skills to improve their self-efficacy and behavioural changes. As such, reducing unplanned pregnancies,

sexually transmitted infections and HIV amongst adolescents has been integrated into SRH. On that basis, the provision, management and care of HIV/AIDS and related illness are premised on the HIV and AIDS policy and guidelines developed by the Government of Lesotho.

2.4.4 National Guidelines for Prevention of Mother to Child Transmission (PMTCT)

The recent evidence reveals HIV can be transmitted to a child during pregnancy, delivery and breastfeeding and account to 90% (UNAIDS, 2017). The literature show that most children infected with HIV die before the reach five years. However, with the introduction of PMTCT strategy, aimed at mitigating the pandemic amongst children and their mothers in the mid-1990s, the situation has dramatically changed. For example, the PMTCT approach has not only undergone successive modification (McDougal, Moteetee et al., 2012), but it has also effectively eliminated vertical transmission. Lesotho, through the MoH, has is committed to provide integrated quality PMTCT services.

The implementation of PMTCT programmes in Lesotho involved the establishment of essential linkages to other support programmes. The study by McDougal et al. (2012) reported that the PMTCT strategy involves the administration of co-package: antiretroviral medications (ARV). PMTCT strategy is highly cost-effective and has been proven to be effective in elimination of vertical transmission. In addition, the government launched PMTCT programme in 2003, later decentralised services to the clinics countrywide. Previously, out of 200 facilities, 191 offered PMTCT services while 61 facilities offer paediatric AIDS care service to all children living with HIV.

The new guidelines guarantee the provision of ART to all people tested positive, including pregnant mothers. The same-day initiation was adopted, and dubbed ‘test and treat’ (GoL, 2016). DNA PCR testing for infants born from HIV mothers was introduced in order to monitor children’s HIV status. Mother-baby packs were introduced in 2011 to provide treatment for pregnant mothers and unborn children. People were enrolled in treatment with CD4 count cells of 200. Recommendations by WHO were made and eligibility to initiation increased from 350 -500 CD4, respectively.

2.4.4.1 Family Planning Guidelines

Expanding accessibility to family planning services to adolescents is considered significant in the continuum of care, necessitating political and financial commitment from governments

and civil society organisations. These would mainly develop policies and any other interventions to reach the most vulnerable groups attending school and those not attending school (UNFPA, 2016b). Family planning services including contraceptives are significant basics to international FP guidelines. The global FP initiative focused on providing approximately 120 million women and girls with FP commodities. Barden-O'Fallon (2017) suggested that healthcare institutions should provide wide ranges of contraceptive methods to enable women's postponement of pregnancy, allow the spacing between pregnancies, or avoid pregnancy altogether.

Couples can choose from a range of contraceptives and the decision to use and to select a particular method is influenced by the level of awareness of family planning methods, places where they can easily access them (Amo-Adjei, Mutua, Mukiira, & Mutombo 2019).

2.4.4.2 General Guiding Principles in the Provision of Family Planning

- Service providers should be familiar with the quality of a care checklist, specifically FP component.
- Family planning commodities should always be available at the facility to facilitate continuous care.
- Human and reproductive health rights for every client seeking FP services should be promoted.
- Health care providers should respect clients and avoid being judgemental to them.
- Confidentiality should be maintained all the times.
- Availability of family planning services to targeted population including adolescents.
- Family planning services should be made available to those who need them, including adolescents, men, people with special needs and disabled people. Any person requesting family planning should not be sent back without a suitable method.
- Family planning should be served as core package, including other health services.

2.4.5 The SRH/ HIV Linkage Project

The initial SRH and HIV nkage project was introduced in 2011 at 10 hospitals. The Butha–Buthe Government Hospital was amongst the selected pilot hospital sites for the purpose of carrying out the project. The motivation for the project, amongst others, was to address the challenges facing adolescents considered common in Sub-Saharan African countries. In Lesotho, sexual and reproductive health situation is as diverse as in any other country in the Southern African Development Communities region (UNFPA, 2016b; UNAIDS, 2019).

Through the SRH and Linkage project, the Ministry of Health and Social Welfare advocates holistic and efficient adolescent-friendly health-care service delivery, which includes access to proper information, antenatal and post-natal care, HIV testing, cervical cancer screening, VMMC and general consultations (GoL, 2014). It is against this backdrop that this research set out to evaluate the SRH and HIV linkage project that has been implemented to improve the lives of adolescents.

2.4.5.1 Evaluation/ Critique of the SRH and HIV Linkage Project

Given the above synoptic overview, an objective evaluation of the project focuses primarily on determining the extent to which the services offered could address the health needs of adolescents. It is worth noting that project evaluation is not necessarily a rigidly constructed process (Landau, 2022). Accordingly, the objectives of the study would serve as one of the mechanisms to conduct such an evaluation, which is already the subject of discussion in both Chapters 4 and 5.

Landau (2022) advises further that any project could be evaluated according to the criteria of its goals, processes, impact, and outcomes. On the other hand, the African Institute for Development Policy (AFIDEP, 2011) informs that the policy perspective is most suited to evaluating the efficacy or otherwise of most projects. From a policy perspective, therefore, researcher upholds that the overall findings in Chapter 5 provide a more evaluative framework and context for the Lesotho SRH and HIV Linkage Project

2.6 CONCLUSION

This chapter provided the theoretical framework supporting this study as derived from various literature sources and scholarship perspectives. Most importantly, the chapter presented both the macrocosmic and microcosmic perspectives regarding sexual and reproductive healthcare services for adolescents in various contexts or settings. Problems engulfing adolescents were perennially discussed as well. The literature review also incorporated sexual and reproductive health policies and guidelines. Strategies to improve health outcomes, provision of friendly adolescent health services and government interventions have also been examined. The next chapter discusses the research design and methodology adopted in the study.

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The preceding chapter largely premised on the reviewed literature pertinent to adolescent-friendly healthcare service delivery in both its generalistic (macrocosmic) and microcosmic (specific to Lesotho) contexts. It is irrefutable that the reviewed literature was critically antecedental to the theoretical framework in which the Theory of Access to Care (TAC) was deemed relevant in this study. The latter is logical, given that the theoretical framework did not emerge from a vacuum, but was a product of the reviewed literature itself (Matua & Van Der Wal, 2015; Mouton, 2014) To this effect, Efron and Ravid (2019) and Yin (2018) augment that the issue of methodology is the subject of theoretical framework in that, the latter also influences the development of an approach that is relevant to the generation of the intended results.

The current chapter, meanwhile, is fundamentally premised on the research design and attendant methodology. In this regard, the chapter details both the conceptual and practical (actual) processes and methods adopted and applied in order to direct the study's resolution of the research problem; achieving its aim and objectives; responding effectively to the research questions; as well as framing and actualisation of the data collection and analysis processes (Babbie, 2018; Leedy & Ormrod, 2019). Moreover, the current chapter presents the sampling framework (to advance the participant-centric component of the study); trustworthiness (for quality assurance, authentication and validation of the findings and their reliability); as well as the applicable ethical issues (for compliance with upholding the integrity of both the participants and the research process entirely). All these research design and methodological aspects were presaged variously in Chapter1 of this study, but are elaborated in further details in the present chapter.

3.2 RESEARCH DESIGN

The research design refers to the general plan adopted and utilised by the researcher to manage the different components (i.e., processes, procedures, strategies, and techniques) of the study into coherent, symmetrical, and logical units; all of which effectively address the identified research problem, as well as the study aim, objectives and questions (De Vaus, 2018; Nowell et al., 2017). According to Ames, Glenton and Lewin (2019) and Bless, Higson-Smith and Sithole (2015), the research design also provides a framework or context to enable the researcher's exploration, description, analysis, explanation, and evaluation of pertinent

literature; as well as the construction and development of specific tools for acquiring and analysing the data collected as informed by the researcher's preferred research paradigm.

The research paradigm relates specifically to the particular worldview or perspective adopted by the researcher as informed by some philosophical principles, belief system, or assumptions concerning reality (Bess et al., 2015). Positivism, constructivism, and pragmatism are three of the most commonly used paradigms in research (Denscombe, 2014). Positivism, which is largely a research paradigm or perspective suited for quantitative research studies, is situated within the worldview of objectivity as the primary standard for understanding the nature of reality. The proponents of positivism credit it largely on account of its capacity to posit researchers as neutral or objective, because they cannot influence their participants' views and the resultant findings of the study. Meanwhile, pragmatism is suited for both quantitative and qualitative approaches merged as the single outcome of a single study (Braun et al., 2019). The proponents of such a research paradigm credit it for its capacity to maximise or triangulate the findings of a study, which emanates from understanding of nature, knowledge, reality, and phenomena from multiple perspectives.

Constructivism on the other hand (also associated with phenomenological, grounded theory, ecological, interpretivist, or ethnographic studies), is wholly and fundamentally focused on a participant-centred view of the world, phenomena, and reality (Polit & Beck, 2017; Rajasekar et al., 2021). From a constructivist perspective, the participants are viewed as interpreters of their own reality which they have experienced directly in their own surroundings. Thus, they are attached spiritually, emotionally and psychologically to the very environment and its ecological surroundings within which they have lived and shared their experiences. In the context of the present study, the constructivist research perspective or paradigm is deemed to be most relevant, given the qualitative research approach that has been adopted in view of the data being obtained from the selected number of both healthcare workers and adolescents from whom the pertinent findings were drawn.

3.2.1 The Qualitative Research Approach

The current research study has adopted and employed a qualitative research design approach, complemented by exploratory, descriptive and analytic elements for maximisation of the findings (Maguire & Delahunt, 2017). Such an approach is premised on the notion of social enquiry that explores, describes, and analyses the way people understand and make

conceptualise the world they live in; that is, their naturalistic or ecological surroundings. Among some of its notable attributes, the adopted qualitative research design approach focuses on the unquantifiable or non-numerical orientation of the data obtained (through the semi-structured interviews in the case of this study) in a cost-effective manner (Walliman, 2016; Yin, 2018). In addition, the qualitative research approach and its inductively-oriented reasoning is characterised by its contribution towards the enhancement or development of particular aspects of theories, rather than testing those theoretic aspects, because data saturation – rather than sample size – is relied on for accuracy and quality of information required by the researcher (Walliman, 2016).

Notwithstanding its positive attributes, the qualitative research approach is viewed as reinforcing both researcher bias and insider subjectivity (Burrel, 2017). Such a view emanates from the researcher's on-site involvement and direct dialogue with participants, while participants respond to questions about a situation to which they are strongly attached, based on their experiences (Clark, Foster & Bryman, 2018). According to Clark et al. (2018), the qualitative approach is also time-consuming due to the amount of planning and processes involved prior to establishing the ultimate findings. Furthermore, the non-statistical attribute in such studies is viewed as presenting a significant degree of observation rather than fact-finding, and provide themes and general trends rather than replicable/ repeatable (Atmowardoyo, 2018; Burrel, 2017).

3.3 SAMPLING CONTEXT OF THE STUDY

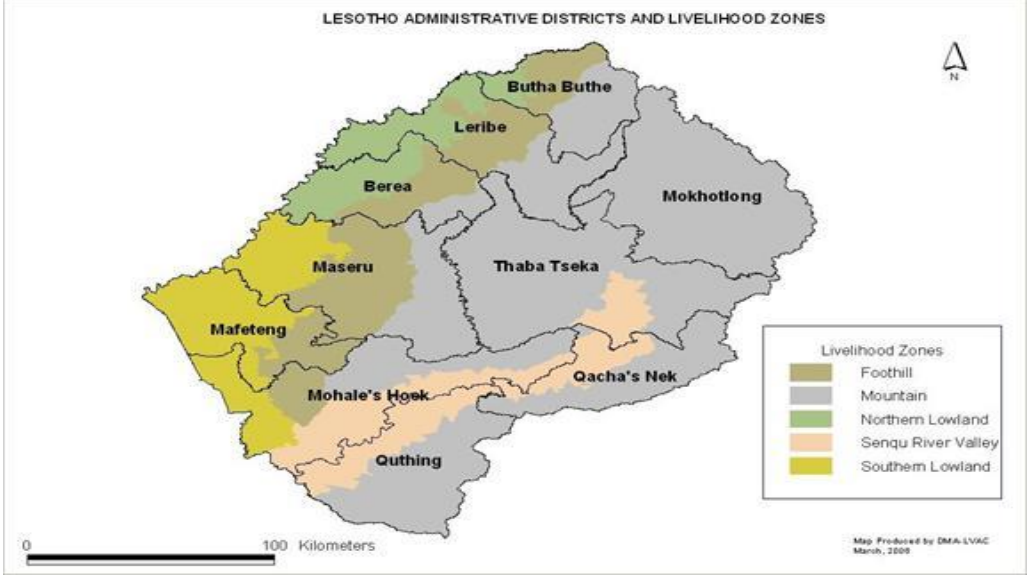
Sampling is basically the selection of a section of a larger population for representation in a study on account of certain criteria, traits or qualities that are deemed helpful in relation to the problem being investigated (Cho, 2018; Yin, 2018). Evidently, people (objects or units) are physically situated or located at a particular geographic setting when selected for participation in a study. Therefore, the sampling context in this section encompasses the study setting, study population and sample size; sampling strategy, and the sampling criteria.

3.3.1 The Study Setting

The study setting is the actual site or geographic location at which the study was undertaken by the researcher (Denscombe, 2014). Amongst other considerations, the identification and specification of the study setting is useful for a determination of the feasibility of the study and availability of suitable participants, given that a variety of demographic factors and logistical arrangements could pose research-related challenge in some instances (Creswell

& Creswell, 2018). The present research study was undertaken at the Butha-Bothe Government Hospital in the district of Butha-Buthe, Lesotho, a small land-locked and mountainous country bordered by the Republic of South Africa (RSA) on all sides. Lesotho is a democratic sovereign State formerly known as a British colony of Basutoland, which was renamed after its independence on the 4th October, 1966. The country, with a total land mass of 30,355 square kilometres, is demarcated into four ecological zones (the Lowlands, Foothills, Mountains, and the Senqu River Valley) and ten administrative districts as depicted in Figure 3.1 below (GoL, 2012).

Figure 3.1: Map of Lesotho and its administrative districts and livelihood zones



Source: Government of Lesotho, 2018:1

From Table 3.1 above, it is clear that Butha-Buthe district encompasses the Foothill, Mountain, and Northern Lowland livelihood zones. On the other hand, Table 3.1 below depicts the population of Butha-Buthe, which is clearly distinct from the actual population of the study participants.

Table 3.1: The Butha-Buthe population

Description	Total Number
Total population (Lesotho)	2.26 0000
Total population (Butha-Buthe)	118242
Live birth	2256
Surviving	2290
≤5 years	11896
≤ 15 years	38473
Childbearing age women	30039

Source: Government of Lesotho, 2018:1

The context of the study is as important as the study population itself (Creswell & Creswell, 2018). This implies that for this study to succeed, it ought to be undertaken in a setting that allows the researcher to gather rich and relevant data. The BBGH is the main healthcare facility in the Butha-Buthe district, and serves a total population of 118242; , comprising 5, 122 males and 5, 863 females at the time of conducting this study. Children under the age of 15 were estimated at 4, 170 and those under the age of five (5) were 1,482 (GoL, 2018).

The Butha-Bothe Government Hospital is situated within Butha-Buthe (BB) town, and is about two (2) kilometres from the Central Village Walk Mall. The BBGH has been mandated to provide adequate and holistic health services to the diverse population within the catchment areas. These include SRH; family planning; all outpatient's department services (OPD) and consultations; HIV testing services (HTS); initiating all HIV positive patients on highly active antiretroviral therapy (HAART); and the provision of monthly ART refills for patients. Other services include the mother and neonatal children's health services (MNCH); antenatal care (ANC); and post-natal care (PNC) for pregnant and lactating women; as well as clinics for children under the age of five years.

The above services are offered to diverse populations residing in the BBGH catchment areas in the entire Butha-Buthe district, which is one of the 10 pilot facilities at which the SRH and HIV linkage project was implementation in 2011. It is largely for this reason that the BBGH was deemed suitable for conducting the present study. The rationale for the choice of the research site was also motivated by the practicality of cost and logistical considerations (Ferraro, 2015). At the time of undertaking the study, the researcher was already working in the Butha-Buthe district. As such, it was convenient for the researcher because travel costs were minimal, and the chosen participants were also immediately available within proximity of the research site; that is, the areas around the Butha-Bothe Government Hospital.

It is important to note that the outcomes of the current study are not necessarily intended for generalisation, given that the study was undertaken at only one (1) of the ten (10) hospitals where the initial SRH and HIV linkage project for adolescent-friendly healthcare services was launched and implemented in 2011. However, the study's recommendations will be inclusive of the other nine (9) healthcare institutions, considering that recommendations are generally intended for improving health service delivery, especially among those hospitals experiencing similar problems identified in the BBGH context. The nine facilities are: Leribe, Berea, Mokhotlong, Maseru, Mafeteng, Mohale's Hoek, Quthing, Maluti, and Qacha's Nek.

3.3.2 The Study Population and Sample Size

The choice of the study population was very crucial for this research study. In essence, the study population refers to the larger group or universe from which a sample is drawn (Etikan & Bala, 2017). In research, it is often not possible to include all prospective and/ or interested participants in the study due to, amongst other factors, the logistical, financial, and practicality considerations for involving huge numbers of participants. To a larger extent, the study population is also a reference point from which the required main attributes, traits, or qualities of the participants are determined (Bless et al., 2015). Thus, the study population possesses the homogenous traits from which the smaller sampled group is derived. The study population consisted of two stakeholder categories, namely: all adolescents and all healthcare professionals (nurses) from the broader community of people residing and working in the catchment of the BBGH with a focus on adolescents.

3.3.2.1 Sample size

Since it was virtually impossible to interview every adolescent and healthcare worker in the BBGH catchment area for representation in the study, a total sample size of 26 participants were eventually chosen for their involvement in the study's semi-structured interviews, comprising 21 adolescents and five (5) healthcare professionals. It is in this regard that the sample size is referred to as the actual number of participants who were selected for their involvement in the study on account of the homogeneity of traits or qualities they possess in relation to the study population (Ames et al., 2019; Gray, 2014).

Most importantly, the sample size was also influenced by data saturation, which does not allocate precedence to statistical or numerical representation of the participants, but to the

point (of the interviews) at which no further data is required (Ary, Cheser, Sorensen & Walker, 2019; Haven & Van Grootel, 2019).

3.3.3 Sampling Strategy/ Technique

A sampling strategy/ technique involves the particular method utilised by the researcher in choosing eligible or 'qualifying' participants for involvement in the empirical (i.e., interview) phase of the study (Ary et al., 2019; Haven & Van Grootel, 2019). Sampling strategies are mainly located in either the non-probability or probability sampling types. The current study's participants were chosen according to the non-probability purposive/ judgement sampling strategy. The non-probability sampling strategy premises on the view that the chance or opportunity for the selection of a participant in a study is uncertain and could not be guaranteed or pre-determined prior to the undertaking of the study. Examples in this regard include: the purposive/ judgement, convenience/ availability, quota, cluster, and the snowball sampling strategy (Creswell & Creswell, 2018). On the whole, non-probability sampling strategies are credited for their capacity to obviate bias and preferential treatment on the part of the researcher because he/ she would not find it possible to know *which* participants would eventually be in the study until its commencement.

Meanwhile, the probability sampling strategy is based on the view that the chances for participants' involvement or selection in the study are certain, probable, or guaranteed (Hawkins, 2018; Matua & Van Der Wal, 2015). Examples of probability sampling are: the simple random, multi-usage, interval/ systematic, and stratified random sampling. Unlike its non-probability variant, the probability sampling strategy is viewed by many research professionals as inimical to the purpose of research since it allows for the researcher to establish with certainty, *who* the participants will be ahead of the study's actual commencement (Hawkins, 2018; Matua & Van Der Wal, 2015).

In tandem with the fundamental prescript of the non-probability sampling strategy, the researcher applied her own judgement and knowledge of the research environment (i.e., the BBGH catchment area in the Butha-Buthe district) in purposively selecting the participants, coupled with the fact that she was already working in the same area at the time of undertaking the study. To the advantage of the researcher, the non-probability sampling strategy enable the researcher to include those participants with the most desired attributes, which further enhanced the acquisition of both rich and insightful data and not just representations concerning the phenomena under investigation as articulated in Section 1.3

of Chapter 1. According to Ames et al. (2019) and Amu and Nyarko (2019), the non-probability purposive sampling technique further ensures that the chosen research participants were sufficiently knowledgeable for the attainment and generation of specific research-related themes on the basis of the relevant information at their disposal.

3.3.4 Sampling Criteria

Sampling criteria relates to the range of pre-determined participant attributes or considerations deemed by the researcher to be relevant in addressing particular aspects of the study; such as the research problem, research aim, and the research objectives (Grove, 2021). According to Leedy and Ormrod (2019) and Rees (2016), the homogeneity and heterogeneity factors constitute the foremost considerations guiding the researcher's decision concerning the prospective participants' involvement in the study. Homogeneity pertains to the similarity of characteristics or attributes of the selected participants when compared to those of the study population from which they were chosen. In contrast, heterogeneity relates to the dissimilarity of traits between the prospective or likely participants and the larger study population

3.3.4.1 The inclusion/ eligibility criteria

As alluded earlier, the inclusion criteria relate to those (homogenous) qualities of the participants that render them qualified for involvement in the study (Grove, 2021; Nowell et al., 2017). Thus, the researcher applied the following criteria for the inclusion of the ***adolescent*** participants in this study:

- adolescents who either participated in the initial SRH and HIV linkage project for adolescent healthcare service delivery, and familiar with, or knowledgeable about it;
- both male and female adolescents between the ages of18-19 years living in the Butha-Bothe Government Hospital catchment areas and receiving health services at the same hospital; and
- be either in or out of school adolescents, willing to participate, and knowledgeable about the information required by the researcher.

The researcher applied the following criteria for the inclusion of the ***healthcare professionals (nurses)*** in this study:

- both male and female primary healthcare nurses who have worked at BBGH for more than two years;

- nurses who either participated in the initial SRH and HIV linkage project for adolescent-friendly healthcare service delivery, or are knowledgeable in SRH, HIV, and/ or social work; and
- nurses who have referred adolescents for further professional assistance outside of BBGH.

The researcher draws attention to the fact that any adolescent or nurse participant who did not fulfil all of the afore-cited criteria was not considered for any involvement in this study, a viewpoint which is also supported by Leedy and Ormrod (2019) and Rees (2016).

3.3.4.2 The exclusion/ ineligibility criteria

As opposed to the inclusion criteria, the exclusion/ ineligibility criteria relate to those heterogenous or inapplicable qualities that render any prospective participant 'disqualified' from any involvement in the study (Hennink, Hutter & Bailey, 2020; Rees, 2016). Accordingly, the following exclusion criteria were applied in this research study in relation to the adolescents:

- both female and male adolescents living outside of the Butha-Bothe Government Hospital catchment areas;
- adolescents who did not participate in the initial SRH and HIV linkage project for adolescent healthcare service delivery, and unfamiliar with, or not knowledgeable about it;
- adolescents younger than 18 years or older than 19 years in chronological age; and
- adolescents who did not access health services at Butha-Bothe Government Hospital and unwilling to take part in the study.

The following criteria were applied for the exclusion of the healthcare professionals (nurses) in this study:

- both male and female primary healthcare nurses who have worked at BBGH for less than two years;
- nurses who are not knowledgeable in SRH, HIV, and/ or social work;
- nurses who did not participate in the initial SRH and HIV linkage project for adolescent healthcare service delivery,
- nurses who are not conversant with, and knowledgeable about the Lesotho SRH and HIV linkage project; and

- nurses who have not referred adolescents for further professional assistance outside of BBGH.

The researcher reiterates that any healthcare professional (nurse participant) who did not fulfil all of the afore-cited criteria was not considered for any involvement in this study, a viewpoint which is also supported by Leedy and Ormrod (2019) and Rees (2016).

3.4 DATA COLLECTION

Data collection is essentially a systematically undertaken process by the researcher for the gathering of both primary and secondary information sources viewed as pertinent to the resolution of the problem under investigation, reaching the aim and objectives of the study; while also answering the research questions (Duffy, Pierson & Best, 2019). Moreover, the data collection process ensures that specific and relevant types of data gathering instruments are chosen for implementation by the researcher (Duffy et al., 2019).

Primary data (which is preceded by secondary data) refers to information that has been sourced or obtained from the sampled human participants for the primary purpose of generating an empirical base of the study in question (Atmowardoyo, 2018). The “primary” aspect in this form of data is induced by the logical fact that most (if not all) research is basically conducted to solve human problems directly or indirectly (Maguire et al., 2017). In addition, primary sources of data are not abstract in their nature, since human beings express their views through behavioural attributes such as feelings, perceptions, emotions, attitudes, and cognition (Babbie, 2018). The semi-structured in-depth interviews conducted in this study are an example of primary data collection tools.

On the other hand, secondary data (which logically precedes secondary data) is the type of information source which the researcher has obtained through other (secondary) means (Aguinis & Solarino, 2019). Such sources mostly conform to the literature review perspective, and include academic books, accredited scientific journals, published and unpublished theses or dissertations, peer-reviewed research papers at academic conferences, search engines, and databases; as well as legislative and policy framework documents or reports (Bless et al., 2015; Cho, 2018). According to Aguinis and Solarino (2019), these theoretically predisposed secondary sources of data also provide a form of formative evaluation for the researcher to judge the value and relevance of the information obtained prior to obtaining

secondary sources as evidence against which to either corroborate or refute the findings of a study.

In the current study, both secondary and primary data collection mechanisms were applied sequentially in the different phases of the research process. For example, relevant literature sources were consulted for obtaining secondary for the researcher's familiarisation with, amongst others, trends and practices in the field of SRH in adolescent contexts. Following the review of literature, the researcher embarked on the in-depth interviews for the primary (empirical/ practical) aspect of data collection. Also significant about in-depth interviews in qualitative research, is the extent to which participants' information could help to validate and enhance the findings of the study (Alpi & Evans, 2019; Patten & Newhart, 2018).

During these interview sessions with the sampled participants (nurses and adolescents), the researcher also conducted protracted observations to determine and evaluate the effects of the participants' non-verbal behaviour on the overall interview proceedings and subsequent study findings (Silverman, 2020). Fieldnotes were used to document these observations and to complement the participants' actual oral responses to the interview questions.

In addition, BBGH registers and records were consulted in order to determine the nature of healthcare services that were mostly utilised by adolescents visiting this particular healthcare facility. Since the semi-structured in-depth interviews constituted the more significant aspect of the collection of primary data (as compared to the protracted observations and fieldnotes), the next section (overleaf) discusses this critical data instrument in more detail. The review of registers was undertaken to confirm the actual numbers of adolescents who benefited from the BBGH adolescent services. The registers included the HIV testing and counselling, antenatal and post-natal care; as well as delivery and family planning registers. The information gained was triangulated with the data from the in-depth interviews.

It should also be noted that the interviews with both the adolescents and nurses only took place after the issuance of ethical clearance (approval) by both UNISA's Department of Health Studies (see Appendix A) and Lesotho's Ministry of Health and Social Welfare (see Appendix D).

3.4.1 The Semi-structured In-depth Interviews with the Adolescents

Interviews are basically the representation of the conversations or dialogues between the researcher and his/ her participants or interviewees (Labaree, 2019; Patten & Newhart,

2018). In addition, such conversations are fundamentally intended to generate information pertaining to a focused aspect of the subject being studied. Hence, the salience of selecting participants or interviewees who are adequately knowledgeable to enable the generation of specific thematic statements that cohere with the researcher's intended purpose for undertaking the study in the very first place (Alpi & Evans, 2019).

It is of critical importance to note that the in-depth interviews with both the adolescents and the nurses only commenced after the researcher's ethical clearance was approved and granted by both the UNISA Health Department's Research Ethics Committee and the Lesotho Ministry of Health and Social Welfare respectively (see Appendix A and Appendix B). Following the approval, the researcher then requested for, and was granted permission to conduct the study at the BBGH as the research site. Thus, each of the individual in-depth interviews with the 21 sampled adolescents were of 45-60 minutes' duration, and were held at pre-scheduled BBGH premises.

The researcher utilised an interview guide (see Appendix G) to ensure that all issues were addressed. Furthermore, the interview guide was translated into the native Sesotho language for those adolescents who were uncomfortable to respond in English. This guide was helpful insofar as focusing the discussion strictly on the subject matter under investigation. The questions were open-ended, and allowed the researcher the liberty to probe the interviewees to further clarify their responses (Labaree, 2019; Patten & Newhart, 2018). With the prior permission of the adolescents, the interview proceedings were audio-recorded to ensure that no information was lost or missed.

At the beginning of each interview session, the researcher greeted the interviewee and read both the participant information sheet and informed consent form, which was signed by both the participant and the researcher to indicate that all details and expected participation were mutually agreed to. The adolescent participants were also informed of their right to ask questions of their own during the interviews for clarification in the event that they were unsure of the researcher's question(s). They were also informed that they could withdraw from the study at any time in the event that they were uneasy with the researcher's conduct, which they could report to the University by calling the telephone numbers shown on both the participant information sheet and the informed consent form.

During each interview session, the researcher ensured also that the participants' verbatim responses yielded detailed 'thick descriptions', which displayed the adolescents' in-depth understanding, perspectives and experiences (Atmowardoyo, 2018; Labaree, 2019). For example, their understanding, expectations, and thoughts concerning the overall implementation of the SRH and HIV programme's processes and outcomes as implemented at the BBGH; as well as any possible changes they may have observed as a result of their participation in the programme. At the end of each interview session, the researched thanked each participant for their time and involvement, after which the data collected was prepared for transcription and consequent thematic analysis.

3.4.2 The Semi-structured In-depth Interviews with Healthcare Workers (Nurses)

The semi-structured interviews with the sampled 5 (five) healthcare workers (nurses) are entailed in the interview guide depicted as Annexure H. The selection of the five professional nurses (in accordance with the inclusion criteria in Sub-section 3.3.4) enabled them to make a major contribution to this study on account of their experiences, expertise and background knowledge on the issue under investigation (Aguinis & Solarino, 2019; Rubin & Babbie, 2017). The involvement of only five nurses was induced by factors such as time and other logistical realities.

To a large extent, most of the details in Sub-section 3.4.1 were also applicable for the nurses' in-depth interviews, each of which was of 45-60 minutes' duration. For practicality reasons, each of the nurses' interviews were held on different days and times from those of the adolescents at the same BBGH premises. However, the questions directed at the nurses were mostly focused on obtaining their understanding of their healthcare service delivery mandate; as well as to obtain their general perspectives concerning the SRH and HIV linkage programme.

3.5 DATA ANALYSIS

Data analysis is informed by the need to translate or convert ordinary information into data as the foundation for evidence-based knowledge (Braun et al., 2019; Rubin & Babbie, 2017). In fact, research scholars contend that information is tantamount to non-knowledge until it has been converted into usable data for specific knowledge fields or disciplines. It is in that particular context that data analysis is regarded as the organisation, synthesis, classification or coding of data collected into various categories accruing from the patterns or trends of its

emergence during the transcription process (Atmowardoyo, 2018; Braun et al., 2019). Furthermore, the analysis of data enables a structured (i.e., non-randomness) development of the study findings.

The data accruing from the audio-recorded semi-structured in-depth interviews were translated verbatim from the audio recordings native language to avoid altering the original meaning and then transcribed into an Excel sheet. The transcribed records were read several times. Codes were developed and were related to the objectives of the study (Herzog, Handke & Hitters, 2019; Silverman, 2020). This was undertaken in order to clarify the ideas, views and experiences of the study participants concerning existing healthcare service provision. The thematic data analysis method was applied in this study for both the adolescents' and healthcare professionals' interview-based information, in conjunction with the researcher's observation-based fieldnotes.

3.5.1 Thematic Analysis

Herzog et al. (20190 and Nowell et al. (2017) alert that the concept of thematic data analysis appears to be replete with some challenges, especially in the qualitatively inclined social sciences where it possibly addresses a functional framework of conducting a thematic analysis. However, the latter authors do acknowledge that in thematic analysis, themes are developed in tandem with the study objectives and integrate the themes accordingly in order to explore a particular issue pertinent to the investigation. These authors further add that the thematic data analysis process does not summarise the data, but interprets and makes sense of the data. According to Patten and Newhart (2018) and Roberts, Dowell and Nie (2019), using the research questions as main themes is disadvantageous because it shows that data was summarised and organised, rather than analysed.

Nowell et al. (2017) differentiates between semantic and latent themes. Semantic themes direct analysts to focus mostly on what a participant has said, whereas latent themes also focus on what has been written. Following the in-depth interviews, the researcher repeatedly listened to the audio-recorded interviews (raw data), after which they were transcribed in conjunction with the field notes in order to enable the researcher's familiarisation with the subsequent coding and categorisation phase during which the self-same data were translated into proper text units. Every hand-written word, phrase, or sentence was considered.

The transcripts were processed in Excel sheet for clarity and manageability. Both the semantic and latent thematic categories were applied, in terms of which common themes were composed and clustered in order to determine any commonality from the different viewpoints of the participants concerned. As such, major themes and sub-themes that frequently emerged were developed and summarised. The generated themes and sub-themes were grouped under different objectives in order to avoid losing focus and including irrelevant or superfluous information (Polit & Beck, 2017; Thomas, 2017).

Overall, the generated individual and clustered themes were ultimately linked to both the research problem and objectives of the study; that is, sexual reproductive health indicators and reasons affecting accessibility and utilisation (and non-utilisation) of SRH services.

3.6 TRUSTWORTHINESS MEASURES

Trustworthiness relates to the measure of, and the degree to which the entire study, its processes and outcomes/ findings project the quality assurance mechanisms and scientific rigour in the view of the research community and the general reading public (Polit & Beck, 2017; Roberts et al., 2019). In addition, it is on the basis of the overall management and scientific rigour of the study that the quality of its findings could be rendered as valid and legitimate contributors to the field of study under investigation. Qualitatively-inclined research studies, the most commonly used trustworthiness measures or criteria are: credibility, transferability, dependability, and confirmability (Nowell et al., 2017).

3.6.1 Credibility

Credibility (known as internal validity in quantitative research studies) depicts the extent which the findings are viewed as believable insofar as they accurately represent the phenomenon the research is measuring. (Marshall & Rossman, 2016; Polit & Beck, 2017). According to Leedy and Ormrod (2019), the credibility criterion necessitates that the research participants' post-data collection viewpoints should serve as the ultimate standard according to which the expected modicum of believability should be established.

Accordingly, credibility was ensured in the study by means of prolonged engagements and member checking, both of which feedback mechanisms through which the researcher engages with participants over an extended period of time beyond the ordinary in-depth interview sessions in order to understand their worldviews; as well as checking or confirming with the participants that their experiences and perceptions were captured and interpreted

correctly during the in-depth interviews (Mouton, 2014; Walliman, 2016). In that regard, the researcher followed- up with the participants for their corroboration of any other aspects of the data. From the researcher's viewpoint, member checking was also essential for obviating any future disputes by the participants concerning any perceived or real misrepresentation of their actual contributions to the development of the study findings.

Triangulation was also implemented to ensure the study findings' credibility through various data collection instruments and research methods in order to optimally yield rich and detailed study outcomes (Elmusharaf, Byrne, Manandhar, Hemmings & O'Donovan, 2016). Accordingly, a protracted review of literature was conducted for the theoretical domain of the study, coupled with the adolescents' registers/ records at BBGH. This was followed by a series of in-depth interviews from two categories of participants, as well as fieldnotes for documenting participant observation during the interviews. The researcher opted for this triangulated approach in order to gain rich, robust and comprehensive data on the understanding that any single or one-dimensional approach would be insufficient to shed more light and understanding on the phenomenon being studied. The methodology, in terms of data collection and analysis as well as sampling techniques, was appropriately selected and validated for responding to the research questions in line with the research design.

3.6.2 Transferability

Transferability (known as external validity in quantitative research studies) essentially relates to the extent to which the study findings could be externally generalised (replicated or applied) to other situations, and across different groups of participants (Hennink et al., 2020; Patten & Newhart, 2018). However, Polit and Beck (2017) emphasise that in qualitative research studies, transferability is often impossible because of the idiosyncrasies of every situation. For instance, the current study sampled only one of the ten hospitals at which the SRH and HIV linkage project was piloted in 2011. Therefore, it would be rather grandiose, if not presumptuous, that the other nine piloted hospital sites had been experiencing the same problems as those in the BBGH catchment areas. However, this does not mean that the same BBGH study could not be independently conducted in different hospitals, after which a comparison could then be made concerning the challenges and successes of the SRH and HIV linkage project.

For the purpose of this study, an audit trail was conducted to ensure the possible transferability of the study findings. An audit trail relates to the comprehensive detailing and

documentation of the entire research process and its outcomes (Creswell & Creswell, 2018; Hennink et al., 2020). Also entailed in an audit trail are the decisions taken by the researcher at various stages of the research process, as well as the rationale for such decisions. Overall, the purpose of the audit trail is to afford future researchers the opportunity to investigate both the possibility and feasibility of the initial study findings being applicable to their own situations with different participants. Also, the audit trail ensures that interested researchers in the field of adolescent SRH would be able to examine the methodologies of the initial study and any possible areas of weakness they could remedy and improve (Creswell & Creswell, 2918).

3.6.3 Dependability

The trustworthiness measure or criterion of dependability (referred to as reliability in quantitative research studies) denotes the magnitude of the research instrument's and study results' replicability, consistency, and stability (Babbie, 2018). Also, the dependability factor is critical for ensuring that the research instrument and its expected findings are able to withstand any perceivable external variabilities. Moreover, the dependability factor enables a logical connection between the purpose of the study and the proposed research design (Clark et al., 2018; Denscombe, 2014).

In this regard, both the explorative (e.g., in Chapter 2) and descriptive (e.g., Chapters 3, 4, and 5) elements were implemented to complement the analytic (e.g. Chapters 4 and 5) dimension of this qualitative approach. Additionally, the dependability of the current study's findings was ensured through the interview questions' unflinching adherence to only those pertinent issues entailed in the research topic. Moreover, the researcher exercised a great degree of reflexivity (self-monitoring) to ensure that she remained objective and unbiased throughout all the various stages of this research undertaking (Ary et al., 2019; Denscombe, 2014).

3.6.4 Confirmability

Confirmability (referred to as objectivity) in quantitative research studies) refers to the degree of the study findings' accuracy and corroboration or verifiability (Babbie, 2018). Furthermore, confirmability is established by involving others (i.e. professionals and practitioners in the research field) who were not directly involved in the study, for their expert views and further input (if any) regarding various aspects of the undertaken study (Atmowardoyo, 2018; Clark et al., 2018). Accordingly, the researcher regularly consulted with her academic supervisor

for guidance throughout the study, particularly in the drafting of the research instruments to ensure that they conform to the research topic, research problem, research aim, and objectives.

The researcher also engaged a professional language editor and research methodology practitioner (see Appendix I) to ensure that there is coherence between the theoretical and methodological aspects of the study; as well as verifying that there is coherence between the study results, conclusions reached, and recommendations proposed by the researcher.

3.7 ETHICAL CONSIDERATIONS

In the context of research-based studies, the issue of ethics focuses primarily on the sanctioned moral, legal, and professional norms, codes of conduct/ behaviour, standards or principles whose intention is to regulate practices concerning the nature of association or relationship/ interaction between the chosen research participants and the researcher (Chauvette, Schick-Makaroff & Molzahn, 2019; Labaree, 2019). Therefore, ethical protocols and considerations could be viewed as a research-induced mechanism to protect the rights of the research participants, as well as those of the institutions or organisations under whose aegis the particular study was conducted (Creswell & Poth, 2018; Guillemin, Barnard, Allen et al., 2018). In the case of this study, the following seven ethical protocols and considerations were applied: protecting the rights of affected institutions; informed consent and voluntary participation; privacy, confidentiality, and anonymity; risk-benefits; debriefing of participants; justice to participants; as well as beneficence/ non-malficence.

3.7.1 Protecting the Rights of Institutions

Protecting the rights of institutions is a mechanism also to ensure that there are no deleterious effects to the professional integrity, reputation and image of the directly involved institutions emanating from the research study and its processes (Maguire et al., 2017; UNISA, 2016). In the case of this study, the University of South Africa and the Lesotho Ministry of Health and Social Welfare (MoHSW) are the most directly affected institutions in different capacities.

Appendix A attests to the authority of UNISA's Department of Health Research Ethics Committee to grant approval for the study to be conducted officially following an internal institutional review. Consequently, an ethical clearance or approval certificate was granted

to the researcher after the acceptance and approval of her previously submitted research proposal to UNISA's Department of Health for pursuance of her Master's degree.

Following the granting of the ethics clearance certificate for permission to conduct the study by UNISA's Department of Health Research Ethics Committee, the researcher then wrote letters of request to both the Lesotho Ministry of Health and Social Welfare's Research Ethics Committee and to the District Health Manager who oversees the BBGH and other healthcare institutions in the district, for permission to conduct the study (see Appendices B, C and D). Therefore, the current research study considered the guiding principles and prescripts as formulated by the respective research ethics committees of both Unisa and the MoHSW.

3.7.2 Informed Consent and Voluntary Participation

The ethical principles of informed consent and voluntary participation imply that the sampled participants took part in the study of their own accord and volition on the basis that all aspects of the study and level of their involvement were fully disclosed to them by the researcher (see Appendix E), after which they signed the informed consent form (see Appendix F) (Ferraro, 2015; Guillemin, Barnard, Allen et al., 2018; Rubin & Babbie, 2017).

According to Bless et al. (2015) and Resnik (2018), researchers should obtain either written or verbal consent from study participants to signify their willingness to take part in the research. However, other research scholars contend that it was inconceivable to obtain either written or oral consent from participants without first disclosing fully to them, the nature, procedures and objectives of the study, the required information; as well as the expected level or nature of their involvement in the study; for example, by only responding to the interview questions orally (Bless et al., 2015; Thomas, 2017). Accordingly, the information sheet was read in Sesotho for ease of participants' understanding. The researcher informed them of their right to withdraw or opt out of the study before, or even after the study's commencement. This was undertaken to avoid any inconveniences and facilitation of their replacement.

The research participants' right to informed consent and voluntary participation premises on their right to autonomy and fair treatment (Resnik, 2018). Autonomy implies that (adult) participants are viewed as self-regulating individuals capable of making their own independent decisions uncoerced, without even expecting any monetary incentives to induce their participation (Putman & Albright, 2018; Resnik, 2018).

3.7.3 Privacy, Confidentiality, and Anonymity

The principles of privacy, confidentiality, and anonymity are not necessarily synonymous, but are symbiotically connected and complementary to each other (Putman & Albright, 2018). Overall, these three ethical principles are also a mechanism to ensure that the participants are treated fairly to avoid causing any kind of harm, whether physical, psychological, mental or otherwise. To that effect, Putman and Albright (2018) further emphasise that these three principles are interstitially linked by privacy by the extent to which the participants are granted the liberty to determine (where, and when necessary) the circumstances and time for the disclosure of their personal details or information. Therefore, the participants' right to privacy, confidentiality, and anonymity implies that their personal and other forms of identification should not be disclosed to unauthorised parties; and that they are kept in safe and secure environments for the entire duration of the study (Marshall & Rossman, 2016; Patton, 2015). However, this could impose difficulties for researchers, particularly in small and rural communities where the identity of the participants could be recognised easily.

In this study, the identities of the participants were not divulged, and they were requested to use pseudonyms or codes when answering all the semi-structured in-depth interview questions. Therefore, codes such as "Participant 1 (for adolescents) and HCW1 (for healthcare workers) were allotted to each participant for the purpose of protecting their identity, and ensuring that no specific answer could be linked to any specific participant (Mason, 2018). In addition, the names and signatures of the participants were also not revealed. Further proof to this effect is that during publication of this research, identifiable information of the participants was not revealed (see Chapter 4 and Chapter 5).

The interviews were held in a secure, non-threatening, and ergonomically conducive boardroom at BBGH, with virtually non-existent possibilities of intrusion. Transcribed scripts of the audio-recorded interviews were kept in files in the researcher's own secure and lockable cabinet, from they will be shredded and discarded after three years of the study's completion of the study (Resnik, 2018).

3.7.4 Risk, Protection Benefits and Debriefing

In social research, protecting participants from any harm is critical, since it was possible for them to be emotionally and psychologically affected during the interviews (Kendall & Halliday, 2014; Wiles, 2013). Such risks were possible in this study, given the nature of this

study and the attendant sensitive issue of sexual and reproductive health. It should be noted, however, that any unanticipated emotional or psychological risk would be attended to expeditiously since the interviews were held on the very premises of Butha-Bothe Government Hospital.

The participants certainly benefited from their involvement in the, which provided them with a moment of catharsis and learning serious lessons concerning SRH education for improvement of their lives as active citizens capable of making safe health-related choices and decisions (Adan & Githae, 2018; Dey & Mishra, 2014). It was inevitable that the interviews with adolescents in particular, would necessarily evoke troubled emotions and experiences, especially that some had experienced the horrors of rape and relationships with older men, which could potentially re-traumatise or re-victimise them during the interviews.

The researcher was able to listen attentively to the participant's traumatic experiences as they were probed further. However, her professional training enabled her to establish mutual rapport and trust, which restored their confidence, optimism, sense of self-worth; as well as being appreciated and respected. The researcher's listening skills became her forte and benefited the participants, while also shielding or protecting them from the risk of re-traumatisation or re-victimisation.

3.7.5 Debriefing of Participants

The debriefing of participants involves the approaches or strategies by means of which the researcher ensures that participants are not exposed or rendered vulnerable to any possible harm as a result of their involvement in the study (Burrel, 2017; Leedy & Ormrod, 2019). Accordingly, the researcher ensured that the participating adolescents were not re-traumatised or re-stigmatised by urging them to discuss issues they were not psychologically ready to discuss (Kendall & Halliday, 2014).

The researcher ensured that she held post-interview debriefing sessions during which participants were able to experience the catharsis of answered questions and removed misconceptions. The researcher is responsibility for protecting the participants' rights (e.g., privacy and confidentiality) even during these individual post-interview debriefings, which are also a form of prolonged engagement with the participants. Following the narrated harrowing experiences by some of the adolescent participants. In Chapter 4, the researcher then advised and referred the participant for further professional trauma counselling. Such referral

emanates writ large from the view by Littman (2018) Referral to the senior counsellor for trauma counselling was suggested Littman (2018), that researchers by themselves cannot at the same time become professional counsellors.

3.7.6 Justice to Participants

The principle of justice entails that research subjects are entitled to fair treatment in respect of the risks and benefits of research (Kendall & Halliday, 2014; Wiles, 2013). As such, it is most advisable for researchers to choose their study participants without any undue influences, discrimination, or considerations of race, physical disability, gender, age, social status, or educational background. In this regard, participants should be entitled to legal recourse in the event their rights were being violated (Ames et al., 2019). Therefore, the purposive selection of participants focused solely on reasons that were directly in accord with the research problem and the aim and objectives of the research study; and not on account of the fact they were readily available (Gray, 2014; Haven & Van Grootel, 2019). In addition to treating all participants equally and fairly, the researcher acknowledged and respected the participants' cultural values and beliefs; as well as the agreements made with the participants as entailed in both the participants' information sheet and informed consent form. For instance, the researcher was always punctual, and ended the in-depth interviews promptly at the time agreed on.

3.7.7 Beneficence/ Non-Malfeasance

This ethical protocol entails the measures or steps taken to do good by ensuring that the participants' well-being is safeguarded, and that they are freedom from exploitation, physical, emotional, spiritual, economic, social or legal harm or discomfort during the entire duration of the study (Chauvette, et al., 2019; Walliman, 2016). The latter authors advise that a potentially harmful investigation to human subjects should rather be abandoned for 'fear' of possible litigious consequences. For instance, it would be considered unethical for the researcher in a study of this nature to reprimand or deride a pregnant adolescent who indulges in smoking and alcohol intake, whether it is during, or after the in-depth interviews. In such cases, the researcher should rather apply her professionalism and use the investigation as a moment for catharsis on the part of adolescents, especially those going through troubled experiences at home, school, or in the community.

Since the current study entails a plethora of challenges experienced by adolescents, it is only humane and benevolent of the researcher to have undertaken the study, in the first

place. It is even more altruistic for the researcher to have undertaken debriefing and referral for the participants, many of whom were apparently health-ignorant due to socio-economic and other circumstances depicted variously in Chapters 4 and 5 mostly.

3.8 CONCLUSION

The current chapter premised largely on research design and methodology adopted in this research study. Included in the chapter are the critical discussions on the research paradigm, research approach, the sampling framework; as well as the data collection and analysis approaches. The chapter further presented discussions concerning the trustworthiness and ethical issues inherent in the study. The next chapter presents the findings of the study, as well as their analysis and interpretation.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents the findings of the study as the definitive evidence of the study's empirical phase, in terms of which the 21 adolescents and 5 (five) professional healthcare workers (nurses) provided their responses to the interview-based questions posed to them by the researcher. Accordingly, the chapter is structured into two main sections: the demographic profiles or characteristics of the participants, as well as the findings themselves. These findings are largely reflective of the participants' responses to the research problem and objectives of the study (Alase, 2017; Denscombe, 2014). The following research objectives provided a context for the thematic development of the findings:

Objective 1: Theme 1: Capability of the hospital in providing ASRH services;
Theme 2: Utilisation of sexual and reproductive health services; and
Theme 3: Quality service delivery and service utilisation.
Objective 2: Theme 1: Poor service delivery due to structural barriers;
Theme 2: Social barriers to SRH services;
Theme 3: Financial barriers to effective utilisation of SRH service; and
Theme 4. Personal factors influencing the utilisation of SRH services
Objective 3: Theme 1: Health care system change; and
Theme 2: Scaling up of adolescent-friendly.

The above-mentioned themes are mainly challenges faced by adolescents, their knowledge on reproductive health services (RHS); pattern of utilisation of RHS; reasons for not accessing and utilizing sexual and reproductive health services (SRHS) and recommendations for improving adolescents' access and utilisation of RHS.

4.1.1 Demographic Information of the Adolescents

Table 4.1 (overleaf) is a diagrammatic representation of the adolescents demographic profiles or characteristics.

Table 4.1 Demographic information of participants

Participants	Age	Gender	Marital Status	Education	
Participant 1	19	Female	Single	Form D	
Participant 2	18	Female	Single	Form D	
Participant 3	18	Female	Single	Form C	
Participant 4	19	Female	Single	Form C	
Participant 5	18	Female	Single	Form B	
Participant 6	19	Female	Single	Form B	
Participant 7	18	Female	Single	Form B	
Participant 8	19	Female	Single	Form E	
Participant 9	19	Female	Married	Form B	
Participant 10	18	Female	Married	Form E	
Participant 11	19	Female	Single	Form B	
Participant 12	19	Female	Single	From C	
Participant 13	19	Female	Married	Form C	
Participant 14	19	Female	Single	Form E	
Participant 15	19	Female	Single	Form E	
Participant 16	19	Female	Married	Standard 7	
Participant 17	18	Female	Single	Tertiary	
Participant 18	19	Male	Single	Form E	
Participant 19	18	Female	Married	Form E	
Participant 20	18	Male	Married	Form E	
Participant 21	19	Female	Married	Form A	
Total	**21**				

Table 4.1 above depicts the adolescent participants' age, gender, marital and educational status. The researcher had (n=21, 100%) participants whereby (n=7, 33%) were married between the ages 18-19 years of age. Single participants between the ages of 18-19 years of age were (n=14, 67%). There are more single adolescents than married adolescents. The researcher noted that adolescent children are becoming more informed about early marriage and being in charge of their lives and future.

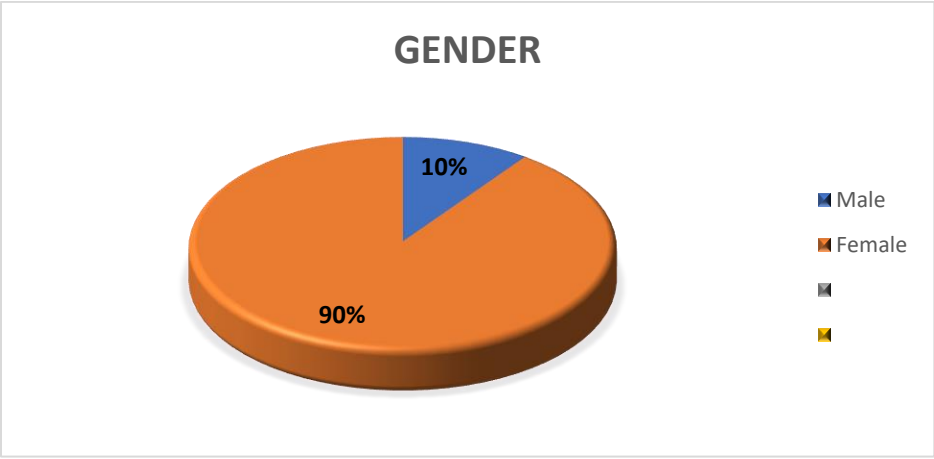


Figure 4.1: Adolescents' gender profiles

Figure 4.1 above depicts participants' gender, the majority of (n=19, 90%) are females followed by (n=2, 10%) male participants. In this regard, there are more female adolescents than males. The reason might be due to the fact that females in general were more likely discuss their personal lives than males. Meanwhile, Figure 4.2 below is a depiction of the adolescents' educational profiles.

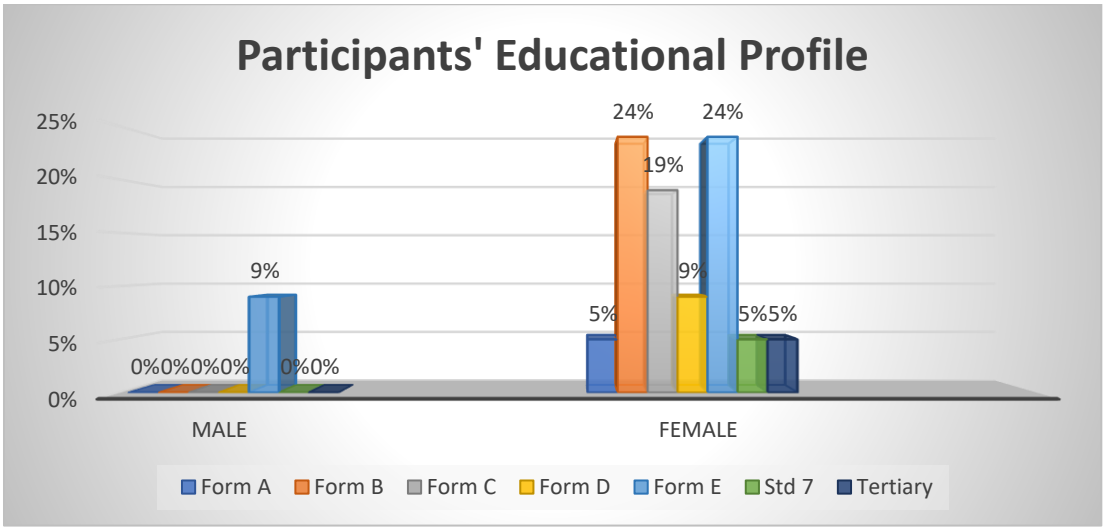


Figure 4.2: Adolescents' educational profiles

Figure 4.2 above depicts participants' educational profile. There were only (n=2, 9%) males in Form E and no Males in Forms A-D as well as Std 7 and Tertiary. On the other hand, the majority of female participants (n=5. 24%) in Form B and Form E respectively, followed by (n=4, 19%) participants in Form C, (n=2, 9%) participants were in Form D and the least number of participants (n=1, 5%) were in Forms A, Std 7 and Tertiary respectively. The researcher noted that female adolescent participants have vision of improving their lives through education that prioritising marriage.

4.1.2 Demographic Information of HealthCare workers

Table 4.2 below is a depiction of the healthcare workers' demographic characteristics. They are referred to as "HCW" for anonymity purposes.

Table 4.2: Demographic information for study participants (HealthCare workers

Participant	Education	Designation	# of Years working with adolescents	Total number of Participants
HCW 1	Tertiary	Nurse midwife	4 years	
HCW 2	High school	Did not mention the position	12 years	
HCW 3	Tertiary	Nurse Assistance	5 years	

Participant	Education	Designation	# of Years working with adolescents	Total number of Participants
HCW 4	Tertiary	Nurse Midwife	3 months	
HCW 5	Tertiary	Nurse Midwife	5 years	
Total				**5**

Table 4.2 depicts demographic information of the study participants (HealthCare Workers) (n=5, 100%). Based on the participants' educational status, the majority of (n=4, 80%) had Tertiary education and the least participants (n=2, 20%) had high school education. The majority of healthcare workers (n=3, 60%) were midwives, followed by (n=1, 20%) and another (n=1, 20%) participant who was reluctant to mention the position. The researcher noted that healthcare workers are qualified professional nurses with midwifery, whose years of experience range between 3 months to 5 years.

4.2 SUMMARY OF KEY FINDINGS

The current section presents the researcher's development of the findings as a product of the thematically analysed responses of the participants, and in relation to the research objectives.

4.2.1 Objective 1: To Examine Adolescent-Friendly Service Provision and Utilisation

4.2.1.1 Theme 1: Capability of the Hospital in Providing ASRH Services

Reproductive health service comprises of information and services on prevention, diagnosis, counselling, treatment and care. Ideally these services are meant for the community including adolescents, to have free and safe access without having to travel long distance and stand in the long queues. Furthermore, these services and treatment should be accessible and affordable to all people despite their gender, age and economic status (Tlaye, Belete, Demelew, Getu & Astawesegn, 2018). Evidence by Thangmixay et al. (2019) revealed that effective delivery of health services is central to the health system therefore, there is a need to explore efforts and new strategies that are geared towards improving access and utilisation of services.

Organisation of service delivery determines if service provision leads to desired outcomes after accessing them. To have an improved health outcome amongst adolescents, hospitals have the mandate to provide holistic services and Butha-Bothe Government Hospital has an adolescent health corner which is a centre within the hospital, where services are rendered to adolescents and young people whose ages range between 10-24 years. As per minimum standard adolescent-friendly services, the corner sometimes provides comprehensive

friendly services (Ajike & Mbegbu, 2016). These have reportedly proven beneficial and accommodating to all adolescents regardless of the gender or race. It is crucial to have an insight on how service delivery is rendered to adolescents at the corner, and participants were asked how the facility organised and offered SRH services to them (Hopkins & Collins, 2017).

This question was meant for probing an in-depth understanding of how services have been rendered at the hospital. As WHO (2017) averred, the hospital or facility should offer adolescent-friendly reproductive health services. The facility should provide services in an efficient manner, it is therefore crucial to be well capacitated with staff, necessary equipped to resume the work, and an enabling friendly and conducive environment. Necessary resources, including equipment and humans should be in place to help with creation and demand (Figueroa, Harrison, Chauhan & Meyer, 2019). However, WHO (2017) further identified the need to include a bidirectional approach as it is significant to fulfil the needs of adolescents. The findings of this study indicate that integration of SRH and HIV component is abridged by insufficient equipment and supplies, availability of the working space and lack of staff, which is linked to the competence in the providing such services.

4.2.1.1.1 Sub-theme1: Availability of SRH services and resources

The majority of participants (n=3, 60%) reported the following existing services at the hospital: ANC, PNC, FP, HTS, TB screening, ART service Cervical cancer screening (CA) and extensive consultations as reported below by the following participants.

HCW 1: *We also provided psychosocial counselling to adolescents. On the other hand, there are some services that are not provided at adolescent health corner (ADHC), such as ART (adolescent have to go to MCH or Baylor which is a hospital within the Butha-Bothe Hospital that manages paediatric and adolescent HIV. It should be noted however that adolescents who get ART at MCH are only those who are pregnant or lactating, as for the rest they are linked with Baylor. Due to lack of space and infrastructure adolescent who came for consultation must go to OPD and get their medication there at the pharmacy. We only manage to provide the supplement to pregnant women and family planning commodities to FP clients, like the rest, they must queue at OPD-pharmacy to get their medication. I believe the hospital is not able to provide adolescent-friendly services as it is believed that the services offered to them should be co-package of services and they should get them at the same place, and the same time one comes for services*.

HCW 2: *Further mentioned 'school health visit as one service they provide to the student at different schools. We taught them life skills. We get the topics from the teachers and prepare our lessons'. Also, the school health visit is not consistency as there is a shortage of staff at adolescent health corner (ADHC). Only one is allocated to work there. It is difficult to stretch arms. School health visit is only possible through the assistance of our partners such as SolidarMed. Honestly, I cannot commit*

that the hospital is providing friendly services. There are neither resources nor human resource to provide comprehensive adolescent-friendly services effectively. There is a lack of space and most of the time, essential drugs are out of stock.

In contrast, the minority (n=2, 40%) was not aware of the existing services in the hospital. The majority (n=3, 60%) was aware of only two services that were provided. It is evident that the facility has minimal resources for adolescents at the corner. The participants (n=2, 40%) mentioned that services such as ART for HIV positive adolescents, the healthcare professional refers them to MCH or Baylor hospital which is another division within the Butha-Bothe hospital that manages paediatric and adolescent HIV. This is due to shortage of staff and privacy. According to GoL (2016) services provided by school health nurses to adolescents work hand in hand with educators, although these services would not have been possible without the assistance of SolidarMed, an organisation that helps in combating HIV/Aids, tuberculosis and malnutrition among children as well as to improve primary health care in rural areas.

HCW 3: *There are no resources to deliver quality adolescent friendly services. The services provided do not meet the needs of adolescents. There are no personnel to assists; even the available staff is 'bitter' because they work under a lot of pressure and must serve many adolescents. There is a lack of infrastructure. This makes it very difficult to provide integrated services. For example, if an adolescent wants to do a Pap smear, the meeting must move to the MCH department as there is no space here*.

Adolescents should be provided with a variety of acceptable services during their visit to the hospital (GoL, 2015). The HCWs shared their opinions on the concept of availability of resources because they mentioned services as ANC, PNC, FP, ART are available for adolescents, under five clinics, HTS, Pap smear (cervical cancer screening), with health education being provided to any adolescents coming for services. The majority of participants (n=3, 60%) mentioned that resources were either minimal or non-existent in hospital. Following are the participants' statements.

HCW 4: pointed out that: *We provided routine ART refill for pregnant women. This includes the Full Blood Count (FBC), Blood group, venereal disease research laboratory (VDRL) test which tests for STIs. TB screening is also offered. We also initiate a person without signs of TB on Isoniazid preventative therapy (IPT) and referral of adults who are positive to Paballong (HIV and TB Centre). Adolescents and young people who are diagnosed with HIV positive and have Positive TB results are treated at Baylor except those who are above 18 years, pregnant and lactating. Lastly, some services are not provided here, such as Voluntary male medical circumcision (VMMC).*

There are no resources for adolescents and young people who are diagnosed with TB and also those who are HIV positive, they are transferred to Baylor hospital for treatment except

those who are above 18 years, pregnant and lactating. Services such as voluntary male medical circumcision (VMMC) are not provided except when there is a donor funding. Gilbertson et al. (2019), mentioned that male medical circumcision (MMC) has the potential to reduce HIV infection from HIV positive females to HIV negative males by over 60%. Health professionals are expected to give holistic healthcare but, in some instances, progress is hindered by staff shortage. Adolescent male patients can only be able to access these services when funding has been provided by the donors. It becomes a challenge to the community due to their economic status; they are unable to pay for private services, hence they attend provincial facilities.

HCW 5: *Contraceptives, ANC, PNC, gender-based violence(GBC) education, treatment of STIs, psychosocial support and counselling, breast and cervical cancer screening, HTS, nutrition assessment, we take Mid-upper arm circumference(MUAC), height, weight of adolescents who came to access PNC services and do Z score to assess malnutrition among children. We also take vital signs.*

The study has thus revealed that young people require information about the existing SRH services targeted to their specific needs. According to Pradnyani et al. (2019), lack of knowledge has been linked to poor access and utilisation of services as thus, is associated with risk-taking behaviour. Pradnyani et al. (2019) view the provision of comprehensive sexuality education (CSE) as improving knowledge and appropriate skills in order to prevent risky sexual behaviour amongst adolescents. Nonetheless, the study by Kumar et al. (2017) had revealed lack of knowledge about SRH has increased health problem. School health nurses provide services even though the condition is not conducive. There is lack of privacy during consultation, time is limited and lack of essential drugs which are constantly out of stock and might be the cause for lack of progress. Lack of infrastructure makes it impossible for health care practitioners to execute minor procedures such as pap smear because of lack of privacy. Adolescents, in need of pap smear were referred to another department such as MCH for privacy and space which is time consuming

4.2.1.1.2 Sub-theme 2: Provision of adolescent-friendly sexual and reproductive health services

Adolescent friendly health services should be available, unbiased, satisfactory and suitable, (WHO, 2017).

Participants 1, 2, 4, 5, 6, 7, 8, 9, 10, 14, 15, 16, 18, 20 and **21** reported to be satisfied with the services provided. They reported getting the requisite services from the hospital.

Ajike and Mbegbu (2016) agreed with the view shared by WHO that adolescent-friendly services attract beneficiaries and should also be reachable, adequate and responsive to the needs of adolescents to succeed in retaining them for continuing care. Odo, et al. (2018) discovered that utilisation of sexual and reproductive health services was low, resulting from discrepancies in both provision and accessibility of the services. The differences were reportedly due to a lack of priority to adolescents' health. The participants of this study revealed that, due to lack of human resource and infrastructure, service provision regarding adolescents have been compromised by the Hospital.

Participants 11,12,13: Reported partial satisfaction with the services seeing the hospital as not providing comprehensive services, as opposed to services mostly provided to and geared towards pregnant women and children.

The above-mentioned participants reported that they must wait for long hours as they are being served by one nurse. Despite this, Odo et al., (2018) reported that it is crucial to obtain and use the service, this promotes quality health and most rural areas lack SRH services despite the efforts made to improve such services. Poor utilisation of SRH services result in negative health outcomes. Nonetheless, this is not a universal problem, some areas in Lesotho, SRH services are available but not being fully utilised (Iqbal et al., 2017a).

Participant 3: *The services are not completely user-friendly as some of the services are not provided here at adolescent health corner (ADHC). Some of us must go to the MCH department to get services such as ART refills, cervical cancer screening. General consultation is not offered here; we must queue at the outpatient department (OPD) together with older people. There are long queues. The services that are provided at adolescent health corner (ADHC) are more geared to pregnant mothers, post-natal and immunisations. The services do not cater for boys.*

The findings by Ryvicker (2019) also suggest that adolescent should have adequate knowledge regarding the availability of SRH services and it is best to sensitise adolescents on existing facilities through the use of social media and local radio stations. Delivery of health education before provision of health services is highly recommended. It has been reported to provide enhance understanding, awareness and skill that assist them to be resilient and open minded

Participant 17*: We get the services well; however, I have a concern, adolescent health corner is supposed to provide services to all adolescent, but it only provides services pregnant women, and nursing mothers. Boys believe that adolescent health corner only offers service to girls alone. Also, for us to get extensive consultation, we have to queue at OPD* ***(rea holimo le tlaase ho fumana lit'sbeletso)*** *which translates to we move from place to place to get all we need. So, the services are*

not completely adolescent friendly. All services should be provided at adolescent health corner (ADHC), and there should be doctors assigned to help us. Also, I have a concern with time. We arrive early at the hospital, but we get services late, and it makes some of us be reluctant to come because we leave the hospital late and arrive home very late as some are from the farthest villages. The challenge we must walk on foot, so if there is a delay in accessing Services, we struggle to get home. The health care worker shout at us and are always in a hurry. They should be patient with us and be extra careful when giving us medication to avoid giving us the wrong the medicine.

In this case, poor utilisation could be linked to other factors than the availability of services. Gebreyesus, et al. (2019) had a different opinion regarding utilisation of services, with their study revealing adolescents' communication with parents on complex issues such as romantic relationships and sexuality are rare. The situation was influenced by social and cultural practices including taboos. Below are the views of the participants regarding the provision and utilisation of friendly services.

Participant 19: *Females mostly utilise the services. The services are not universal; for example, no boys are accessing the services at adolescent health corner except those who are accompanying their partners for antenatal care (ANC). The services that are provided are for women, you know (nodding the heading) services for pregnant women, for nursing mothers, contraceptives and immunisations. For other people, they must go to causality or OPD to get services, especially if one wants to see a doctor.*

The results of this study incorporated other factors including financial struggle to pay for transport and consultation fees. Moreover, limited capacity of health sectors in providing friendly services to adolescents is associated with awkward opening and closing hours, location, unfriendly staff, and lack of privacy, the feature which is consistent with Habtu and Helamo's (2018) study

HCW 1: *Other services are not provided at ADHC because of lack of human resource. Prioritisation is made when providing the SRH services and mainly ANC, PNC and family planning are given. Services such as ART refill are provided at MCH. Most services are co-package and partially friendly services; however, they are not integrated services (provision of all services at the same time)*.

The above-mentioned HCW expressed different views of provision and utilisation of adolescents' friendly services. As with the in-depth interviewees, the informants mentioned that the services at the hospital's ADHC department was falling short of fulfiling the minimum standards required for the adolescents' friendly service project.

HCW 2: *Not all services are provided at ADHC because of lack of space and human resource as one nurse has been allocated to work at an adolescent health corner. Other services such as ART refills, male medical circumcision (MMC) and pharmacy are found in another department within the hospital. Also, there is stock out of some drugs, so adolescents do not get them as expected.*

ADHC does not resources for adolescents. It is not a comprehensive facility which could accommodate all patients. Medication for repeat ART is dispensed in another department. Some patients get annoyed and decide to go home because they are going to be confronted with long queue. The biggest challenge that confronts the healthcare workers is to minimise default by patients. Those patients who decide to not to get ARTs on the same day are likely not to return the following day, which poses a problem on the cycle. In some cases drugs are out of stock and the expectation on the adolescents of being cured diminishes.

HCW 3*: Service provision does is not responsive the needs of adolescents because of shortage of staff. As a result of been overworked nurse become 'bitter' due to the overload of work as one must serve many adolescents a day that came for ANC, PNC, family planning and do the lab test. There is a shortage of space. Again, there is available equipment at ADHC however we are not able to use here as there is not space. We desperately have to move to the MCH department to conduct the Pap smear if we need to do them*.

HCW 4: *Adolescents are not able to access all the services in one place. They are offered adherence counselling at ADHC and must travel to the MCH department to get ART refills. Adolescents who get ART refill at MCH are above 18 years. Others are getting services at Baylor Paediatric hospital. Unfortunately, Baylor only works with HIV positive adolescents as for the rest they must access services at ADHC. At MCH, they are mixed with adults, so the service provider if not adolescent friendly at all. There is a lack of space, so the health education that is provided to adolescent is general, not specific to individual needs. They are not able to ask questions or say their experiences. For example, they are not able to prove if the treatment has some side effects. They are shy to speak about sex and sexuality education when they are given education in the presence of adults. There is also a shortage of staff, and they make the provision of services poor as the nurse is always overworked.*

Adolescents are shy to speak about sex and sexuality education when they are given education in the presence of adults. There is also a shortage of staff, and they make the provision of services poor as the nurse is always overworked. As much as there is available equipment at ADHC however HCWs were not able to use those services due to limited space. They desperately have to move to the MCH department to conduct the pap smear if we need to do them

HCW 5: *We are not able to provide services to adolescents to meet their health needs with kind of services they need without moving from place to place to get services. Some of the services are not offered here; they must go either MCH or Baylor. At the time when the nurse is on leave or attended a workshop, ADHC is closed. Most of the time, one nurse is allocated to work here. It takes a long time to serve others because those who came for ANC must be check and do some test some may come to assists to provide service as MCH department becomes congested. However, due to the schedule, they may not work there for a long time. Adolescent males are not coming to access services, as most of the services are female oriented.*

Services such as voluntary male medical circumcision (VMMC) are not provided except when there is a donor funding. Health professionals are expected to give holistic healthcare but, in some instances, progress is hindered by staff shortage. Adolescent male patients can only be able to access these services when funding has been provided by the donors. It becomes a challenge to the community due to their economic status; they are unable to pay for private services, hence they attend provincial facilities.

4.2.1.1.3 Sub-theme 3: Attitude of health care worker working with adolescents

Factors that attribute to low utilization of SRH services include unfavourable behaviour and negative attitudes of healthcare workers. The negative attitude and ill treatment by healthcare workers discourages adolescents from utilising existing services making them miss follow-up appointments expected of them. An adolescents' friendly environment which improves access to SRH services would require healthcare workers to demonstrate positive attitudes, support, caring and inviting behaviour, resulting in demands for services (Pandey 2019). The study participants also stated their concerns regarding attitudes and behaviour of the healthcare workers as explained below.

Participants 1, 20 and 21 did not respond on the treatment given by nurses and Doctors as they come to seek services.

Adolescents (n=3, 14%) reported a very unpleasant experience at the facility, the healthcare workers' attitude was unfriendly, and they sometimes got discouraged to return for treatment or assessment. The majority of participants were unable to respond to the question about the healthcare workers attitude. The researcher thought the reason could be that they did not wish to be embarrassed or humiliated by healthcare workers.

Participants 3,5,7,8,9,10,11,13,14,15,16, and **18** mentioned that they wert content with the way they are being served.

On the other hand, the majority (n=12, 57%) of participants felt that the services received from healthcare workers were satisfactory.

Participant 2: *We are afraid of the nurse as we always should at them. Most of the time they advise us, and they now take the role of our parents. At times they look at us as we are nothing but promiscuous insane individuals when we disclose our medical problems. I remember one day there we so many people at adolescent health corner, we were told to move to the MCH department and the nurses there were not friendly at all. We are asked in public to show by raise of hands which*

services we are coming. At the time, I did not want people to know that I am using contraceptives, but they will know as I had to raise a hand to show that I need that service. If you fail to ask or answer a question or arrive late, they threaten us that we are not getting the service.

Participant 6: *We are not treated well by the health care workers. They shout at us and say nasty things about us as we come to access the services. They say nasty things. At your age, why did you engage in unprotected sex? Sister, you see now you reap the results of your bad behaviour. After this incident, I did not want to come back for the services.*

Participant 11: *Nurses should not shout at us. They should stop acting like our parents.*

The participants (n=3, 14%) above, mentioned that healthcare worker's behaviour at the facility made them feel uncomfortable to confide in them because they become judgemental and have negative attitude towards them. The majority of adolescents use contraceptives without their parents' knowledge ,but the fact that they realised that they are sexually active, and still at school, they put all their trust in healthcare workers. Instead of being advice based on health issues they are being shouted at and called names.

Participant 12: *The nurse shouted to us and told us that she was not going to give us services because they arrived late. She is tired as she has been working since morning and there was no one to relieve her. My friend was hurt because she was sick, she said she would instead go to St Paul health centre than coming here again*.

Participant 14: ***Ba seke ba rofa batho, eish****, that moment when you are sick, and you meet a doctor or a nurse and give you an attitude, telling you that you hurried to get engaged in adult staff.*

Participant 17: *We are afraid to disclose our sensitive information to the nurses because of judgemental attitudes. For example, when my friend came here, she was scolded by a nurse telling her is has engaged in promiscuous behaviour, that is why she has contracted sexually transmitted infections. The health worker further said '****ke mohlola a lietsa'*** *which translates as it's a habit for her to engage in sexual activities.*

Participant 19. *The nurses send us home if we arrive late for the services. They do not take into consideration the distance and location we come from. It hurts us to go for services and the next thing you are sent away without the services you need****. Manurse a khopo, ha ba friendly****, they shout at us, and I decide not to come back for the services they should also be careful of the medication prescribed to us so that we get the correct one*.

It is evident that healthcare workers have bad attitude towards adolescents based on the statements by (n=4, 19%) which is similar to other participants' experience with healthcare workers.

Participant. 4, 6, 7, 15, on the contrary, stated that the services are friendly. *Nurses do not shout at us; they explain things to us and help us on time.*

On the other hand, the minority of (n=4, 19%) participants were treated in a professional manner at the facility. The insecurities as well as fear of unknown presented by adolescents, should be addressed in a manner that will make them more comfortable when they attend the facility. It is important for participants to have confidence and trust towards healthcare workers so that they could be free and be able to give proper history on their health challenges.

HCW 1: *We as a service provider are posing judgment attitudes to adolescents accessing services here. When the adolescents come to ask for certain services, we judge them and ask them some silly questions. (**O le mokalenyane o batla thero ea malapa. O ba e hlotse**) adolescent is young to have asked for contraceptive. They perceive adolescent as promiscuous*.

HCW 2: *We sometimes shout at them as we are tired. Remember you start work early and do not even manage to go for lunch so if they do not do what you tell them to do we shout at them or even send them back home without giving services. (**Re e be re khathetse kanete**- we are tired at this times) After lunch, we do not serve those who were there in the morning when we screen their health booklet, so they do not get services. They must come the following day. This affects service provision because they sent away, they never come back.*

HCW 3: *Nurses turn to take the role of the parent. The way we talk to them is not conducive as we shout at them like their parents*.

HCW 4: *At times we do not talk nicely to them, so they do not open up and share their sexual reproductive health problems. Sometimes they hide their illnesses.*

HCW 5: *Adolescents told me that nurses are cruel. They are even afraid that we will tell their parents about the services that they came to seek*.

The attitude of HCWs towards adolescents make them vulnerable in a manner that they have difficulty in expressing themselves and become afraid to open up about their health issues. All HCWs (n=5, 100%) agree that they do have moments whereby their emotions become unbearable and see themselves shouting at adolescents. They justify this as trying to protect them because they appear to be very young from being sexually active and their actions are motherly. On the other hand, adolescents come to them to get comfort, guidance and assurance that all will be health wise. All HCW participants (n=5, 100%) agree that they have a negative attitude when talking to adolescents. Their justification is the fact that they work long hours without any lunch or rest due to long queue and staff shortages. They blame the management as well as fatigue. Other healthcare workers complained that the adolescents tended to lie and they have to perform intensive examination for a minor situation. Healthcare workers further mentioned that, due to the fact that they live in the same area as most

adolescents, they know their families hence they act like parents to them. As much as they are nurses, but it hurts them to see youth coming to the clinic with all sorts of diseases. They sometimes get tempted to inform their parents even though they are aware that they will be acting against the code of conduct.

4.2.1.2 Theme 2: Utilisation of Sexual and Reproductive Health Services

Sexual and reproductive health services are one of the services the facility provides for the adolescents. The centre further established the health corner specifically for adolescents, unfortunately not many are aware of that and the utilisation of the services by adolescents is not as expected.

4.2.1.2.1 Sub-theme 1: Knowledge on the existing service

Knowledge of the current services is attributed to proper utilisation of the services thus resulting in improved health outcomes (WHO, 2017). The researcher interviewed (n=21, 100%) adolescents based on their knowledge on the existence of reproductive health services at ADHC of the Butha-Bothe Hospital.

Participants 2, 6 *only knew two services, ART treatment and counselling.*

Participant 1: *did not know anything about the existing services*.

Participant 1: *mhhhk with a frown on the face 'I do not know the services that are provided here. My friend informed me about an adolescents' health corner. She told me that life skills are provided, and I got interested*.

The majority of (n=18, 86%) participants were aware of about the existence of the reproductive health services at ADHC of the Butha-Bothe Hospital. They proffered that the available services include family planning, antenatal clinic (ANC), post-Natal clinic (PNC), delivery, immunizations, cervical cancer screening, HIV testing services, TB screening and comprehensive consultations. On the other hand the minority of (n=3, 14%) participants mentioned that they were not aware of any services provided by the facility. Limited knowledge of the existing services is reported as the underlying factors fuelling poor access to sexual and reproductive health services (Akatukwasa et al., 2019).

The HCWs have pointed out that most adolescents only knew of very few existing services in the facility.

HCW 1: *The people who know of the services that we provide are the pregnant, lactating adolescent and those who came for family planning services. Others, I believe they are not aware of. Most of the queue at the outpatient's department, and you will find them when they are referred here.*

HCW 2, 3 and 4 stated that *most of them do not know the existing services. There is nothing that directs them to adolescent health corner. No poster, billboard in the hospital that show the department where one can access services. Most of the adolescents know about ANC, PNC and contraceptives, and these are pregnant and lactating mothers and those who utilize contraceptives.*

The majority of HCW (n=4, 80%) agreed that most participants were not aware of the existing services and programmes in the facility. There were no signs such as posters, billboards in the hospital that can direct people to the specific department where one can access services. Adolescents who are aware of the services are the ones who attend TB clinic, HIV clinic, those who come for contraceptives, pregnant and lactating, ANC, and PNC. They stated that the available services include family planning, antenatal, post-Natal, delivery immunizations, cervical cancer screening, HIV testing services, TB screening and comprehensive consultations. Limited knowledge of the existing services is reported as the underlying factors fuelling poor access to sexual and reproductive health services (Akatukwasa et al., 2019).

Participant 21: Shaking his head, *I believe they are not aware of the existing SRH service because of the way service provision is structured. The above services are mostly utilised by an adolescent female. Other adolescents who are not pregnant, lactating access derives at OPD. Even if they come to access SRH services, they will be sent to OPD because we are overloaded here. We only focus on MCH clients*.

Male participants are aggrieved, they feel that lots of attention is given to female adolescents. They feel that the facility was designed for females and not males. Another complaint they had related to the difficulty of being referred to other health facilities far from their homes for circumcision.

4.2.1.2.2 Sub-theme 2: Types of SRH services mostly utilised by adolescents

Providing adolescent-friendly health services in health corners was intended for implementing comprehensive RH services to adolescents within the existing health facilities. This included co-package such as ANC, PNC, delivery, contraceptives, HTS, TB screening, cervical cancer screening and general consultations. Majority of the participants reported the following ANC, PNC, and delivery, immunisations and family planning and HIV Testing Services. Anti-retroviral treatment, TB screening, general consultations, health educations and nutrition are part of the SRH services. Furthermore, HTS, TB screening, ANC, PNC,

contraceptives and immunisation were reported to be the most highly utilised of all other services.

Participant 5: *err, I almost forgot to talk about health education. Every morning before we get the services, health education is provided on different topics. The most important thing is that nurses want us to bring forth the topic that we want to discuss on that particular day.*

Participant 2, 6: *Family planning and pregnancies services*.

HCW 1: *ANC, PNC, delivery and immunisations*

HCW 2: *ANC, PNC, delivery services and contraceptives*

HCW 3: *adolescent female only utilises ANC, PNC, contraceptive, but*…

HCW 4: *The services mostly utilised ANC, PNC and contraceptives' the mentioned services are utilised by adolescent's female due to the re-organisation of service provision at the hospital*.

HCW 5: *ANC and immunisation mostly*

Based on the majority of participants, the facility provides services such as family planning as well as ANC, PNC, delivery and immunisations for pregnant and lactating adolescent females. Health education is also provided. Shortage of staff and unconducive working conditions limit service delivery. Lack of infrastructure compels the healthcare workers to seek alternative accommodation for privacy.

4.2.1.2.3 Sub-theme 3: Record review of clinical utilisation

Data were collected from the registers to validate the pattern of use of the services by adolescents at the hospital. In what follows are extracts of data from the registers during the period of 2017 and 2018. This enabled the researcher to triangulate the responses given on utilisation of the services. The researcher was also able to see that the trends of service utilisation are increasing among adolescent female and declining among adolescence boys. The call for interventions that can be integrated in SRH service provision to improve services delivery to adolescent boys as they are left behind.

The use of SRH services by the adolescents was measured against access to these services. The study found out that the use of SRH information was statistically related to access to these services by the adolescent girls. Respondents who indicated that these services were accessible cited having used these services for more than once. Below is the table showing the accessed services in two years for adolescents aged 18 and 19 years.

Table 4.3: Services accessed by adolescents in BBGH over a two-year period

Services provided	Total # of an adolescent who accessed service in Jan-Dec 2017	# Adolescent aged 18-19 who accessed services in Jan-Dec 2017	Total # of an adolescent who accessed service 2018	# of adolescents aged 18-19 who obtained the services in Jan – Dec 2018
Antenatal care	248	63	245	54
Delivery	330	42	449	39
Post-natal care	196	15	206	20
HIV testing services	906	210	1070	241
Family planning services	583	146	350	81
Outpatients	800	320	909	256
Antiretroviral treatment	95	11	384	16
Cervical cancer screening	73	6	157	27

Source Ministry of Health patient's register's 2017/2018

Table 4.3 above attests that in 2017 there were 73 adolescents screened and 6 of them were between the ages 18-19 years old while in 2018 there were 157 and 27 adolescents between the ages 18-19 years old accessed the services, which was increased by 8.9% (GoL, 2014b). In 2017, there were 583 family planning patients, and 81 of them were between the ages 18-19 years, while in 2018 there were only 350 adolescents who accessed family planning services, 81 of whom were between the ages 18-19 years, that is 9.3% increase. In Section 5.3.5, these findings are elaborated further .

4.2.1.3 Theme 3: Quality Service Delivery and Service Utilisation

4.2.1.3.1 Sub-theme 1: Availability of resources

To provide holistic care to adolescents, there should be enough equipment and space to allow the smooth running of the services. As such, the hospital should provide services in a convenient time, more especially in a welcoming environment (James et al., 2018). In addition, the facility should be well resourced with drugs at all times, enough skilled human resources. this help to improve service delivery and hence provision of friendly SRH services.

Participant 1: *Mentioned that one nurse serves us. She becomes 'bitter, harsh to us because of being overworked. I do not blame her. In the morning she will be okay. ijooh come midday she is no longer patient with us*.

Participant 6: *There should be some other nurses to work here. Having one nurse to provide services to many people makes it difficult to deliver quality services. We delay get served. We get hungry and cannot afford to buy food because we do not have money*.

Participant 13: Stated that *there should be a doctor and additional nurses working at an adolescent health corner. Most of the time, we do not get the medication, and we are told to come the following week. 'Mkkk' imagen where do we get the transport to return to the hospital. We miss the appointment due to lack of enough resources.*

Participant 20: *We should always get medication when we are sick. Sometimes you are given an appointment to come maybe next week and promised medication would-be there, but when you come, it is not there. This does not help us; she attested*.

The minority of participants (n=4, 19%) averred that the shortage of staff at the facility, compromises service delivery. HCWs appeared to be tired and hence their emotions towards adolescents are at their extremes. The facility has a tendency of running out of medication. Enough human resources will assist the HCWs to relieve the burden of long queues as well as the improvement of service delivery and the provision of friendly SRH services.

The HCWs proffered that they spent few minutes with each patient and omit some of the services in order to accommodate high demands and reduce long queues. The issue of shortage of staff is a burden that taints every health worker stationed at the ADC. This situation caused poor quality service, to the extent that adolescents' problems were not being attended to timeously.

HCW 1, 2, 3, 4 and 5 stated: *There is a shortage of staff to accelerate quality friendly services to adolescent. There is also a lack of medical equipment, so we make referrals to QMMH and sankatana (HIV –cancer specialty hospital) if there is a medical condition that cannot be treated at the hospital. For example, we do cervical cancer screening; anyone found with signs of cancer is referred to the referral hospital as we are not able to be provided treatment. Also, there is a lack of infrastructure, which also influences limited-service provision. The adolescent must move from one place to the other to get other services*.

HCW 2: Mention that*, the facility sometimes run out of essential drugs and other services are not provided this include among others VMMC which is provided only when there are resources (human and material from donor funding supported by Jhaphaego).*

The majority of HCW (n=5, 100%) confirmed that there is shortage of staff in the facility which compromises service delivery and friendly service towards adolescents. The shortage of services such as VMMC, which is provided *ad hoc*, when there is availability of funds from donors become a challenge because, male adolescents were being referred to nearby facilities which have resources. Lack of infrastructure hinders holistic health care to

adolescents. As such, HCWs perform cervical cancer screening; and if anyone is found to be with signs of cancer should be referred to the facility which will assist with further investigations and treatment.

4.2.1.3.2 Sub-theme 2: The services provided are acceptable, accessible, appropriate and equitable

The World health organization (WHO) framework for quality of care explicitly stipulates that service delivery should be implemented adequately in the right way. This framework offers a useful guide to work on successful health service provision for adolescents. It harmonises initiatives that make adolescents access necessary health services. It is evident that the quality-of-care framework provides a useful working definition of adolescent-friendly health services. In order for services to be considered adolescent-friendly, they should be available, tolerable, appropriate and unbiased.

Participant 4: *We fail to come for services on time due to transport. We come from remote places where there are few local buses; therefore, if we miss travelling early, we miss the bus. In the end, we travel on foot and arrive late at the hospital. It is true that SRK services are free; however, if you are sick and need to see a doctor, we must pay before the consultation. If the Doctors say you must do* ***(seipone)*** *- X-ray you also must pay for it. If I do not have that money, I stay at home and take traditional medicine*.

Participant 8: *At times when you come for services you are given appointment for the following week. Again, we are not given services at one building. Most of the services that got here are for pregnant people, and other adolescents must go up there to get services. We are certified, but at the same time, we have challenges. We arrive early at the hospital and depart late. There is only one nurse who serves us here, and there is a lot of work for her, especially during those days when there are many people who came for services*.

Participant 10: *I fail to come for services on time because of lack of transport and consultation fee. I stay far from the hospital, so it is not possible for me to travel on foot all the time as I will be carrying the baby with me. Also, I am afraid to travel through the donga because I might be attacked*.

Participant 18: *Some facilities are far from the villages and adolescents do not have transport to go to the facility. They cannot afford to buy food while there are at the facility due to financial constraints.*

All adolescents, without any discrimination or favour should be provided with available health services and be part of positive contribution to their health (James et al., 2018). For some reasons, adolescents were unable to utilise the available services at the facility. The majority of adolescents cited challenges of distance and transportation to and from the facility. The waiting was too long on the queue, and they had to rush back home using public transport.

Extended- waiting hours became barriers to effective adolescents' friendly services. Added to these are financial constraints reported by adolescents in the interviews.

Participant 9: *I can get all the services, for example, I came here for family planning, and I am sure I am going to get the services. My child also came for immunizations, and he will get the service.*

Participant 15: (With a sigh) *The services that are provided to us are ok. I do not find a need to go to another facility. However, the services only meet the needs of adolescent girls only. Boys are not catered for. Most services are associated to pregnancy, childbirth and after birth services. This is the reasons why they do not come for services. As you have seen, the waiting room is full of pregnant women and mother, who brings their children to get an immunisation, so I believe they do not feel free to come here. Err, the idea of being crowded by women, who always have something to gossip about… scares us.*

On the other hand, minority of adolescents are happy about the service delivery at the facility, they are able to access the necessary services such as family planning and mother and child simultaneously.

HCW 1: *SRH services are available to adolescents, but they are not equitable to all. e.g. Services are more female-oriented, so they do not cater to adolescents' boys*.

HCW 2, 3, 4 and 5: *ADHC is a mini MCH for pregnant and lactating mothers. The services provided are not equitable because we do not provide services to other groups of adolescents except the pregnant and lactating mother. Also, we serve those who come to access family planning services*.

The majority of HCWs (n=5, 100%) were not satisfied about the service delivery for adolescents. Availability and accessibility of health care services is determined by elements such as non-discrimination, physical accessibility, equity and affordability and are fundamental to provision of friendly SRH services. The HCW showed their concern regarding equity, availability of services. They concluded that services provided do not fulfil minimum standards and are not adolescent friendly.

4.2.1.3.3 Sub-theme 3: Client satisfaction on the services provided

The interviewed participants reported being happy about the available services. Though adolescent said to be certified, some had concerned with the way survives are rendered at the hospital.

Participant 4: Mentioned that *Every time I come here; I get the services that I need. Though I am okay with the services, the provision of the services is biased. The way adolescent health is structured, it provides services that are female oriented. The existing services are contraceptive, ANC, PNC, delivery services immunisation for children. Few of the services are provided to adolescent males such as HIV Testing service, and TB screening and health information. We are not*

able to get SRH education because there is a combination of adolescents and adults at OPD. Girls are lucky, especially those that are pregnant. Focus is on then, as for us, we still face the challenge of queueing with older people over there.

Adolescent said to be satisfied some had concerns with the way services were rendered at the facility. Access and utilisation of adolescent-friendly services remain a key concern in the promotion of sexual and reproductive health. It is therefore evident that tailored reproductive health services should be made available, accessible, responsive, and user-friendly to adolescents both girls and boys (Abrafi, Boamah-Kaali et al., 2018). In most African countries, services targeting adolescents reproductive health needs are limited or non-existent. This is because the service providers are hesitant to extend reproductive health services to adolescents, making the health system unfriendly for them (Pandey 2019).

Participant 14: *I am satisfied with the services. Most of the time when I am here, I got all the services I came for, but there are still some challenges though. We delay getting the services as there is one nurse who is allocated to work with adolescents. Again, there is a lack of infrastructure; we have to go to other departments such as the Laboratory to take the samples, go to the pharmacy to get our medication in case we went for a consultation. Some of my friends, especially boys, do not come here for services because they said the services are for adolescent girls. So they don't find the need to come here for the services*.

Participant 8*:* *There is those time when there is stock out of the commodities, and you are told to go back and come maybe after some weeks. We are not even given the exact dates when to go back because even the nurse is not sure as of when the commodities will be available. We do not access integrated services; we have to go to other departments. We are certified. However, we spent most of the time at the hospital, we arrive early, but we are not served on time.*

Shortage of medication and staff is a major concern at the facility. The participants reported some of their friends as shying away from coming to health facilities for services because of queuing with adults for consultations and prescribed drugs. Some barriers such as the availability, accessibility, acceptability and equity of health services. In many places, health services such as emergency contraception and safe abortion are not available to anyone, including adolescents and are reported to hinder the utilisation of health services. Even where health services are available, adolescents are unable to obtain them for a variety of reasons – restrictive laws and policies. Some health services provided to some groups of adolescents, for example, in Lesotho abortion services are not offered at any of the health facilities except in cases where the life of the child or that of the mother is in danger (GoL, 2010).

The health services to the recipients have reportedly been unacceptable. For example, a long-waiting hours and long queues for services, sometimes at places not suited for such sensitive health services delivered to adolescents, and at other instances having both marginalised and well-to-do adolescents, being served inequitably and unequally. In other words, services may be offered, reachable and satisfactory, but biased (WHO, 2016).

4.2.2 Objective 2: To Identify Factors That Hinder Access to, and Utilisation of Adolescent-friendly Services

Access and utilisation of SRH services are governed by complex socio-economic, cultural and psychosocial and structural factors. Nash, O'Malley, Geoffroy, Schell, Bvumbwe and Denno (2019) stated that, the ease of use of the RHS and their procedures for utilisation partially determined adolescents' access to the services. Barriers that hinder adolescents to utilise services include lack of confidentiality and long distances to the facility. In addition, physical accessibility was found to be another factor hindering adolescents to utilise services. To a lesser extent, marital status and lack of information about locations of SRH services were mentioned as hindrance factors to access and utilisation of adolescent-friendly services.

4.2.2.1 Theme 1: Poor Service Delivery Due to Structural Barriers

4.2.2.1.1 Sub-theme1: Lack of space, privacy and confidentiality

The health institution is accountable to offer the conducive environment to the patients. The health care institution is expected to safeguard the patients' right to privacy.

Participant. 12: *There is not enough space to accommodate us all at adolescent health corner. Even the examination room is so small that we are not able to make any movement. Other people who are coming to be served are most likely to hear us talking with the nurse, and other patients hear our private information. It is not good because these people can use our information and mock us when we are at the community*.

The institution, therefore, advocates an environment which provides for sufficient physical privacy, in terms of oral discussions of a personal nature coupled with protection of confidential information (James et al., 2018). Otherwise, the patient's wellbeing could be jeopardised and the fundamental trust between patient and healthcare workers destroyed by random access to data by the improper disclosure of identifiable patient information. Participants complain of limited resources and crowded examination rooms. Privacy is limited and adolescents are unable to talk freely to HCWs. A friendly service environment for adolescents, geared towards improving access to and utilisation of SRH services, would

need nurses and other healthcare workers to provide support, care to adolescents. On the other hand adolescents would be attracted to visit the facilities for services (Jonas et al., 2018).

Participant. 4: *Space is small. Most of the time, you will find us sitting outside even during the time health education is given. This is happening because of lack of space as most people who are here are pregnant women and lactating mother so. You see, chairs are fully occupied*.

Jonas et al. (2018) further reported that lack of infrastructure may not allow providers to effectively do their routine work as mandated. Such facilities lack adequate confidential services and products for adolescents. For the participants, though services are available, adolescents feel uncomfortable to use those services, they feel their rights are being violated, there is lack of privacy.

4.2.2.1.2 Sub-theme 2. Female-oriented SRH service provision

Although most of the interviewees were satisfied with the services provided, some mentioned that service provision is mostly biased as it focused on female-centric services. The adolescent health corner in BB offers services mainly to adolescent girls which is a challenge to male adolescents who feel that they are being excluded. This is because of the way service delivery provision has been structured. It works as a mini-MCH designed for pregnant, lactating and family planning recipients. The facility should fulfil the SRH standards by providing services to both male and female adolescents. As mentioned by Kirungi, Kasozi, Kasozi, Pio Kiyingi and Musoke (2019), the current female-oriented programmes should involve adolescent males in all matters of SRH. Both health care professionals and health care institutions need to create a friendly environment for adolescent male and encourage their participation in SRH programmes.

Participant 17: *Highlighted that they get the services well; however, I understand that adolescent health corner should serve all adolescents, both female and male. What I see here is that the services given are for pregnant and lactating mothers. It is expected that every adolescent coming for consultation be given services here. Male adolescent considers ADHC as a place where only pregnant, lactating mothers, as well as family planning receipts, are served. This is one of the right reasons male adolescents are not interested in coming here. They are sent to OPD to get services as most of the time there is one nurse who serves at ADHC.*

Even though adolescents did not necessarily view these services as gender-biased, most of the services available at the facility were female-centric. Few services cater for male adolescents and those services are not user-friendly as they must queue with adults in the OPD department for services. The SRH minimum standards should fulfil the needs of all

people in the SADC region including adolescent girls, young women, women of a reproductive age, men and boys, minority groups including sex workers, people who inject and use drugs, prisoners, men having sex with other men (MSN) and lesbians, gays, bisexual, transgender, questioning and intersex (LGBTQI), migrants, refugees, mobile populations, people living with disabilities and victims of sexual exploitation (Kirungi et al., 2019; WHO, 2018).

4.2.2.2 Theme 2: Social Barriers to SRH Services

4.2.2.2.1 Sub-theme 1: Long distances, queues and waiting hours

WHO (2017) reported that adolescent-friendly services should be easily reachable, however, because of long distances to hospitals, some adolescents are not able to access these services.

Participant 12, 16: *Pointed out that 'nurses should serve us on time. We delay getting services, and thus arrive home late*.

Participant 17: Stated that *We are staying far away from the hospital*.

Participants had challenges with logistics to hospital, public transport is not on time and is available on specific days. Adolescents mentioned reasons such as long distances to hospital, long queues and long waiting hours for getting assistance as challenges that make them to default on treatment or decide to utilise traditional medication as an alternative. This is attributed to poor and lack of access roads, resulting in people travelling long distances for health services. Adolescents have also been reported to be uncomfortable and impatient for long queues. Participants did not raise any of these concerns to HCWs because they noticed that they are unfriendly.

4.2.2.2.2 Sub-theme 2: Fear of having an HIV test

WHO guideline and HIV policy has recommended that service providers should mobilise Provider Initiated testing and counselling, which was viewed as a very effective strategy for demand creation. Many people are afraid to do the test before seeing a doctor. The WHO recommended that health care providers should recommend HIV Testing and Counselling (HTC) to all adults and adolescents who visit health facilities. It also applies to medical and surgical services, public and private facilities, inpatient and outpatient settings and mobile or outreach medical services. HTC should be recommended by the health care provider as part of the normal standard of care provided to the patient, regardless of whether the patient

shows signs and symptoms of underlying HIV infection or the patient's reason for presenting to the health facility (Francis et al., 2018).

Participant 16 and 17 pointed out that *adolescent males are afraid to seek SRH services as they will be asked to have an HIV test. Most of them are reluctant to seek medical care just because they do not want to get tested. So, in most facilities, you are told to get an HIV test and thereafter can see a doctor or nurse. Services are not provided if you are not tested. You will be told to see the counsellor so for them it is a waste to come for medical services, they delay and only come when they are terminally ill*.

Although PITC was recommended, it does not derail HIV testing guidelines which an individual should consent. If one does not feel ready for testing, one can opt out. Apparently, comprehensive knowledge regarding PITC model is still limited. As such, people should not be coerced at taking an HIV test (GoL, 2018).

4.2.2.3 Theme 3: Financial Barriers to Effective Utilisation of SRH Service

4.2.2.3.1 Sub-theme 1: Lack of money for transport and consultation fees

In Lesotho, SRH services are rendered free by both primary as well as secondary healthcare providers. The government of Lesotho introduced free services at the clinics and subsidised costs to an amount of M15.00 (equivalent to R1,463.97) for consultation and lab tests at the hospital. Services such as antenatal and post-natal, contraceptives, HTS, ART and counselling services are free for adolescents at hospital. However, other services such as delivery services, ultra-sound and hospitalisation are not free. Although the ANC and PNC services have been offered freely, all people who come to the mother and child waiting homes before delivery had to pay certain amount of money.

Participant 6: *I don't come for an appointment because I do not have money for transport.*

Participant 13: *Not all the services are for free, you go for an x-ray, or you're sick you want to see a doctor, you have to pay 15, or you will not get the medication. Sometimes we get hungry, and we do not have money to buy food because one person is serving us, she finished late.*

Due to unemployment and money to be paid for delivery services most adolescents opted to deliver babies at home with the assistance of their mothers or neighbours, which is a huge risk. Mother and baby could easily contract infections or die. Adolescents mentioned the fact that they were unable to pay for delivery services.

HCW 2: *I wish there were something we can do. We always mobilise adolescents and tell them that services are rendered for free but not all the services. They go for a consultation they must pay, but if the consultation were done by us here, they would not pay. That is not possible, most of the time*

only one nurse is scheduled to work at adolescent health corner, with the number of pregnant women, those who came for PNC and contraceptives we cannot manage to assist them all.

Devkora, Maskey & Pandey (2020) supports this argument and point out that the lack of transport to the facility, before and during delivery hinders adolescents /women to attend the recommended ANC. Furthermore, the reason for adolescents to deliver babies at home deliveries was as a result of lack of both transport and service fees. The commendation made by Devkota et al (2020) to mitigate the challenge of home deliveries, this would require focusing on financing of SRH services, and integration of ANC services during community outreach. Also, there should be health posts such as mobile units, situated near the remote areas where delivery can be conducted. The revealed that financial struggles attribute to non-utilisation of services.

4.2.2.4 Theme 4. Personal Factors Influencing the Utilisation of SRH Services

4.2.2.4.1 Sub-theme 1: Ignorance

Adolescents had little awareness of existing preventive reproductive health services, because of having no forums for sharing such information. The study by Oluwatson and Ayodeji (2020) revealed that knowledge and perception of SRH are deficient among adolescents in developing countries. The study participants had concerns regarding poor access of SRH services. Adolescents reported that they lack access to friendly services and information about SRH. In that regard, commodities were always out of stock, the lack of human resources, poor infrastructure and biased services were major concerns for adolescents and HCWs had similar observations.

4.2.2.4.2 Sub-theme 2. Knowledge/ awareness regarding sexual and reproductive health

Adolescents were asked about their understanding by sexual and reproductive health. During pilot of the interview guide, the researcher changed some questions which were ambiguous. Instead, adolescents were asked about the changes that occur during adolescence. The researcher interviewed (n=21, 100%) adolescents, whereby the majority of (n=18, 86%) expressed comprehensive knowledge regarding adolescent sexual and reproductive health while (n=2, 9%) had little knowledge, and only (n=1, 5%) participant lacked the knowledge.

On the other hand, when participants are asked about male sexual reproductive health, their response was that boys develop deeper voices, their shoulders and chest broaden, and that they start producing sperms during adolescence.

Participant 8: *We do not listen to the older person; we are more prone to peer pressure. Our peers influence us to engage in substance and alcohol abuse to prove that we are grown up, as a result, end up with a messed life, we do not pass well at school*.

Participant 12: *Substance and alcohol use at the early stage is dangerous as most of us sleep around without protection due to the influence of alcohol*.

Adolescents also reported that they started engaging in substance and alcohol use at an adolescent stage due to peer pressure.

4.2.2.4.3 Sub-theme 3: Knowledge/ awareness on HIV, STIs and available contraceptives

On the issue of HIV /STIs, adolescents were interviewed on the perception, durability and aesthetics of HIV/STIs.

Participant 11: *HIV could be transmitted through breathing it in the air.*

Participant 15 and 17: *Further pointed out HIV can pass through bodily fluids. Also, can pass from infected mother to the unborn child during pregnancy, delivery and lactating period through breasts milk.*

Participant 9: *When a person is diagnosed with STIs, that can be managed, but one must visit the health facility with the partner so that they can both be treated. They must take the treatment as per the prescription: correct dose at the right time until they finish their medication. They also cautioned people about blood contact, unprotected sex, but encourage the use condoms*.

Participant 3, 4, 8, *Adolescents engaged in risky sexual behaviour and are at higher risk of falling pregnant at a tender age, they do back streets abortion which results in maternal death*

The majority of (n=20, 95%) participants knew how HIV is transmitted, prevented treatment as well as management of HIV and STIs. Participants mentioned that HIV is transmitted through contact with HIV +positive blood to a negative person, having piecing objects on the skin, especially those used by an HIV positive person. It can also be transmitted through unprotected sex or touching the wound of a person without the use of the glove. Even though the interviewees appeared to know the mode of transmission, only (n=1, 5%) adolescent was unaware of how HIV is transmitted hence he emphasised the need for abstinence from sexual intercourse before marriage.

Adolescents are more susceptible to sexually transmitted Infections (STIs) including HIV/AIDS, as well as the social consequences such as school dropouts, child marriage and poverty. Other problems experienced by adolescents include living in poverty, having low education, low education attainment expose adolescents to life threatening experiences as

they lack correct knowledge and skills necessary to protect themselves (Roy, Sahoo, & Sarangi 2017). Following are the responses of participants on the knowledge and availability of contraceptives.

Participant 1: *Condom, contraceptive pill and injections but I do not know their names*.

Participant 2: *Contraceptive pills, but I do not know their different names*.

Participant 3 and 8: *Injections, contraceptive pills, Norplant (Mahlokoana)*.

Participant 3: *I am not quite sure, I heard from the conversation in a taxi. When I come to access services, I arrive late, and by that time the health education is already given*.

Participant 4, 5 and 6: *Did not know the available contraceptives*

Participant 7: *Depo and contraceptive pills, two-months injection, and Norplant, but I am not certain about it because I do not used it*.

Participant 9: (with a smile) C*ontraceptive pills, Norplant, Intrauterine contraceptive device (IUCD). I am not sure about the other ones because I use injection, so I just heard about those while I was here at the hospital*.

Participant 10, 12, 13, 14 17, 20 and 21: *Contraceptive pills, injections, condoms and Norplant*.
Participant 11, 15: *Contraceptive pills, injections, Norplant, IUCD, female and male condoms*.

Participant 18: *Condoms, IUCD, contraceptive pills, Norplant, (TT- seemed not sure of this answer), Surgery- cutting of the sperm duct in male(vasectomy) and cutting of the oviduct (bilateral tubal ligation) but I am not definite if it is performed here.*

The majority of participants (n=20, 95%) were informed and knowledgeable about contraceptives. They mentioned that they got detailed information at the facility during health education sessions. Only (n=1, 5%) participant who was unaware, confirmed that she's not quite sure, because she was always late for health education due to transport challenges. Furthermore, adolescents are more susceptible to sexually transmitted Infections (STIs) including HIV/AIDS, as well as the social consequences such as school dropouts, child marriage and poverty (Francis et al., 2018). Other problems experienced by adolescents include living in poverty, having low education, low education attainment expose adolescents to life threatening experiences as they lack correct knowledge and skills necessary to protect themselves (Roy, Sahoo, & Sarangi 2017).

4.2.2.4.4 Sub-theme 4 Knowledge/ awareness of the challenges facing adolescents' health during an adolescent stage

The problems confronted by adolescents are increased number of pregnancies, diagnosis of STIs include HIV. These problems affect the health of adolescent adversely as a result they have poor health outcomes. It was also reported that adolescents' problems were linked to utilisation of services. When services are utilised, there is like hood that they can address some of the challenges. For example utilisation of contraceptives could prevent unplanned pregnancies (Tlaye et al., 2018). In low-income countries, adolescent problems include teenage pregnancy and child marriage due to high illiteracy rate especially in low rural communities. Across the world, about 11% of all pregnancies occur among adolescents aged between 15–19 years, with about 95% of these pregnancies occurring in low-and lower-middle-income countries (Petroni, Steinhaus, Fenn, Stoebenau & Gregowski, 2017).

In this regard, it was reported that many girls have dropped out of school and got married at the tender age, as a result they have to take family responsibility of parenthood and most of the time they experienced difficulties in those marriages. Another reason for drop out of school was poverty. Adolescents are forced into marriage so that the husband can take care of her (Oluwatson et al., 2020). Poverty and low educational attainment had been linked with increased risks of maternal and neonatal health. Adolescents need to be equipped with skills and information to enable them to make informed decisions (Vongxay et al., 2019). Evidence from the ground continues to confirm that adolescents lack self-protection skills as a result they are unable to protect themselves from acquiring HIV and delaying teenage pregnancy (Binu et al., 2018).

Therefore, education has reportedly been the most significant intervention to protect adolescents against sexual reproductive health problems, including risky sexual behaviour and injury or death. For example, high school education provides the most considerable benefits for girls, increasing their self-efficacy and motivation to prevent early pregnancies. However, empowering adolescents to take responsibility for efficiently improving their wellbeing refutes the argument. According to Michie, West, Sheals and Godinho (2018), information is crucial for clients, though it is rarely insufficient for behavioural changes. Michie et al. (2018), however, views research as having to look at complex influences on behaviour rather than knowledge. It is worth noting that teenage pregnancy is associated with adverse health outcomes in mothers and new-borns and is the key cause of death amongst adolescent girls.

Lesotho is also experiencing challenges in sexual and reproductive health including an increase in HIV incident. The following illustrate the knowledge of the participants regarding the challenges facing the quality of their health:

Participant 1: *As we grow up, we get into relationships with older people, and it is not easy for us to negotiate safer sex. There is a severe problem of teenage pregnancy, which results in maternal deaths, low birth weight or premature babies. Eventually, there are school dropouts, as some schools do not allow us to attend school while we are pregnant. Also, adolescents are diagnosed with STIs (HIV gonorrhoea), which makes us susceptible to cancer*.

Participant 2: *Health problems that adolescents encounter include rape, domestic violence, car theft,* ***banana basenyeha*** *(girls become destroyed by being pregnant) and most of them have backstreet abortions and throw their babies in the toilet while other kill them with their hands. Adolescents start to use drugs and this influence them to kill their babies. They use methylated spirit and vinegar to do abortions. They also use tablets, but I do not know the name of those tables. Adolescents are prone to infections after abortions. Again, they use the drug, and these drugs affect them mentally, and later they are diagnosed with a mental problem. They are also at the risk of conducting HIV/AIDS.*

Participant 3: *Adolescents can be raped; they can also do sex work. Some can become pregnant at an early age and end up being infected with HIV. They can end up doing abortions while others can commit suicide after positive HIV status. There is also a problem of maternal death.*

Participant 4: *Many of the adolescents do not accept themselves as they live in poverty. They compare themselves with others. As a result, they start to date older people so that they can get money. The money they get from the '****sugar daddy'*** *is used to buy nice food at lunchtime when they are at school. At the same time, they buy clothes so that they can look beautiful, just like their friends. Also, they do not pass at school because their mind is preoccupied with the relationships, and they have stress, yet they still have parents who look after them'. Some engage in sex work.* ***Ba rata monate*** *(like disco or party) so they sleep around when they are drunk .as a result they conduct HIV*.

Participant 5: *There are many problems. We end up dating men. We engage in sex to get money so that they can cater to their needs. They drink alcohol, which influences them to engage in unprotected sex. People take advantage of them when they are drunk. They end up contracting STIs*.

Participant 6 and 15: *Adolescent become pregnant at an early age. We are abused by our parents.*

Participant 7: *Pregnancy*

Participant 8 and 16: *They happen to have children at the tender age. At times they are abused. They are also engaged in criminal activities and end up in jail*

Participant 9 and 18: *Our friends influence us to get into relationships with older people or to engage in sex to get benefits.eg. money. They use this money to support their families. They get into relationships with older people, and they are not able to negotiate safe sex as they fear the older partner. They are also influenced by poverty to be promiscuous. Also, there is unplanned pregnancy, and they contract STIs. When they are pregnant, they resort to doing abortion which put their lives at risk. Later in life, they are stigmatized and labelled to have a child without a father. They also do not*

have food to feed the child and cloths as a result; they go and search for a job. They are promised job in RSA, unfortunately, there is no such work, human trafficking. Our parents also remind us that we have added a burden into the family, so we end up having stress. As a result, we want to kill ourselves. We are even afraid of our peers as we are diagnosed with HIV, so they gossip about us in the community.

Participant 10: *Rape and HIV*.

Participant 11: *Drug abuse, rape and they contract HIV, so they end up killing themselves if they do not get counselling. They have children at an early age*.

Participant 12: *Girls get raped; they sleep with older people. We sleep where we want and do not return home. Boys start to propose love to older women. We have HIV, and STIs and girls become pregnant.*

Participant 13: *Older people start to propose love to us and promise us money. We are not free to go as we want. We get raped by our siblings, and this causes hatred among family members. Our parents end up refusing to pay school fees.* ***Ha, ba sa bapala karolo e le batsoali*** *(refuse to take responsibility as parents) because we are not believed that we were rape by our blood*.
Participant 14: *Girls get pregnant. Use of alcohol and drug abuse with peers, theft. They love parties and end up engaging in sexual activities with proper consent. At times boys are forced to engage in sex by girls. They get STIs*.
The majority of (n=19, 90%) participants mentioned that one of challenges facing the quality of their health was drug abuse. They averred that as adolescents they are confronted by peer pressure whereby, they have to conform to their friends' pressure. Poverty is also one of the challenges which pushes them into being in relationships with older people who will assist them with their day-to-day finances, whilst they on the other hand they become intimate. Health problems that adolescents encounter include rape, domestic violence, contracting STI, HIV/Aids, car theft and pregnancy.

Some adolescents mention that most of adolescents have backstreet abortions and throw their babies in the pit toilet while others kill them with their own hands. Adolescents are prone to infections after abortions

Participant 17: *They are being taken advantage of, so they end up engaging in sex. It is not recommended before marriage*. *They are influenced by their peers and end up having a relationship even if they were not ready to do so. Errr... They are greedy, looking for money. They end up dating older people who end up giving money in return to use. So, they do not initiate save sex and end up contracting HIV, STIs, pregnant and later drop out of school. Their bodies are not mature enough to carry the baby full term and end up with child morbidity*.

Participant 18: *Further stated that as boys enter adolescence, they develop a feeling and propose love to older women and end up engaging in sex. They later feel embarrassed, and it becomes hard to have a relationship with age mates. They end up with low self-esteem. These affect them, and*

their future will not be bright. They are also obliged to raise the child alone with the stigma of not having the father of the child around. Lack of job opportunities also put us at risk.

The minority of (n=2, 10%) male adolescents mentioned that they have the same challenges of peer pressure as their counter parts. Furthermore, they cited the fact that due to poverty they too have the same challenge of dating older women who can support them financially, although in most cases they indulge in drugs and alcohol to relieve pressure because they have a tendency of comparing themselves to the well to do kids. They do feel embarrassed of dating older women and sometimes have multiple relationships whereby they impregnate their girlfriends and have to abandon school and look for jobs. Furthermore, they use the drug, and these drugs affect them mentally, and later they are diagnosed with a mental problem. They are also at the risk of contracting HIV/AIDS

The challenges faced by adolescents do not only affect them, but their families become affected. Poverty, lack of information, peer pressure and insecurities were cited by adolescents as the major problems they have to deal with. These challenges could be defeated by moral support, continuous information through health education and reduction of poverty through government projects and NGOs.

4.2.2.4.5 Sub-theme 5 Peer pressure

During adolescent stage, adolescents are concerned with building strong relationships with their peers. It is during this stage where they are more susceptible to peer pressure. Peer pressure influence adolescents in risky behaviour engagements. They are bound to conform to the norms of the peer group as they seek peer approval and acceptance (Nalikwago, Alaii, Borne, Bukuluki & Crutzen, 2018). Peer influence has been reported in risky sexual behaviour, thereby exacerbating the problems encountered by adolescents (Nalikwago et al.,2018).

4.2.2.4.6 Sub-theme 6: Early sexual debut

Adolescent sexuality is a crucial aspect to investigate during health education and discussion with adolescents. The timing of an adolescent's first sexual intercourse is an integral part of sex and sexual education. Adolescents should be equipped with skills and information so that they can make informed decision when it comes to sexual activities (Lindberg, Maddow-Zimet & Marcell, 2019). In addition, research by Lindberg et al. (2019) suggests that adolescents who engage in sex at younger ages have high chances of being pregnant and getting infected with HIV and other STIs. Sexual debut exposes young persons to myriad

negative sexual and reproductive health outcomes. Early sexual intercourse is also found to increase the risk of unwanted pregnancies and poor educational outcomes especial for adolescents in schools.

A constellation of these outcomes further leads to increased vulnerability, to poor sexual decision; even if they know about risky behaviour that can impose them to higher risk of contracting transmissible illness (Amo-Adjei &Tuoyire,2018). The results from the study by Rytter, Kolte, Briend, Friis and Christensen (2014) revealed that a sexual initiation at the tender age increasingly leads to risky sexual behaviour. The assessment of the implications of risky behaviours, revealed that, multi-layered factors at the individual, family, and community levels, predict early sexual debuts.

At the individual levels, variables such as low aspiration and low self-esteem, lack of knowledge of reproductive health and HIV/AIDS, and attitudes to premarital sex are revealed (Asante et al., 2018).

Participant 2: *Due to poverty, adolescents engage in sex at a young age as they want to gain something in return. As a result, they end up falling pregnant and most girl's* ***bant'sa limpa ka sepiriti le vinegar*** *(girls fall pregnant and resort to doing backstreet abortion using methylated spirit and vinegar).*

Participant 3: *We engage in sex before marriage, and we end up being pregnant. When we realise that we are pregnant, we do abortion, which results in the death of the mother or child or both*.

The participants pointed out that they engaged in sexual intercourse at the tender age. This is mostly influenced by the fact that girls do not accept the circumstances in which they live

4.2.2.4.7 Sub-theme 7: Rape, incest and adolescent's pregnancy

Other participants had different views. They mentioned rape and incest as other health problems affecting them both physically and emotionally. In Africa, adolescent pregnancy is high. Other challenges associated with adolescent pregnancies include maternal and child morbidity, hypertensive disorders, infections, low birth weight and preterm delivery (Kassa, Arowojolu, Odukogbe & Worku, 2018). In support of the above evidence, Abebe, Fitie,and Wogie,(2020) reported that children of adolescent mothers were 1.65 and 4.94 times more likely to be born prematurely and face intrauterine foetal death (IUFD).

In addition, challenges of preterm delivery were also reported at 1.58, 1.36, and 1.16 times more than the adults. Low birth weight in teenagers and adults was 24% vs. 9% teenage

pregnancy (Abebe et al., 2020). Adolescents also reported pregnancy as one of the major problems, resulting in delivery complications with the bodies not being mature enough to carry the baby to the full term. Teenage pregnancy has thus been associated with multifaceted factors including rape and incest. child malnutrition.

4.2.2.4.8 Sub-theme 8: Malnutrition

Poverty and poor economic status have attributed to inadequate diet among adolescents more especially in rural areas. The result of indagate diet has contributed a lot to the poor nutritional status of adolescents and their unborn children (Degu, Amene & Thilagavathi, 2020). Poor nutritional status such as lack of necessary minerals and vitamins that are need by the body has been dealt with in previous literatures. This condition is referred to as malnutrition or undernutrition. It has been reported as of the most common cause of morbidity among adolescents throughout the world (Degu et al., 2020).

Adolescent girls were given little health and nutrition attention. Focusing on adolescent girls' nutrition prior to conception is one way to break the intergenerational cycle of malnutrition as it could increase the risk of dangerous infections, which mostly hurt the growth of children as well anorexia nervosa or bulimia. Therefore, there is a need for more rigorously designed observational studies to understand the nutritional epidemiology of adolescent pregnancy. It is also essential to develop future dietary interventions for adolescents (Rytter et al., 2014). Following is the response of participant on malnutrition.

Participant 17: *Malnutrition is a serious concern among adolescent's children. We are not able to take good care of our babies. There is no food, and our parents are reluctant to assist us as they say (**re fumane moputso**) we reap the result of our behaviour. Poverty miscues us, most of us have to raise our children alone as our so-called boyfriends are not involved*.

Adolescents are prone to malnutrition which is a dangerous aspect which affect their health and it has been overlooked. Poverty and peer pressure are cited as contributing factors. Health education could alleviate poor health and unbalanced diet.

4.2.3 Objective 3: To Discover Adolescents and HCWs' Views on Ways of Improving Adolescent-friendly services provision and utilisation

Access to youth friendly health services is vital for ensuring sexual and reproductive health (SRH) and well-being of adolescents. In many parts of the world, adolescent's friendly services (AFS) have been noted to provide improved health-status. To achieve improved adolescent friendly service provision the following concepts have to be prioritised: adequacy;

accessibility and equity; and acceptability (Homer et al., 2018). Recent literature on adolescent programmes have identified school-based education as an effective method to improve SRH education (Vongxay et al., 2019). Cislaghi and Shakya (2018) reported that, focus should be on training health professionals but also modify facilities for adolescents and make them adolescent-friendly facilities. Therefore, that will include giving adolescents change to have their views on planning, designing and execution of adolescent related projects (Cislaghi & Shakya, 2018).

However, there should be distribution of information through different platforms including social media, TV and provision of health education in school and public gatherings. Awareness-building activities targeting adolescents and the distribution of free contraceptives should be improved as well (James, Pedro & Imrie 2018). Adolescents and health care providers were asked to give their views on how to improve the existing provision and utilisation of services. That question was asked to explore their inputs or recommendations on how best to improve adolescents' friendly services. To answer this question, adolescents stated several recommendations as listed below.

4.2.3.1 Theme 1: Health Care System Change

Despite the health care system reform and efforts to invest in the public sector, inequalities such as poor infrastructure and limited resources influence service delivery. The majority of the people have relied on public health system despite poor infrastructure, limited resources and inaccessible SRH services. Van Boekholt, Duits and Busari (2019) suggested that private healthcare sector employs the majority of health care professionals with more skills, thereby showing the private health sector as assisting the public health sector through partnership.

Through a partnership with the private health sector, the public sector can achieve more, notably support on skilled human resource, funding to cover infrastructure cost and medication. In terms of resources, the study revealed a shortage of space for rendering services, thus compromising privacy and confidentiality. They also suggested that there should be more staff assigned to provide services to them.

4.2.3.1.1 Sub-theme 1: Proper infrastructure

Lack of proper infrastructure prompts adolescents to seek treatment to different hospitals.

Participant 9: *Services should be provided under one building to avoid moving from one place to the other. As a result, we wait for a long time here*.

Participant 15: *There should be more space… there is a need for extra rooms so that we can get all the services together*.

Participant 19: *There should be more rooms so that pregnant women, lactating mothers and those who came for contraceptive should be in separate rooms. Also, we should not go to OPD for consultation, there should be a doctor assigned to consult adolescent here… ADHC. There should be different rooms for different services, and health education should also target a certain group. For example, I may have come for preventive services alone and health education given that day be based on breastfeeding. It is a waste of time as I will not listen to that information as it is not relevant to me.*

Shortage of proper infrastructure is a challenge in most provincial facilities. Adolescents appear to be frustrated by lack of infrastructure and long queues. There should be different rooms for different services, and health education should also target a certain group of people.

4.2.3.1.2 Sub-theme 2: Capacity building of staff working with adolescents through workshops, training, mentoring and supervision

Capacity building of the nurses and/ or any other hospital staff members assisting in the provision of SRH services is vital for adolescent health. Training, workshops and mentorships have been identified as essential to improve service. Healthcare workers need on the job training to capacitate them by organising and providing SRH services (Keogh et al., 2016). Furthermore, mentoring should be done on a monthly basis to fill the gaps and provide customer-care and soft skills training so as to address attitudes of healthcare providers and make them amenable for service provision. All these would positively influence the utilisation of the SRH services.

The participants from the in-depth interviews did not mention anything about the training of the hospital staff. One would ask whether services are of good quality or whether the participants are just happy with them as they are. According to the WHO (2016), adolescents have different expectations as well as preferences. Therefore, it may be difficult to understand or predict what they perceive as friendly services.

HCW 1: *Stated that there should be more training for the staff*.
HCW 2: *There should be comprehensive training on SRH*.
HCW 3: *There should be training to capacitate staff. An individual should do follow-ups after the training. Also, there should be mentoring done on monthly bases. This will assist in identifying gaps then the provision of services, and it will prove that service delivery has been done effectively and nurses will not lose interest in the work*.

HCW 4 and 5: *Capacity building should be given to nurses to improve service delivery. Also, there should be an evaluation of how services are provided and to assess knowledge and skills among the health care workers. For example, an assessment should be done to see if nurses working with adolescents can insert no plant. Also, they should be taught about customer care so that they can master service delivery, especially adolescent-friendly services*.

It is motivating to note that different groups of adolescents, world-wide, identify two key common characteristics. They want to be treated with respect, having privacy and information to be kept confidential at all times. The nurses had their views on capacity building. They mentioned that there should be an evaluation of how services are provided and to assess knowledge and skills among the healthcare workers. For example, an assessment should be done to see if nurses working with adolescents have empathy. Also, they should be taught about customer care so that they can master service delivery, as well as being adolescent-friendly.

4.2.3.2 Theme 2: Scaling-up of Adolescent-Friendly Services

Adolescents' sexual and reproductive health services should reach every adolescent regardless of their race, ethnicity, education attainment and gender. Majority of the participants (n=5, 100%) suggested that SRH services should be scaled up to the communities to reach all adolescents. To effectively roll out adolescent friendly-reproductive health services (AFRHS), mobilisation and sensitisation of adolescents and the community is crucial.

4.2.3.2.1 Sub-theme 1 Mobilisation and sensitization of the community on existing services through public gathering, social media and local radio station Moeling and pamphlets

Awareness of the existing health services is the most fundamental aspect in understanding service provision and utilisation. It is, therefore, essential to provide adolescents with adequate knowledge. This would enable them to know if the services they need are offered or not. In order for HCWs to be able to reach all adolescents, they should have intensive mobilization, sensitisation of the public and adolescents. That will enable adolescents to have more knowledge concerning reproductive health issues. If adolescents know the existing services, utilisation will increase, thus calling for scale-up of services to the broader community of adolescents.

Participants suggested several possible activities enabling the facility to share information on the services offered. Amongst others were mobilisation and sensitisation through public

gatherings or community outreach. The health facility should provide and expedite SRH services outside the hospital to the community. All these would maximise access to services including many adolescents who would, otherwise, travel long distances for services.

4.2.3.2.2 Sub-theme 2: Life skills

Participant 13: *We should be taught life skills so that we can be equipped on how to overcome our problems. Most of the time we end up in trouble because we lack skills, so we tend to use the information we get from our peers, which most of the time are incorrect*.

Adolescents recommended more information on life skills to empower themselves for the outside world. Lack of skills and information makes them disadvantaged, and they rely on information from their peers and succumb to peer pressure.

4.2.3.2.3 Sub-theme 3: Targeted campaigns, tournaments and fun walk to increase awareness

As part of designing long-term interventions and campaigns, competition is needed to raise awareness on SRH services and build respect and dignity for adolescents seeking SRH services. The participants reported to have had sport activities such as soccer tournaments, or campaigns, fun walk, adolescents' meetings. The majority of participants mentioned that they would be busy with sporting activities to delay engaging in sexual activities.

4.2.3.2.4 Sub-theme 4: Peer educator's involvement during the implementation of activities

Identification and selection of peer educator play a significant activity in improving access and utilisation of adolescent health services. Peer education helps adolescents to obtain clear information related to sexual behaviour as well as STIs and HIV/ Aids. Peer training is participatory and involves all adolescents. In addition, it may include innovative and entertaining activities which also provide crucial information. Training also opens opportunities for adolescents to ask questions without fear of being judges and labelled, thus influencing demands for services.

4.3 CONCLUSION

The chapter has primarily presented and discussed the key findings from a largely participant-centric perspective in consonance with the constructivist-phenomenological research paradigm (worldview) (Creswell & Creswell, 2018) as articulated in Section 3.2 of Chapter 3. These findings also emanate from the researcher' s content and thematic analysis of the qualitative data derived from both the 21 adolescents and five nurses who were eventually sampled for this particular purpose. The chapter has also discussed and

interpreted the findings in relation to both the theoretical framework and the relevant literature reviewed for this study's secondary data. The next chapter presents the conclusion, limitations as well as recommendations of the study.

CHAPTER FIVE

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

The chapter mainly provides the main conclusion, recommendation and limitations of the study. The purpose of the study was to evaluate friendly service utilisation by adolescents in Butha-Bothe Government Hospital, in the Butha-Buthe district, Lesotho. In addition, the study also sought to identify challenges faced by adolescents concerning their health, and to propose recommendation for improving service delivery and utilisation. The following summary of the key findings was directed

5.1.2 Summary of Key Findings

In line with the research questions, the objectives were set to allow the study to achieve the following objectives:

- To identify ways in which the facility could organise and offer SRH service to adolescents I need of such services.
- To identify any health challenges facing the provision of SRH services.
- To explore the adolescent and HCW views on how best improve adolescents' friendly service provision and utilisation.

5.2 OBJECTIVE 1: TO IDENTIFY WAYS IN WHICH THE FACILITY COULD ORGANISE AND OFFER SRH SERVICES TO ADOLESCENTS

5.2.1 Capacity of the Hospital in Providing SRH

The researcher assessed the friendly service utilised for adolescents in the Butha-Bothe government hospital in the Butha-Buthe district in Lesotho. It was found that the hospital did not fulfil the criteria for youth-friendly service provision, as set out by the National minimum standards for SRH integrated services provision. The hospital did not satisfy the requirements for the eight minimum standards required for adolescent-friendly services recognition detailed by the researcher in Subsection 2.5.6 of Chapter 2, although performance in relation to some specific clinical service provision criteria was encouraging. The study revealed notable high levels of inequities in service provision and utilisation. SRH services were mostly provided for pregnant and lactating adolescent mothers, more especially those coming for contraceptives.

James et al. (2018) revealed that service SRH should be given to all adolescents irrespective of gender and impairment. According to the study findings, the current system used in Lesotho in provision of adolescent friendly services does not consider equity during service provision. As such, services for male adolescents were not available, unlike as female adolescents, especially those who are pregnant or lactating. Adolescent boys who requested for circumcision were either referred to other facilities or had to wait for the donors to fund the hospital. The reason for that is that adolescent boys are reluctant to seek health services for fear of being tested for HIV, breach of confidentiality as well as being stigmatised. It was also discovered that way adolescent corner is structure, it does not accommodate both sexes. It seems to be gender-biased as the focus was mainly on pregnant and lactating mothers. The WHO recommended that health care facility should provide integrated services for adolescents.

The hospital should, therefore, provide comprehensive services for both adolescent girls and boys. The study found the following services to be available and mostly utilised: ANC, PNC, HTS and contraceptives. Mulugeta et al. (2019) further suggested that the government should include provision of high quality and age- appropriate health services. In addition, documented evidence during provision of services was also recommended. Mulugeta et al. (2019) further suggested that services should be available, accessible, acceptable and appropriate to adolescents. Therefore, the study found this recommendation to be consistent with the suggestions by the study participants. In addition, the physical accessibility was also highlighted as one barrier to reduce utilisation of SRH services.

It was found that adolescents travel long distances, mostly walking due to lack of transport to reach health facilities. The finding explicitly revealed that the services are offered in awkward times, such as late opening and early closing time during the weekdays. They open around 08h00hrs and close at 16h30hrs, the same time when adolescents come out of school. Adolescents were expected to pay for consultation in case one is sick, and free services are accommodated for mother-child health. Minimum Standard 4 was particularly about the facility environment in relation to the availability of drugs, supplies and equipment, which are constantly out of stock. Also noted is that infrastructure and resources influenced provision of adolescent friendly services, resulting in client’s dissatisfaction.

5.2.1.1 Availability of Resources and Provision of Friendly Services

For the facilities to provide adequate friendly services, resources should be available. These include human resource, equipment and infrastructure. In this study the participants reported dissatisfaction with service provisions concerning lack of resource. For example, shortage of staff. The study revealed that only one nurse is allocated to work at adolescent health Centre, serving a larger population of adolescents. The stock out of drugs and insufficient of diagnostic clinical equipment were identified. Patients are referred to the National Referral Hospital if they need special treatment and or expertise. Furthermore, the study identified lack of personnel to assist with provision of services and lack or poor infrastructure attributed non utilisation of SRH services. The rooms where services are provided are too small, those adolescents who require pap smear had to be accommodated in another department. The study found out lack of resources impede negatively in providing friendly services

5.2.2 Attitude of the HealthCare Workers

It is crucial to take cognisance of the requirements of provision of friendly services. Among crucial aspect, respect, care and support are significant. The study revealed that healthcare workers have negative attitudes towards them. Participants complained that nurses shout at them, they feel judged by the health care professionals and confidentiality is breached. Furthermore, the participants complained about being stigmatised, as such, they were uncomfortable to access services in hospital. Therefore, those conducts by HCWs resulted in reduced utilisation of SRH services by adolescents. A study conducted by Tilahun, Alemu, Egata & Reda (2012) reported that adolescents felt embarrassed or had discomfort to discuss sensitive topics with their health care providers. They were also disappointed with the questions from the healthcare workers, most of which appeared judgemental. For example, some adolescents decided to access services from other health facilities because of ill-treatment by the healthcare workers.

It was discovered that adolescents were treated with disrespect and even denied access to services by health care providers who constantly remind them of their ages and sometimes threaten them to divulge information to their parents. The participants mentioned that at times they were not given services, especially when they arrived late due to logistics, or they had extra lessons at school. The healthcare workers do not take into consideration, the distances from the village to the facility. This argument was supported by (Jonas et al., 2018), who averred that reduced use of SRH services includes the unfavourable behaviours and attitudes of healthcare workers towards adolescents seeking the services. Healthcare

workers' actions discouraged adolescents from attending clinics and keeping follow-up appointments. Lack of respect for adolescents' privacy and previous ill-treatment by healthcare workers were some of the reasons that discouraged sexually active adolescents to seek SRH services.

In addition, lack of skills necessary for providing services to adolescents, as well as social norms towards adolescent sexual practices result in inadequate treatment of ill adolescents. Denno et al. (2015) suggested health facility intervention, which includes training of health providers and staff to improve their knowledge, attitudes and skills to appropriately respond to the needs of adolescents. Adapting a physical layout involving separate rooms for consultations for privacy or confidentiality has been considered crucial to community interventions, outreaches and school visits. Besides, the study highlighted the need for training on customer care for the purpose of training and equipping healthcare workers with best skills in service delivery to patients, including adolescents at hospital. Accordingly, the study found the recommendation on improving care for adolescents worthwhile.

5.2.3 Client Satisfaction Concerning Services Provided

The findings revealed that most of the study participants were satisfied with the services provided. However, there were participants who were concerned about the service provision. They complained about waiting for too long in queues. In an ideal situation, a person does not have to spend the whole day at the health institution. However, some participants reported that they were being served by one nurse which caused the delay in getting the services on time. On the other hand, it was reported that due to the pressure at work, the nurses do not talk nicely with adolescents. They shout at them, making them feel uncomfortable and degraded. The issue of the health care worker's attitude was condemned by Jonas et al. (2018), who reported that healthcare workers' behaviour discourages adolescents from seeking services and keeping follow-up appointments.

The reasons mentioned include lack of respect for adolescents 'privacy and ill-treatment by healthcare workers. In addition, lack of skills for providing services to adolescents, as well as unfavourable social norms towards adolescents' sexual practices. The results of unfavourable behaviour and attitudes towards adolescents contribute to serious barriers that hinder them to access and utilise the existing SRH services. The participants reported that after getting poor service at the hospital, his friend decided not to get services at the hospital anymore; instead, he decided to go to the other clinic where he will be treated with dignity.

In addition, the out of stock of drugs also influenced poor access and utilisation of services. They reported reluctance to come for subsequent appointments for fear of being told to come again in the next week due to stock-out of drugs.

5.2.4 Conclusion

In general, the provision of adolescent friendly services has been compromised. Lack of resources including staff, poor infrastructure, medical equipment has posed a threat to services provision. Patients must be transferred to referral hospitals, and that also cause psychological or emotional instabilities to the clients. Lastly, negative attitude of healthcare workers also attributed to non-utilisation of services. Adolescents report that nurses shout them, as a result they resort by not coming to access the services

5.3 OBJECTIVE 2: TO IDENTIFY ANY HEALTH CHALLENGES FACING THE PROVISION OF SRH SERVICES.

In order to provide comprehensive and integrated friendly adolescent services, it is important to explore the challenges that can impede on proper service delivery. To achieve this objective, factors such as resources, knowledge and awareness regarding existing services, long distances and queues, were explored to find the implications they have on services provision.

5.3.1 Factors Influencing Poor Service Delivery

5.3.1 1 Lack of Space, Privacy and Confidentiality

Evidence from previous studies revealed that respect for privacy and confidentiality, especially in active rural communities, was reported to be a basis of acceptance of health service delivery for adolescents. Akatukwasa et al. (2019) highlighted adolescents' discomfort with physical privacy constraints in health centres, such as open doors or counsellors' desks being located near a window or partition that insufficiently muted voices. As such, the lack of private consulting rooms denies adolescents confidentiality and privacy.

Health facilities are in open and public areas where they can be easily accessed, this does not translate into practical use by adolescents who need the services. They rather highlighted challenges, inadequacies and gaps in policies intended to address adolescent reproductive health problems. Adolescents are more likely to consult a health care provider if confidentiality is prioritised. Such an assurance results in patients more likely to return for follow-up visits. Also crucial is knowledge regarding the minors' consent laws amongst

service providers and the ability to maintain confidentiality for adolescents with medical records.

5.3.2 Long Distances and Queues

Despite many collective efforts, most Sub-Sahara African countries are still facing significant challenges of adolescents and youth sexual and reproductive health service utilisation. A Kenyan study revealed that long queues, unfavourable working hours, mixing out of school youth and the school going youth and lack of money negatively affected utilisation of youth-friendly reproductive health services. Reducing distances to health facilities is a priority to improve coverage, accessibility and ensure easily accessible services in terms of location (Akatukwasa et al., 2019). A study by James et al. (2018) highlighted that adolescent boys complained about the limited operating hours coinciding with their schoolwork.

The participants complained about long distances to the hospital, awkward operating hours, and that most of the school going adolescents are reluctant to come for services because of the non-conducive opening and closing hours. It was highlighted that the hospital opens at 08h00hrs in the morning, but service provision starts late, with one nurse providing services and this makes it hard for an adolescent to arrive home on time as they have to travel long distances and sometimes had to rush for public transport which is consistent on time. The study, therefore, recommends opening on weekends to accommodate adolescents, to be able to access services without missing school.

5.3.3 Knowledge/ Awareness

5.3.3.1 Knowledge of the Challenges Facing Adolescents

Adolescents were able to identify common SRH problems they experienced. Their responses were specific and reflected the individual, social and economic environment factors as the main drivers. Problems commonly mentioned included early sexual debut and unprotected sex, unwanted pregnancy, infection including STIs HIV/AIDS, unsafe abortion, sexual violence, rape and incest. Other concerns related to poverty and unemployment, which worsen their vulnerability to drug and substance (Kusheta et al., 2019). Furthermore, Kushela et al. (2019) mentioned that Africa is reported to have high rate of adolescents infected with STIs. This population is vulnerable to multiple sexual and reproductive health problems including gender inequality, sexual coercion and partner violence, early marriage, polygamy, female genital mutilation, unplanned pregnancies, closely spaced pregnancies, abortion, sexually transmitted infections (STIs) including HIV/AIDS.

Kusheta et al. (2019) further indicated that adolescents in Sub-Saharan Africa were not well informed about SRH matters, because their significant sources of information are friends. Other informal sources such as parents lack of information and teachers or healthcare workers as their confidante, for reaching their adolescents, thus neglecting their primary responsibility for children. Research suggests that adolescent-parent communication may be an effective strategy to improve healthy sexual and reproductive health behaviour. The universal access to sexual and reproductive health-care services set by the United Nations would not be realised unless adolescents were reached out through various interventions including parents-child discussion about SRH issues in low- and middle-income countries (Akatukwasa et al., 2019).

Such interventions should slightly shift from cultural norms which discourage talking about sexuality between adolescents and parents. Besides, the study suggested that adolescents should be engaged in sports activities which are believed to keep them busy, and this may have an impact as most of them may not be involved in risky behaviours the study also revealed that adolescents engaged in risky sexual behaviour due to peer influence. Three (n=3, 14%) adolescents mentioned that due to the influence of alcohol, they ended up engaging in unprotected sex. As Morris et al. (2015) pointed out, adolescents' sexual and reproductive health is strongly linked to their particular social, cultural and economic environment. At the same time, Nash et al. (2019) concurred with the participants, observing a high rate of adolescent pregnancy in Sub-Saharan Africa.

Early childbearing in adolescence is linked to poorer health outcomes, lower education attainment and lower socioeconomic status for women and their offspring. Adolescents experience the same problems as above in Lesotho. For example, most adolescents who have had their first child have been reported to be of lower educational status. According to the LDHS (2014), adolescent pregnancy is more common to adolescents whose level of educational is limited and living in rural areas. However, besides the afore-mentioned challenges, the study has highlighted an issue of adolescent-child malnutrition. The participants reported poverty and lack of food at home as the reason for not being able to properly feed their babies.

5.3.4 Knowledge or Awareness of the Existing Services Utilised by Adolescents

With reference to knowledge or awareness of the presence of adolescent SRH services in BBGH, the results indicate that the majority of adolescents were aware of the existence of these services. This knowledge was consistent among all study participants despite slight variations. In support of this evidence, clinical review of registers was done to take note of the services that were highly utilised by adolescents.

5.3.5 Service Utilisation-Clinical Records

The study revealed that most SRH services utilised were ANC, PNC and contraceptives. According to the records (review of registers). There was also an increase in cervical cancer screening among adolescents.

In 2017, 906 adolescents and young people accesses HTS services and 210 were aged between 18-19 years who accessed, and this accounts for 23.1%. In 2018, 1070 adolescents accessed HTS and 245 were aged between 18-19 years and is rated at 22.8%. This shows a decrease of 0.3% in utilisation of HTS services in a two-years period, 2017 and 2018, respectively.

In 2017 and 2018, 243 and 245 adolescents accessed ANC services. Out of 243, only 63 were aged between 18-19 years and out of 245, 54 were also adolescents aged between 18-19 years. The statistics showed a decrease of 3.9% in 2017 and 2018, respectively. On the other hand, though, there was a decrease in access to other services. According to the records, there was also a decline of 5.4% in ANC records, in 2017, 248 and 68 were aged18-19 while in 2018, there were 245 and 54 were aged 18-19. The study reported decline in access in most services. The evidence was confirmed by the response from study participants. They indicated that most female adolescents knew about the programme, thus increasingly utilising HTS and contraceptives.

A decrease in utilisation of SRH was mainly influenced by the fact that adolescent health corner which was utilised as a mini MCH and provided services that are mainly female-oriented. Generally, utilisation of services by adolescents has decreased. The study has further revealed that service provision of SRH is biased, and services were mainly for females. The participants revealed that most adolescent males were afraid to access services because they were scared of being tested for HIV test and they felt that confidentiality was non-existent, and they didn’t want to be stigmatised. There have been

some HTS campaigns conducted to create demand for HTS services within the male population including adolescents. Labhardt and Lejone (2018) supported the above evidence by mentioning that in most cases, uptake of HIV testing is shown to be above 90%; testing coverage remained below 90% because of absent people at the time of the campaign.

This evidence applied for men and adolescent boys, both of whom are more susceptible to a high risk of acquiring HIV and poorer clinical outcomes once infected. The other challenges facing Lesotho include low uptake of PMTCT, HTS, VMMC, condom use and ART by males, key population, adolescents and young people. There is a need to capacitate health workers to deliver quality services as well as increasing demand for testing, prevention and adherence to treatment and facilitating service uptake (GoL, 2018).The new evidence suggested that to increase HTS among adolescent's male, HIV self-testing (HIVST), is recommended. This process allows people to collect specimens, perform tests and interpret the results by themselves often in a private room.

This is an emerging approach that can extend HTS to people who might be reluctant or unable to attend to the existing HTS as well as to people who frequently do the tests (Onokerhoraye & Egbemudia, 2017). Males have been found to be reluctant to gather at the same place as females in Lesotho; therefore, it may not be ideal for attending to both males and females in the same room. There should be separate rooms for service provision of sexual and reproductive health issues to adolescents of the same sex. The WHO (2017) observed the importance of age and gender of adolescents regarding specific information related to them. Adolescents need different approaches and messages, and they should be segregated by age groups as in 10-14 years, 15-19 years, 20-24 years respectively (WHO, 2017).

5.3.6 Conclusion

Comprehensive and integrated service provision highlight the integral component of friendly services provision. It is imperative to identify and resolve challenges affecting service provision, in order to assist program implementers to successful utilise the available resources for improving service delivery. Various factors affecting provision and utilisation of friendly SRH services were explored, including challenges faced by adolescents, their knowledge regarding existing services, long distances and queues they follow before being served. Furthermore, lack of infrastructure such as rooms for privacy and confidentiality was discussed as it has an impact on service delivery.

5.4 OBJECTIVE 3. VIEWS ON IMPROVING FRIENDLY SERVICES OF ADOLESCENTS

In recent years, efforts have been made to strengthen adolescent-friendly services. However, the focus was not only to ensure the availability of health services, but also making its provision accessible, acceptable, equitable, appropriate and effective. These efforts aim to increase the ability and willingness to obtain services, mostly adolescents who need them the most (Adan & Githae, 2018). Furthermore, adolescent-friendly services were reported to be crucial in improving the sexual and reproductive health and well-being of adolescents. This study has recommended the effectiveness to implement the initiatives that will address the service provision and utilisation of services.

The study by Akatukwasa et al. (2019) suggested that adolescents' friendly services (AYFS) are meant to assist adolescents in overcoming barriers to quality sexual and reproductive health care services. Service providers should comply with the requirements of national guidelines for the provision of adolescent and youth-friendly services. Adolescents' needs, concerns and confidentiality within a conducive environment should be catered for. The participants believed that proper infrastructure with safe rooms for privacy and confidentiality are crucial for improved service delivery and utilisation

5.4.1 Detailed Activities to Enhance Improved Friendly SRH Services

5.4.1.1 Health Care System Change: Infrastructure, Availability of Resources

The integration refers to the process of bringing together SRH and rights, HIV, and co-packaging services in one service point to ensure complete accessibility of a comprehensive, efficient and effective services. Integrated SRH- co-package services are considered to have several benefits, such as greater efficiency and cost-effectiveness compared to stand-alone models. It is evident that integrated and improved services ensure client satisfaction and influence utilisation (Ali et al., 2018).

Integration of SRH-HIV co-package services have strong justification. According to UNFPA. (2022b), it is critical to mitigate the high-risk sexual behaviour and optimise the utilisation of sexual and reproductive health services through integrating HIV and SRH services for an adolescent. Although adolescents feel motivated when informed about the use of contraceptives and knowledge about HIV/Aids and prevention of unwanted pregnancies, they have limited access to information about where to access these services. Furthermore, inadequate linkage of SRH services often lead to missed opportunities in addressing their

needs. Research shows that integration of reproductive health services into HIV services would be key to adding high quality contraceptive services (GoL, 2015).

5.4.3 Mobilisation and Awareness-Raising Activities (SRH)

Adolescents should be made aware of activities such as tournaments, targeted campaigns and fun walk to improve the utilisation of SRH services (WHO, 2022). For example, public gatherings, school health visits and presentations on the local radio station such as Moeling FM are vital in this regard. The participants reported that the hospital nurses should visit local schools to sensitise and inform adolescents on the existence and availability of SRH services. Billboards inside and outside the hospital have also been found to be useful for explicitly showing the services available within the adolescents' health corner and direction to such services. In this regard, Ali et al. (2018) supported the above argument, suggesting that there should be public forums, to engage in local media, design public service announcement, creation of billboards campaigns, the drafting of pamphlets and social media campaigns to attract adolescents and the community,

The recent evidence suggests that the goal of the education campaigns is to generate awareness, motivate and encourage funding and for high demand creation for access to the services. However, there should be specific programs tailored to target the intended audience during the awareness campaigns. At the same time, peers are believed to remain the most reliable source of information. Therefore, efforts to capacitate them with more skills and knowledge on SRH issues could leverage the existing channel (Horner et al., 2018). WHO (2022) suggests that the engagement of peer educators is crucial in encouraging peers to give SRH education, thus boosting their self-efficacy. Early pregnancy can be prevented by engaging adolescents of the same age group, to participate in SRH education.

5.4.4 Scaling up Adolescent-Friendly Health Services

Safe environments for the provision of the friendly adolescent SRH services were the adolescent health corner. Furthermore, adolescent centres could potentially offer an integrated site or a "one-stop" approach where integrated SRH services are provided (Miller et al., 2017; WHO, 2017). Adolescent centres, especially in urban settings have proved to be effective, focused on youth development and reduction of the incidence of sexual and reproductive health (SRH) which is a challenge for adolescents. As such, adolescent-friendly health services, school visits, community clubs and improved adolescent and youth centres are notable. However, Svanemyr, Amin, Robles and Greene (2015) posit that integrating

adolescent-friendly services into the existing health delivery service is more effective than establishing separate stand-alone adolescent centres or clinic.

Adolescent-friendly services, whether both general and SRH-related centres, should reach all adolescents including married or unmarried adolescent girls. The study revealed contradicting information on the above phenomenon. Majority of adolescents reported many adolescents coming for services as pregnant and lactating adolescent mothers. As a result, most are left unattended, especially boys, as they do not find adolescents health corners within the hospital setting as a conducive environment to them. It is worth noting that both boys and girls coming for general services experience challenges of having to queue with adults. This situation overlooks the recommendation that all the services geared towards adolescents should be in a separate building to promote privacy and confidentiality.

On that note, adolescent centres are commonly considered useful platforms for promoting adolescents' participation and empowerment, offering training in vocational and life skills. Aventin et al. (2021) pointed out specific needs of adolescent girls and boys are met through the specific SRHR needs. For them, it is essential for both in- and out-of-school adolescents and young people to access good quality, age-appropriate, scientifically accurate and comprehensive life skills-based sexuality education (CSE), which is also linked to SRH and youth-friendly services. There is also a need for building the capacity amongst educators and peer educators to deliver quality life skills based CSE services. This evidence was supported by the participants who suggested that peer educators should be identified and trained.

One of the main objectives is for the peer educator to teach other adolescents at the community level. It is imperative to bridge the gap by providing education to adolescents at the health centres to provide equitable SRH services to both male and female adolescents. The participants have supported the above evidence, thus revealing that there should be an adolescent and youth centre with enough room and necessary equipment for smooth provision of SRH services to adolescents. It has also been found out that the current system used in adolescent health corners does not provide equitable services, as most of the services offered are female-oriented. Therefore, there is a need to have a new building adolescent health centre (ADHC). The centre should be big enough to give all sexual and reproductive health (SRH) to both females and males. With the environment welcoming and non-threatening, adolescents would be attracted because of a high demand for services.

5.5 LIMITATION OF THE STUDY

The study was only conducted in one of the ten (10) pilot hospitals that were selected by the MoH to provide SRH services to a diverse population of adolescents and young people. As a result, the study findings cannot be generalised to other healthcare institutions. Thus, the external validity of the findings may not be applicable. Secondly, the study population comprised both the adolescent girls and boys. However, only two (2) male adolescents were interviewed. This raised a concern regarding possible bias in selection of the participants. The study aimed at interviewing an equal number of adolescent boys and girls. However, the researcher faced challenges of having both sexes equally, thus rendering gender representativity as disproportionate.

The majority of adolescent girls accessed the services, and boys were not accessing services at the adolescents' corner. The study revealed that only males who accessed the services were the ones who attended the facility with their wives. While the study targeted 30 participant adolescents, only 21 adolescents were available for interviews. One of the reasons is that the eligible adolescents were very few. The interviews were conducted during the weekday, when most 18-19-year-old adolescents were at school. However, most, if not all the interviewees were out-of-school adolescents. Finally, the findings could only be generalised for this sample, but not to the broader population within the Butha-Buthe district. Notwithstanding its possible limitations, the study could be informative and valuable to other prospective researchers.

Furthermore, the findings of this study may be utilised as a basis for understanding the best practices to improve adolescent-friendly SRH services provision and utilisation. The researcher discovered that some research could also be conducted following this study with a focus on the following areas:

- An intensive evaluation to assess adolescent friendly service provision and utilisation in rural and urban hospitals
- Qualitative research to assess the socio-economic and legal factors contributing to backstreet abortions amongst adolescents in Maseru

5.6 RECOMMENDATIONS TO HEALTH SECTOR, MOH, PUBLIC AND ADOLESCENTS

- To mitigate adolescent SRH problems, a solution-oriented approach is needed. Engagement and training of peer educators and capacity-building of nurses,

equipping them with comprehensive knowledge and skills, is required to cater for adolescent health needs including poor service delivery.

- The need for community and facility interventions, coupled with mobilisation and sensitisation programmes is crucial. This could be undertaken through public gatherings, the local media, school health visits as well as awareness-raising activities such as health campaigns and tournaments.
- The management of the hospital needs to explore possibilities of extending adolescent centres and capacitating wellness centres with more staff.
- In addition, the primary needs and long-term strategies focused on improving friendly service provision and utilisation in newly built adolescent centres, where all adolescents irrespective of their gender would access SRH services. The facility should have enough rooms to accommodate different serving points, thus accommodating even adolescent boys.
- Incorporating technology into health education would be an innovative strategy for social networking and internet forums to disseminate sexual and reproductive health information. Basing programming on adolescent interests and generational characteristics may produce a more active and informative audience.
- Offering accurate and reliable health information in a non-intimidating, confidential manner is crucial for adolescent skills in technology.
- Special attention should be to rural and remote communities with the programmes, resources and services being carefully and creatively implemented with targeting adolescent population. Finally, identifying and training peer educators has been considered an effective strategy in SRH education for adolescents.
- This study provided valuable insight for the Ministry of Health to revamp the current health services in accordance with the criteria which are still lacking based on our findings.
- It is recommended that the Ministry of Health could allocate more budgets on infrastructure improvement, training and health promotional activities pertaining to adolescent health services to ensure adolescent health services can be delivered optimally. More staffs should be allocated at primary healthcare facilities to ensure no single service is underprioritized.
- Future qualitative study to explore the perceptions of healthcare providers regarding facilitating factors and barriers in providing adolescent-friendly health services is

recommended to assist policymakers in setting up realistic requirements of health clinics to become adolescent-friendly.

5.9 CONCLUSIONS

This chapter has discussed the findings based on the study objectives. The research findings indicated that the hospital has not provided adolescent-friendly SRH services. The current system mainly focuses on the provision of MNCH services to pregnant and lactating teenage mothers. This research, therefore, urgently calls for a refocus on service provision to fulfil SRH minimum provision standards. In this regard, the reorganisation of the SRH service provision would yield more useful outputs.

Challenges facing access to and utilisation of SRH services were also explored. The study revealed that there is a high rate of teenage pregnancies, resulting in illegal abortions. The incidence of teenage pregnancy followed by a series of infectious diseases such as STI and HIV, and cervical cancer has also been noted. However, adolescents' problems have been attributed to lack of self-esteem, love for money and peer influence. Also noted are structural factors such as poor service delivery worsens the situation of adolescents and do not encourage adolescent seeking behaviour.

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APPENDIX A: UNISA ETHICAL CLEARANCE/ APPROVAL

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

NHREC Registration # : Rec-240816-052

CREC Reference # 2019-CHS - 0241

Student No : 50752693

Decision:
Ethics Approval from 01 April 2019 to 31 March 2022

Researcher(s): T'sepang Thaanyane -Kabi

Supervisor(s): Dr.T.R Netangaheni
Department Sociology
Email: robert.netangahe@gmail.com
Cell: 076 189 5087

An evaluation of Sexual and Reproductive Health project on friendly health services utilization by adolescents in Lesotho.

Qualifications Applied: Masters

College of Human Science ethics committee hereby acknowledge your application for Research Ethics Certificate; approval is granted for three years on condition that the researcher should submit annual progress report.

The **Chair of College of Human Sciences Research Ethics Committee Reviewed the High Risk Application** on the **12 April 2019** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.
The proposed research may now commence with the provisions 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 should be communicated in writing to the Department of Psychology Ethics Review Committee.

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(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. 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. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No field work activities may continue after the expiry date **(31 March 2022).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number **2019-CHS-0241** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature : 

Dr Suryakanthie Chetty
Deputy Chair : CREC
E-mail: chetts@unisa.ac.za
Tel: (012) 429-6267

Signature : 

Professor A Phillips
Executive Dean : CHS
E-mail: Phillap@unisa.ac.za
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APPENDIX B: REQUEST FOR LESOTHO MINISTRY OF HEALTH AND SOCIAL WELFARE ETHICAL CLEARANCE/ APPROVAL

The Ministry of Health and Social Welfare
P.O BOX 0254
Maseru West
Lesotho, 105
05 October 2018

Dear Sir/ Madam,

SUBMISSION OF RESEARCH PROPOSAL FOR ETHICAL CLERANCE

TITTLE: An evaluation of Sexual and Reproductive Health project on friendly health services utilization by adolescents in Lesotho

I wish to submit the above stated research for ethical clearance. I am a master's student at the University of South Africa pursuing Master degree. I will conduct this research for academic reasons in partial fulfilment for the award of Master of art in social behavioural studies in HIV/AIDS. Collection of data for this research is tentatively scheduled to commerce in October –November 2018. The proposed study will entail the following: in-depth interviews and key informant interview as data collection methods. During the data collection, the researcher will use audio tape to record the information and field note which will later be used during data analysis.

The information sheet will be read to the study participant to provide the study participants with the insight of the study and also to make them understand the details concerning voluntary participation. The study participants are a total of 30 male and female adolescents aged 18-24 years. All participants aged 18 and above who are willing to take part in the research will sign a consent form. The results of the study will be recorded, and confidentiality will be kept protecting the study participants. Participation in the study is not compulsory, and study participants will not be forced or promised gifts and incentives to attract them to take part.

The study finding will be formally documented and will be presented to you after completion of the research.

Yours sincerely

T. Thaanyane

T'sepang Thaanyane –Kabi

APPENDIX C: LETTER OF REQUEST TO CONDUCT THE RESEARCH AT BBGH

P.O BOX 0254
Maseru West 105
Maseru, Lesotho
06 July 2018

The District Health Manager
Butha-Buthe 400
Dear Sir/Madam

Re: Requisition to conduct research

Research Study: An evaluation of Sexual and Reproductive Health project on friendly health services utilization by adolescents in Lesotho

This letter serves to request permission to conduct the study at BBGH. I am a master's student at the University of South Africa pursuing Master degree. I am conducting this study for academic reasons in partial fulfilment for the award of Master of art in social behavioural studies in HIV/AIDS. The proposed study will entail the following: in depth interviews and informant interviews as a means of data collection methods. During the data collection, the researcher will use audio tape to record the information and field note which will later be used during data analysis. Review of registers will also form part of data collection and the information gathered will be triangulated with the informant and in-depth interviews.

The information sheet will be read to the study participant to provide the study participants with the insight of the study and to make them understand the details concerning voluntary participation. The study participants are adolescents aged 18-24 years both males and females accounting to total of 30. All participants aged 18 and above who are willing to take part in the research will sign a consent form. The results of the study will be recorded, and confidentiality will be kept protecting the study participants. Participation in the study is not compulsory, and study participant will not be forced or promised gifts and incentives to attract them to take part. The study finding will be formally documented and will be presented to you after completion of the research.

Yours sincerely

T. Thaanyane

Tsepang Thaanyane-Kabi

APPENDIX D: LETTER FROM MINISTRY OF HEALTH AND SOCIAL WELFARE FOR ETHICAL CLEARANCE/ APPROVAL

LESOTHO

Ministry of Health
PO Box 514
Maseru 100

Category of Review:
[x] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other _____

REF: ID148-2018

Date: October 23, 2018

To
T'sepang Thaanyane-Kabi
Master of Arts candidate
UNISA

Dear Ms. T'sepang ,

RE: An evaluation of Sexual and Reproductive Health Project on friendly services utilization by adolescents in Lesotho

This is to inform you that the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[x] Protocol dated October 22, 2018
[x] English & Sesotho informed consent form dated October 22, 2018
[x] Data collection tools in English and Sesotho dated October 22, 2018
[ ] Participant materials *[insert types, versions*
[x] Other materials: CV of the PI, declaration by participant and interpreter dated October 22, 2018

This approval is **VALID** until October 22, 2019.
Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 22226317.

Sincerely,

DR. NYANE LETSIE
Director General Health Services

DR. LIMPHO MAILE
Member, National Health Research Ethics Committee (NH-REC)

APPENDIX E: PARTICIPANT INFORMATION SHEET

Ethics clearance reference number: …….

Research permission reference number: …….

May, 2019

Title: An evaluation of Sexual and Reproductive Health project on friendly health services Utilization by adolescents in Lesotho

Dear Prospective Participant

My name is Tsepang Thaanyane-Kabi and I am doing research with DR T.R. Netangaheni a senior lecturer in the Department of Sociology towards a MA in Social Behavioural studies in HIV/AIDS, at the University of South Africa. We are inviting you to participate in a study entitled:

An evaluation of Sexual and Reproductive Health project on friendly health services Utilization by adolescents in Lesotho

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out if the Hospital is providing adolescent friendly services.

WHY AM I BEING INVITED TO PARTICIPATE?

Adolescents are targeted group because they can reveal necessary inform regarding friendly service provision and utilization of sexual and reproductive health services.

Adolescents will be informed about the study and we shall seek permission to interview them as they come to access the services. Participants have the right to refuse to take part in the study if they are not comfortable. No one will be forced to take part. A total number of 30 adolescents and 4 healthcare workers will be interviewed.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves in-depth interviews with adolescents and key informant with the healthcare workers. Each interview is estimated to take a maximum of 45 minutes and the interviews will be tape recorded so that all necessary information is captured. This will assist the researcher during data analysis to get the details of the responses from the study participant. The question will require demographic information, knowledge on the challenges

adolescent encounter and problems associated with adolescence and factors that hinders access to SRH services. Also, they will be asked to suggest on the interventions that can be implemented in order to improve adolescent's friendly service provision. The researcher has planned to schedule a week (5 working days) to conduct all the interviews.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

The researcher should obtain a written or verbal consent from study participants to take part in the research and no one should be forced to participate. All participants aged 18-19 years will be asked to sign a consent form. Free and voluntary participation will be guaranteed to the study participants. This will be supported by signing of the consent form. Participant will also be fully informed about the nature, procedures and objectives of the study and their participation. This is requisite for their participation in the study. They had to make an informed decision about whether they want to be part of the study or not. They will also be made aware that they have the freedom to withdraw from taking part in the research when they feel they are not ready however it should be before the study commences so that their replacement can be sought.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct benefits from the study. After the completion of the research, it will inform the Ministry of Health on the gaps identified and recommendations to improve adolescent's friendly health services

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is no risk anticipated. However, if there is any case where the participant feel discomfort, referral to the senior Counsellor will be made to help the client with counselling sessions and support.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your name will not be recorder anywhere and the signed consent form will be kept in a safe drawer where the researcher is working (lockable personal cabinet). That no one, apart from

the researcher and nurses will know about your involvement in this research. All information will be kept confidential. Your name will not be recorded anywhere, and no one will be able to connect you to the answers you give. Participants will be labelled by participation number.

The data gathered from the interviews will be used by the researcher for the purposes of her studies and even for publication. At the same time, the results of the study will be used by the hospital and Ministry of Health for recommendations. A report of the study may be submitted for publication, but individual participants will not be identifiable in such the report.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The transcribed interviews will be stored on the computer and there shall be no information that will link the participants with the transcribed interviews. The audio taped interviews will be recorded on the hard drive disk and kept in a safe place. After the period of 3 years the data will be destroyed by formatting the hard drive disk

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There are no monetary incentives or gifts that will be given to the participants to attract them to take part in the study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

The study has received an approval from The Ministry of Health Lesotho, ethical research committee. I have also submitted an ethical application at Unisa research ethical committee.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Tsepang Thaanyane-Kabi on +266 57255661 or email address tsepangthaanyane@yahoo.co.uk. The findings are accessible for 2019-2020.

Should you require any further information or want to contact the researcher about any aspect of this study, please contact +266 57255661 or email tsepangthaanyane@yahoo.co.uk .Should you have concerns about the way in which the research has been conducted, you may contact DR T.R . Netangaheni at +27761895087 or email robert.netangahe@gmail.com. Contact the research ethics chairperson: Dr Zanetta

Jansen on +277 0124296322 or email Jansezi@unisa.ac.za if you have any ethical concerns.

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

Tsepang Thaanyane- kabi

APPENDIX F: IN FORMED CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to before the study commences. There will be no penalty if the participant withdraws from taking part.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the in-depth /key informant interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname……(please print)

Researcher's signature……..Date……

APPENDIX G: NTERVIEW QUESTIONS FOR ADOLESCENTS

Interview guide for in depth interviews with adolescents

The information gained from the interviews will be kept confidential and no information will explicitly point to an individual. The interview will take about 45-60 minutes only for everyone. Your participation is highly appreciated.

Section A: Background Information of Participants

This section of the interview guide refers to the background or biographical information of the sampled research participants and is mainly planned to enable the researcher to easily make comparison of participating groups of respondents.

Personal Information

a) Age of the respondent ……
b) Gender of the respondent…….
c) Level of education of the respondent ……..

Section B: Reproductive Health Service Delivery and Utilization

1. Knowledge of SRH services

a) What developmental changes adolescents experience as they grow in adolescence stage? Please explain
b) What are the challenges adolescents are faced with as they grow up?
c) Your knowledge concerning:
   i) HIV and STIs transmission?
   ii) Preventative measures to prevent HIV and STIs?
   iii) Treatment and management of HIV and STIs?
d) Which contraceptives are available to adolescents at the Hospital?
e) Which educational materials on sexual and reproductive health are available for adolescents at the health Centre?
f. How are the attitudes of healthcare workers towards adolescents they serve?

2. Which SRH services are available for adolescents at the hospital?
   a. Which services would you like to get that are not available at the hospital?
   b. Which services are mostly utilised by adolescents? And the reasons
   c. Are the provided services friendly and do they meet the need of adolescents?
3. Recommendation for improvement of SRH service provision and utilization

a. What recommendations would you give for improving SRH services provision and utilisation?
b. What strategies/interventions could be put in place to improve and maintain the services for adolescents in BBGH adolescent corner?

APPENDIX H: INTERVIEW GUIDE FOR HEALTHCARE WORKERS

Section A: Background information of participants

This section of the interview guide refers to the background or biographical information of the sampled research participants and is mainly planned to enable the researcher to easily make comparison of participating groups of respondents.

Personal Information

e) Age of the respondent ……

f) Gender of the respondent…….

g) Level of education of the respondent ……..

h) Marital status of the respondent …….

Section B: Reproductive health service delivery and utilization

1) How is the health care service provision organised and delivered to adolescents who came to access services at the hospital? Please explain
2) Are the available SRH and HIV services provided meet the needs of adolescents? Please explain
3) Which SRH services are mostly utilized by adolescents? Please explain
4) What are the social, personal and structural challenges that adolescents encounter that hinder effective utilisation of SRH services? Please list and explain
5) Which interventions can be integrated in SRH and HIV linkage project to create demand for utilisation and effective service delivery? Please explain

APPENDIX I: EDITOR'S LETTER

I, the undersigned, hereby confirm my involvement in the academic and language editing in respect of checking and correcting, text redaction, research methodology compatibility and technical compliance for the manuscript of **Ms Tsepang Celestinah Thaanyane-Kabi (Student Number: 50752693),** submitted to me for her fulfilment of the requirement for the Master of Arts (MA) in Social Behaviour Studies in HIV & AIDS degree registered with the University of South Africa (UNISA), and entitled:

An evaluation of a sexual and reproductive health project on friendly health services utilization by adolescents in Lesotho

As an independent academic editor, I attest that all possible means have been expended to ensure the final draft of **Ms T.C. Thaanyane-Kabi's** thesis manuscript reflects and encapsulates all her external examiners' concerns, suggested corrections, and recommendations in compliance with acceptable research methodology practices and language control standards expected of postgraduate research studies at her academic level.

In compliance with expected ethical requirements in research, I have further undertaken to keep all aspects of **Ms T.C. Thaanyane-Kabi's's** study confidential, and as her own individual initiative.

Sincerely.

T.J. Mkhonto
BA Ed: North-West University, Mafikeng (1985)
MEd: School Administration; University of Massachusetts-at-Boston, USA, Harbor Campus (1987)
DTech: Higher Education Curriculum Policy Reform, Design and Management; University of Johannesburg (2008)

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Signed: _____ **Date:** 16 November 2022

Dr T.J. Mkhonto dd/mm/yyyy

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APPENDIX J: TURNITIN SUMMARY REPORT