AN EXPLORATIVE STUDY ON THE ENABLERS AND BARRIERS IN ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS (GIRLS AND BOYS) AGED 12-19 YEARS OF ESIDADENI, MKHAMBATHINI, SOUTH AFRICA

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An Explorative Study on the enablers and barriers in accessing sexual and reproductive health services among adolescents (girls and boys) aged 12-19 years of Esidadeni, Mkhambathini, South Africa.

A research project submitted to Van Hall Larenstein University of Applied Sciences in partial fulfilment of the requirements for the degree of Master in Management of Development (Specialisation: Social Inclusion, Gender, and Youth)

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DEDICATION

I dedicate this thesis to my entire family for their undying support, prayers throughout the year.

ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	AntiRetroviral Therapy
CSE	Comprehensive sexuality education
CAPS	Curriculum and Assessment Policy Statement
DoE	Department of Education
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
KZN	KwaZulu-Natal
LO	Life Orientation
LS	Life Skills
NGO	Non-Governmental Organisation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SA	South Africa
UNFPA	United Nations Populations Fund
WHO	World Health Organisation

ABSTRACT

Adolescents' access to contraception and other sexual and reproductive health (SRH) services has been described in previous studies as a problem to many communities in Africa. The Department of Health and HelpHer.Org provides sexual and reproductive health services to adolescents in Esidadeni through various programmes. South Africa's government has improved various policies to give adolescents more autonomy in accessing SRH services. The Esidadeni community, on the other hand, has a high proportion of teen pregnancies, unsafe abortions, and sexually transmitted diseases. Using a case study, this thesis investigated enablers and barriers to sexual and reproductive health services among teenagers aged 12 to 19 in Esidadeni, Mkhambathini, South Africa.

Three focus group discussions were held with six adolescent girls, six adolescent boys aged 16 to 19, and parents (4 men and six women), semi-structured interviews with 12 adolescents (12 to 15 years), and all key informants were also conducted to collect data. All of the respondents were selected purposively from the Esidadeni community, and all interviews took place at the respondents' preferred locations. The focus groups and semi-structured interviews were conducted in Zulu and were audio-recorded and transcribed verbatim in English. Basic expressions in FGD were identified using descriptive codes, and interview transcripts were organised into themes and sub-themes and given more analytical coding labels. The Gender at Work Framework framework approach was used for qualitative research, as it provides a systematic structure that allowed critical analysis.

Key findings from the research showed that adolescents in Esidadeni have a number of sexual and reproductive health services available to them though they face barriers in accessing them. The adolescents reported having limited knowledge of SRH services available in Esidadeni. This has led to unplanned pregnancies, whereby some adolescents resorted to conducting unsafe abortions, eloped, or committed suicide. It was also found that adolescents are exposed to sexually transmitted infections, which are sometimes left untreated. Due to shame and embarrassment, they sought treatment from traditional healers to avoid being seen at clinics. Some challenges they face include unsupportive attitudes from service providers, community, and family, unequal gender dynamics in relationships, communication issues with parents and community members, myths and misconceptions, and a lack of privacy.

From the key findings, myths, and misconceptions that hamper the adolescents' decision to access sexual and reproduction services, it is advised that HelpHer.Org works in collaboration with the Department of Arts and Culture in designing programmes that raise awareness about the safety of contraception. For example, to have safe sexual encounters, adolescents require access to a private facility and get contraceptives without fear of negative judgements, and recommendations were made to the Department of Health and HelpHer.Org to provide specific rooms in the health care premises to prevent adolescents from mingling with adults.

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1.0 INTRODUCTION

Adolescents make up around one billion of the world's population, with 70% of them living in developing countries (Kyilleh et al., 2018). There are approximately 10 million (10-19 years old) in South Africa, accounting for about 20 percent of the country's population (Statistics South Africa, 2018). Hidata et al. (2015) state that due to the physical development of secondary characteristics, which occurs faster during adolescence than at any stage of development, teenagers are at risk of early sexual debut (Ross, 2013). According to Magnusson, Masho, and Lapane (2012), an early sexual debut is associated with sexual intercourse while high on drugs or alcohol, risky sexual behaviours, such as having multiple sexual partners, lower condom use rates, and unexpected pregnancy. Many people are unprepared for this transition, as they lack comprehensive sexual and reproductive health knowledge and face significant barriers to accessing quality SRH services (Kennedy et al., 2013).

UNAIDS (2020) states that South African adolescents aged 10 to 19 33 000 adolescent girls tested HIV in 2018 compared to 4200 adolescent boys. In addition, Johnson, Dorrington, and Moolla (2017) argued that teenage pregnancy is a severe issue in South Africa, with nearly a third of all female teenagers reporting pregnancies. According to evidence from Sub-Saharan Africa, 35 percent of pregnancies among 15–19-year-olds were unplanned, unwanted, or untimed, and the relationships of the youths were unstable (Bankole and Malarcher 2010). Only around two-thirds of unwanted pregnancies culminate in births, with the other one-third ending in unsafe abortions (Bankole and Malarcher 2010). Mchunu et al. (2012) A study conducted in Soweto, South Africa, reported that, 23 percent of pregnancies carried by 13–16-year-old young women ended in abortion, while 14.9 percent of pregnancies carried by 17–19-year-old young women resulted in abortion. Furthermore, the Department of Health (2018) states that a huge proportion of teenagers became pregnant again three months after giving birth.

According to UNAID (2015), a national survey of teens in South Africa, one-third of all adolescents aged 12 to 17 are sexually active. Selby (2015) states that young boys are increasingly resorting to sex-enhancing tablets indicating they are engaging in sexual intercourse at an early age. They are engaging in transactional sex with older women as well as engaging in same-sex sexual activities. The adolescent boys are impregnating fellow adolescent girls, and some get married, thereby burdening their parents, who have to look after them and their offspring (Selby,2015). Consequently, many adolescents are often treated for Sexually Transmitted Infections like syphilis, gonorrhea, trichomonas vaginitis, and genital herpes, according to the Department of Health Report (2018).

With over 26 000 pregnancies documented in 2015, KwaZulu-Natal (KZN) has the highest adolescent pregnancy rate, Statistics South Africa (2016). KwaZulu-Natal is one of the nine provinces in South Africa and has the second-largest population, according to Statistics South Africa (2016). A large proportion of people in KZN are Zulu-speaking and are concentrated in rural areas. South African rural areas are home to 52 percent of the population and 75 percent of the impoverished (Vergunst et al., 2015). Rural areas are populated mainly by children, adolescents, and the elderly, with the employable men and women seeking jobs in cities (Vergunst et al., 2015). With a population of little over one million people, Umgungundlovu is the province's most populous district (Bradford, 2016). The district has the highest HIV prevalence rate in the province and the country (39.8 percent compared to 29.2 percent nationally). The incidence rate among young people aged 15-24 years is at an all-time high (15%), with young women bearing a disproportionate risk. This has major health implications for rural families.

With teenage pregnancy and unsafe abortions remaining enormously common in South Africa, they have been linked to a lack of access to sexual and reproductive health services, among other factors (Jonas et al., 2016). There were no comprehensive sexual and reproductive health policies in South Africa during the apartheid era (Waldman and Stevens 2015). In addition, most health resources were directed to the white minority in urban areas, depriving black majorities in rural and less developed sections of the country of equal access to population control through contraception (Waldman and Stevens 2015).

South Africa's policies on sexual and reproductive health and rights are regarded as "among the most progressive and comprehensive in the world." Nonetheless, despite the impressive legal provisions, many South Africans are unable to address their reproductive needs due to social and financial barriers and a lack of health infrastructure and services in many areas, resulting in a wide range of sexual and reproductive needs ill-health among the population Waldman and Stevens (2015). Furthermore, Waldman and Stevens (2015) also sited that the right to reproductive health is guaranteed to all citizens in the Constitution, but sexual health is not mentioned. Sexual and Reproductive Health issues are one of the leading causes of high illness and death rates among youths worldwide (Mokdad, 2016).

Whereas one in every five women of reproductive age (15-49 years) in South Africa has an unmet contraceptive requirement, the unmet need is considerably greater for adolescent girls aged 15-19 years (31%) (Demographic SA. Health Survey, 2016). This has led to a proliferation of backyard abortion centres where adolescents go and terminate unplanned pregnancies, which are risky as most lose their lives and suffer serious gynaecological complications (van Zyl, 2017). However, there is a wide range of Sexual Reproductive Health services available for South African adolescents. Family planning counselling services, prenatal and postnatal care as well as delivery, termination of pregnancy, post-abortion care, treatment and prevention of sexually transmitted infections, including HIV, and information and counselling services about sexual and reproductive health care among the services provided (World Health Organisation, 2016). According to Mokdad (2016), adolescents have comparatively poor access to health services. Poor access to health services could be because of their cognitive maturity or socioeconomic factors. Denno (2015) argues that several factors may raise the likelihood of bad sexual and reproductive health actions in adolescents and deter them from receiving appropriate sexual and reproductive health services. Hence, this thesis investigates enablers and barriers to accessing sexual and reproductive health services among adolescents (girls and boys).

1.1 Problem Statement

There are high rates of teenage pregnancies, unsafe abortions, sexually transmitted infections (STI) among adolescents in rural KwaZulu-Natal due to limited access to sexual and reproductive health services. These problems have been exacerbated by early sexual debut among adolescents. This affect their school attendance and quality of life. Despite the South African Department of Health and Non-Governmental Organisations such as HelpHer.org offering sexual and reproductive health services, not much is known whether the available services are accessible to adolescents. The aforementioned factors that have been on an upward trajectory have prompted the researcher to carry out an in-depth study into enablers and barriers to accessing sexual and reproductive health services among adolescents aged 12-19 in Esidadeni, Mkhambathini.

1.2 Objective

To investigate enablers and barriers in accessing sexual and reproductive health services in adolescents (girls and boys) aged 12-19 years in Esidadeni, in Mkhambathini Umgungundlovu, KZN, with the aim of helping HelpHer.org to identify priorities for community intervention, and redesign programs to improve access of sexual and reproductive health services for adolescents.

1.3 Research Question

What are the enablers and barriers to accessing sexual and reproductive health services among adolescents (girls and boys) in Esidadeni, Mkhambathini, South Africa?

1.3.1 Sub Questions

- What are the sexual and reproductive health services currently available for adolescents in Esidadeni, Mkhambathini South Africa?
- What are the factors that influence the accessibility of sexual and reproductive health services among adolescents 12-19 years in Esidadeni, Mkhambathini?
- What are the current challenges faced by adolescents to access the sexual and reproductive health services in Esidadeni?
- What are the attitudes to accessing sexual reproductive health services by adolescents 12-19 years of Esidadeni in Mkhambathini?

  -What are the attitudes of health care workers towards providing sexual and reproductive health services to adolescents in Esidadeni in Mkhambathini?

  -What are the community's attitudes towards accessing sexual and reproductive health services by adolescents in Esidadeni in Mkhambathini??

1.4 Defining key concepts

Adolescence: This is a period of maturation, a period of psychological human growth between childhood and adulthood, with the cultural goal of preparing people to take on adult roles. Adolescence is traditionally defined as a period between 10 and 25, depending on the literature. It is determined by the commencement of puberty and the end of physical growth, which includes changes in sex organs and physical traits such as height and muscle mass and a period of considerable cognitive growth and maturity. Pre-teens typically become aware of their sexuality at an age when they are still relatively intellectually and emotionally immature due to these physical changes, especially in girls, (Kastbom, 2015). Kastbom (2015) further argues that adolescent girls also have increased hormone levels as their bodies develop physically, which leads to a strong desire for intimacy and sex. Therefore, adolescence is a life stage defined by physiological and psychological, social, and cultural shifts marking the passage from childhood to adulthood. Thus the sexual and reproductive health becomes the issue of concern.

Sexual and reproductive health: Is defined as a state of physical, emotional, mental, and social well-being in all elements of the reproductive system, rather than the absence of diseases, malfunction, or infirmity, according to the World Health Organization's World Health Statistics (2017). However, various organisations define sexual and reproductive health differently. Therefore, this study will adopt the definition from UNFPA, 2014b, which state that sexual and reproductive health refers to people's ability to live a responsible, satisfying, and safe sex life, as well as their ability to reproduce and the freedom to choose whether, when, and how frequently they reproduce.

Müller et al. (2016) suggest that since adolescence is often when people make their sexual debut, appropriate SRH services can help prevent unintended pregnancies and HIV and reduce exposure to

sexual violence and coercion. Making SRH services "adolescent-friendly," according to the World Health Organisation (WHO), is critical to enhancing young people's access to SRH services. Sexual and reproductive health providers should not limit teenagers but ensure anonymity, treat them with respect and without judgement, and are both accessible and inexpensive to them (WHO, 2012). Thus, sexual and reproductive health among adolescents becomes an issue of concern from the above-stated narrative.

Enablers and Barriers: According to Flottorp et al. (2013), these are factors of healthcare practice and its users that can obstruct or support service improvement. The authors further argued that a thorough assessment of the enablers and barriers is critical to establishing an effective implementation strategy.

Enablers: are things or systems that facilitate something to happen. This study looks at enablers as processes that make sexual and reproductive health services accessible to adolescents.

Barriers: are opposites of enablers; hence these hinder or limit the accessibility of these services. The lack of SRH services causes a significant share of the world's health problems in all the countries, WHO, World health statistics (2017). Adolescents who receive contraception and other sexual and reproductive health services have been shown to have improved health outcomes (Shariat, 2014). To reduce unmet contraceptive requirements and unplanned pregnancies, increasing the availability and accessibility of SRH services for teenagers is critical (Jonas et al. 2020).

Accessibility*:* Old literature has defined access in the context of entry into the health care system (Yao, Murray, and Agdjanian, 2013). It also refers to a patient's ability to enter the primary care system without encountering unduly high financial, geographic, or organizational hurdles (Vergunst, 2015).

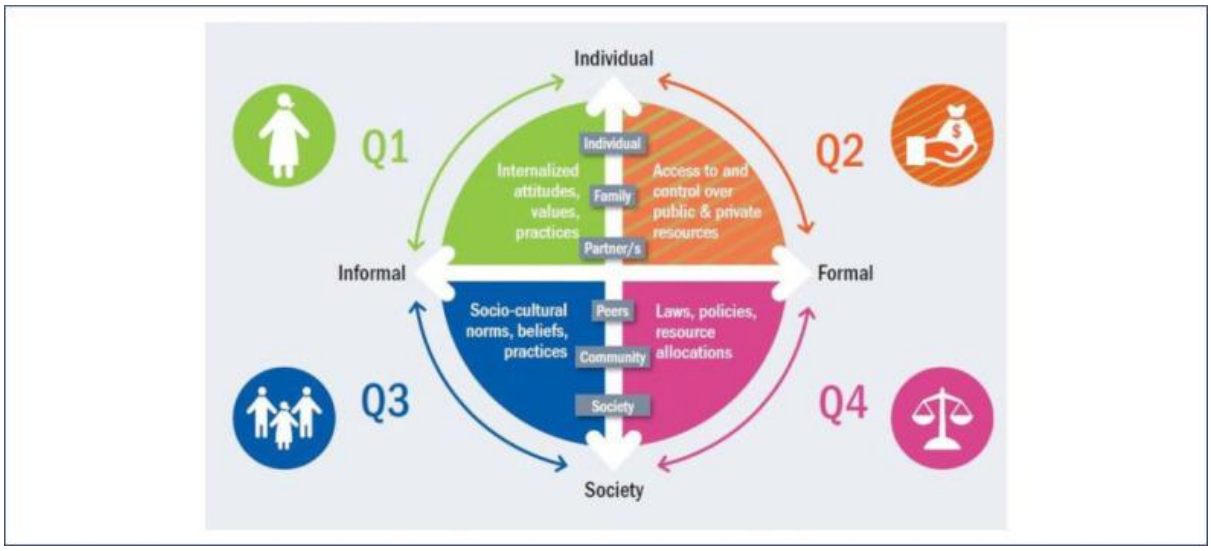
2.0 LITERATURE REVIEW

This chapter reviews literature, specifically looking at the study's theoretical and conceptual framework and investigating the enablers and barriers to accessing sexual and reproductive health services among adolescents. The chapter also examines literature based on the research questions to see what is known or not known about the questions raised in the study.

2.1 Theoretical framework

The theoretical basis for this study is based on Ken Wilber's Theory of Everything's gender at work framework (Sandler et al.). According to Harvey and Safier (2021), the framework can be used in various settings, including households, communities, and countries, to assist people in understanding where power imbalances occur and how to address them. Also, change agents in both organisations and communities can use the theory to identify opportunities and impediments to gender equality, outline a change plan, and drive evaluative efforts to track progress (UNFPA, 2009). The framework contains four quadrants.

Figure 1:Gender at work framework Model



Source: Rao et al. (2015, p 228)

The Gender at work framework was used as a guideline in this research study to explore the setting in which both male and female adolescents access and utilise sexual and reproductive health services. The framework aided in looking at the individual awareness of the services and their willingness to seek them. Individual components were examined according to the framework's top left quadrant **Q1**, adolescents' internalised attitudes, values, and practices govern the adolescents' behaviour to seek services. The family and their opposite sex aquaintances or partners also play a huge role on the adolescents' awareness of SRH services.

The second quadrant **Q2**, access to resources, according to Harvey and Safier (2021), discusses how adolescents (male and females) access resources. This study will look into factors that enables or hinders adolescents to access sexual and reproductive health services. The factors include economic and physical access. These entail the financial status of the adolescent, whether they will afford any costs related to get the services they want. For example, in some societies, contraceptives for women are expensive compared to men's, resulting in minimum access for women to get contraceptives. The physical accessibility is in relation to whether the health facilities are reachable with little or no costs. Information access is another factor that makes adolescents access the services.

On a systemic level, visible power is wielded through laws and policies, **Q4**. Constitutions and institutional policies are examples of formal rules and policies. If these laws and policies are discriminatory or unfair, that is, if they perpetuate uneven power dynamics between men and women, those underlying structures and systems must be rectified (Harvey and Safier, 2021). Formal legislation that maintains gender inequality, for example, criminalise or restrict abortion, whereas the male is left blameless.

Informal institutions like social norms often play a significant role and belong on the bottom left quadrant **Q3**. Culture is the collection of beliefs, history, and ways of doing things that make up a community's unspoken rules of engagement (Batliwala, 2012). According to UNFPA (2009), one example concerns the gender power dynamics that influence adolescent girls' ability to control their sexual health, including fertility or male involvement in family planning decisions (Batliwala, 2012). It entails examining societal norms surrounding adolescent access to and use of sexual and reproductive services. Above all, culture establishes what is considered genuinely significant and is passed down from generation to generation. Batliwala (2012) states that this sphere is substantial because of its ability to both induce and prevent events. For that reason, culture can exclude a set of individuals, including adolescents, making the system difficult for them to access resources. Community leaders have a significant influence on cultural dynamics and recognising the value of new directions. Also, a lack of gender equality further hampers the spread of sexually transmitted infections. Women's loss of control over their bodies and sexuality, whether owing to the patriarchal system or other social aspects, puts them at risk of unexpected pregnancies, UNFPA (2009).

2.2 Conceptual design and Operationalisation

2.2.1 Sexual and Reproductive Health Services in South Africa for adolescents

Adolescents in South Africa currently have access to five SRH services. Children under the age of 18 can consent to HIV testing, male circumcision, contraception, including contraceptive counselling, and virginity testing on their own, according to the Children's Act No.38 of 2005. The Choice of Pregnancy Abortion Act no.92 of 2007 allows a woman of any age, even a girl child, to consent to a pregnancy termination without help. The legal framework also mentions several general health rights that help people gain autonomous access to sexual and reproductive health services, such as consent to medical treatment and obtaining scheduled pharmaceuticals without a prescription. On the other hand, (Strode and Essack (2017) state that consent to contraceptives and contraceptive counselling can be given to a child as early as the age of 12, prescribed medication from the age of 14, and sterilisations from the age of 18. Thus, Barer (2014) pointed out that the entire system of providing contraception, abortion, and quality of services is a huge unmet need. Nevertheless, the accessibility and use of these services depend on physical, economic, information, social-cultural, and public policy access of the health systems within which these services are delivered.

2.2.2. Factors affecting accessibility

Individual awareness

Adolescents can make their own reproductive health decisions. Individuals' decisions are influenced by their knowledge, personal perception, shame, and stigma in seeking or utilising SRH services (Ninsiima, Chiumia, and Ndejjo 2021). Some of those choices include abstinence, the use of condoms, contraception, the decision to keep a pregnancy, and the use of safe abortion services (Kyilleh et al., 2018). However, according to a study conducted in Kenya, adolescents experiencing stigma and fear of sexual and reproductive health services are less likely to use them than their peers (Renju et al.,

2010). Helamo et al. (2017) state that adolescents do not seek formal treatment for reproductive health concerns due to shame and fear of being judged by their community.

Public policy access

Policy and legislation may be punitive or restrict access to sexual and reproductive health care for adolescents. Young people were often denied access to health services in many regions of the world when they were available due to restrictive laws and regulations (Alli, Maharaj, and Vawda 2012). According to Mueller et al. (2018), international and domestic legal frameworks influence adolescent sexuality and SRH services to teenagers. In addition, decision-makers can control sexual and reproductive health policies, social conventions, cultural ideas, and the embedded cultures within state organisations (Pugh, 2019).

Furthermore, mainly governments establish the years of legal age. For example, according to the Department of Justice and Constitutional Development- Sexual Offences Act, in South Africa, the age at which adolescents can have sex is 16 years (Strode and Essack, 2017). It does, however, indicate that adolescents from 12 to 15 years old may engage in consensual intercourse with persons of the same age range (12 to 15 years) without fear of legal repercussions. In addition, adolescents aged 12 to 15 may also have intercourse with persons two years older or younger than them (Strode and Essack, 2017).

To be able to provide sexual and reproductive services to adolescents, the age of consent must be published to the public as a whole (Strode and Essack, 2017). Thus, the current South African legislation favours the older adolescents (16 to 19 years) to access sexual and reproductive health services but not catering for 10 to 15-year-olds (Waldman and Stevens, 2015). For instance, 12 year-olds may want to engage in sexual intercourse, whereas their age might have challenges in purchasing contraceptives. In sum, the age at which an adolescent is permitted to consent to sex frequently conflicts with the age at which the adolescent is allowed to consent to medical services (WHO, 2015). Adolescents in South Africa have access to five sexual and reproductive health services presently.

However, many South Africans are unable to manage their reproductive requirements despite remarkable legal provisions due to social and financial constraints and a lack of health facilities and services in many places (Waldman and Stevens, 2015). Consequently, this results in various sexual and reproductive ailments, which may need money to get the necessary treatment.

Physical and Economic access

Adolescents may be restricted to services where they are available due to economic and physical factors. Treatment centres are more accessible if they are close to the household and if transportation costs and spare time are affordable (Probst, Parry, and Rehm, 2016). Physical access, also referred to as geographical access, can be defined as the distance between health facilities and the population needing the service (Yao, Murray, and Agdjanian, 2013). Geary et al. (2014), define socioeconomic barriers as a broad phrase for the pressures that prohibit persons born into lower socioeconomic classes from progressing to receive sexual and reproductive health services than those born into wealthy classes. For example, adolescent girls with a low socioeconomic background are more likely to have unwanted pregnancies because they lack the financial resources to meet necessities, including contraception (Yakubu and Salisu, 2018). In addition, early pregnancy and parenthood are physiologically dangerous for girls, and they can jeopardize their educational and economic prospects (Morris and Rushwan, 2015).

On the other hand, rural individuals are more inclined to delay seeking medical help than their urban counterparts (Vergunst et al., 2015). Currently, South Africa's health services are delivered through two separate systems: public and private entities (Waldman and Stevens, 2015). The public system is accessible to people with or without health insurance, whereas the private requires users to pay for

the services (Waldman and Stevens, 2015). In Mkhambathini, for example, there are two public clinics that serve seven wards, meaning people receive services for free.

Additionally, Wood and Hendricks (2017) argue that adolescent girls in South Africa and Tanzania engage in sexual interactions with elderly males to meet their fundamental needs. The adolescent girls purposefully become pregnant in South Africa to receive government assistance intended for teenage mothers (Lambani, 2015). The government grant is given to improve their economic situation considering the consequences of their condition.

Information access

Adolescents' physical and mental well-being is dependent on their awareness of reproductive health care. According to Morris and Rushwan (2015), friends, the entire family, teachers, and healthcare professionals impact adolescents' access to sexual and reproductive health information. A previous study discovered that adolescents' lack of knowledge about risks of unprotected premarital sex predisposed them to unexpected pregnancies, unsafe abortion and its complications, and sexually transmitted illnesses (Okereke, 2010).

Teenagers' access to information about sexual and reproductive health services is influenced by a variety of factors. For instance, the education sector can incorporate sexual and reproductive health in its school curriculum. The National Department of Education (DoE) (2011) has undertaken to roll out comprehensive sexuality education as a component of the Life Orientation (LO) programme in South Africa. Comprehensive sexuality education is defined as a rights-based and gender-focused approach to sexuality education that aims to equip adolescent boys and girls with knowledge, skills, attitudes, and values (Kato-Wallace et al., 2016). Furthermore, the curriculum is done to lower high HIV, teenage pregnancy, and STI rates and prevent the continued occurrence of these difficulties (DoE, 2011). Therefore, comprehensive sexuality education teaches abstinence as the greatest approach for preventing unwanted pregnancy amongst adolescent girls and the correct use of condoms and contraception (Yakubu and Salisu, 2018).

Finally, having access to information about reproductive health care is crucial to make educated decisions. These young people's decisions could positively or negatively impact their lives, their families, and society as a whole (Kyilleh et al., 2018).

Social-cultural access

Culture

Restrictive norms and stigma surrounding adolescents and youth sexuality, inequitable or harmful gender norms, and discrimination and judgement by communities, families, partners, and providers are examples of cultural barriers (Geary et al., 2014). WHO (2020) claims that rural areas with cultural norms and practices have a greater adolescent pregnancy rate. As boys grow up, however, they are often indoctrinated to conform to rigid definitions of emotion-repressing, violent, sexist, and heteronormative manhood in many cultures (Kato-Wallace et al., 2016). On the other hand, in South Africa, Tsawe and Susuman (2014) claim that studies have shown that a lack of skills needed to provide services to teenagers and unfavourable social norms against sexual practices result in inadequate treatment of adolescents.

As pubertal development kicks in, sexual displays and behaviors emerge in early adolescence (between 10 and 14) (Kagasten et al., 2018). While romantic and, to some extent, sexual encounters in early adolescence are considered normative, particularly in developed countries, they are not regarded as conventional in other places (Tolman & McClelland, 2011). Akers et al. (2011) argue that, in many African contexts, sexual experiences and relationships in early adolescence are disapproved. The disapproval is exacerbated by taboos that regard adolescent sexuality as bad or immoral (Müller et al., 2018). Hence, implying that adolescents have restrictions to access vital knowledge about their

sexuality, their sexual and reproductive health, as well as the SRH services due to fear of people finding out

On the other hand, religion also plays a part in adolescents' access to SRH services. For example, some churches like Roman Catholic and Indigenous apostolic sects are against contraception, telling their congregants that contraception has side effects and that it is sinful to use contraceptives as it is akin to the murder of would-be children(Selby,2015).

Gender

Socio-cultural factors influence gender relationships in the use of SRH services. Dlamini et al. (2017) reiterate that literature has revealed significant gender disparities in power relations in sexuality issues. For instance, in Umgungundlovu, the community fails to condemn violence against women, especially sexual violence against adolescent girls. Furthermore, due to the influence of masculinity and sexual orientation social constructs, which impact how they view sexual and reproductive health services and their use, adolescents encounter additional barriers in accessing and using sexual reproductive health services (Shabani et al., 2018).

Additionally, due to the notion that condom use signified adultery, Dlamini et al. (2017) state that young women and adolescent girls have been shown to do very little to encourage the utilisation of condoms by their partners to protect themselves from HIV or early pregnancies. Thus resulting in teenage pregnancy and sexually transmitted diseases amongst adolescent girls.

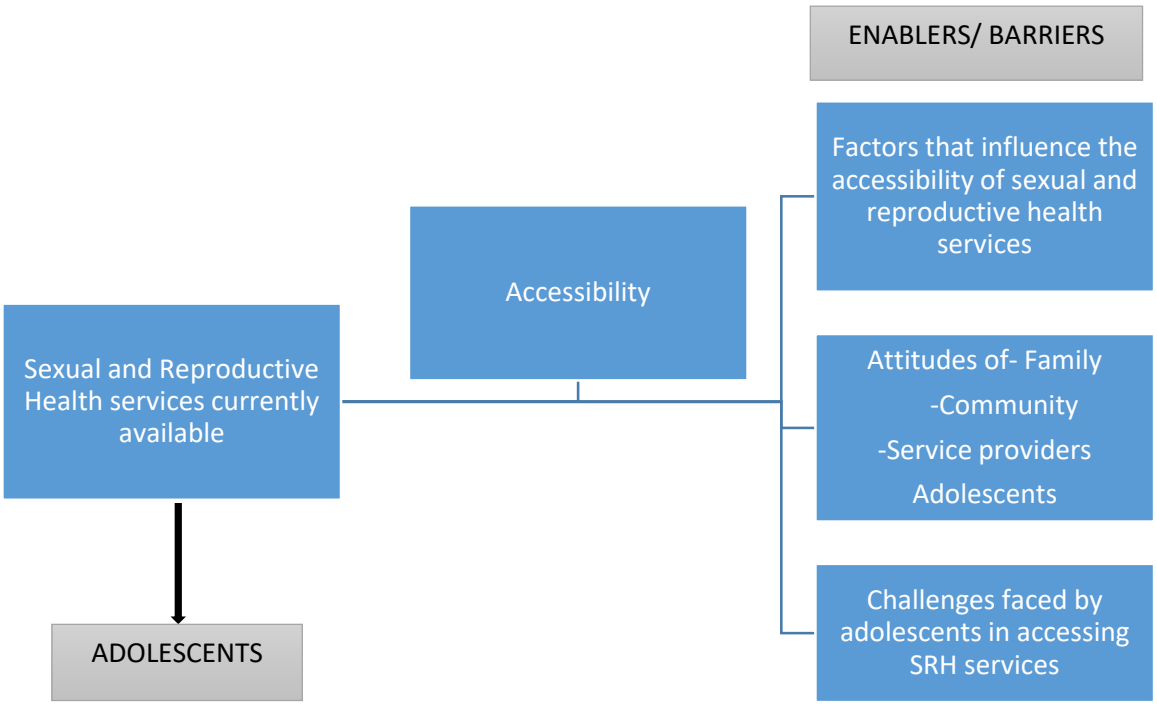
2.2.3 Attitudes to the accessing of sexual reproductive health services

It is essential to provide adolescents with respectful, non-judgemental, and confidential services so that they can make an informed decision (WHO, 2015). In the past, Sexual and reproductive health services were mainly for mother and child health services (Alli, Maharaj, and Vawda 2012). Both men and youth were denied entrance as a result of this. Because of the stigma associated with youth sexuality in the past, access to sexual health care was limited for fear of encouraging promiscuity within this age group (Alli, Maharaj and Vawda 2012).

2.3 Conceptual Framework

Enablers and barriers to accessing sexual and reproductive health services among adolescents (girls and boys) in Esidadeni, Mkhambathini.

Figure 2: Conceptual Framework



Source: Author (2021)

Figure 2 illustrates the conceptual framework that the researcher designed to access enablers and barriers to accessing sexual and reproductive health services. The framework's elements are adopted from the gender at work framework and aim to look at four aspects which are, Individual awareness-questions like, do adolescents have knowledge on the sexual and reproductive health services available to them, will be addressed. Secondly, based on figure 2, access to resources aims to investigate factors that influence the accessibility of SRH services. Finally, the laws, policies, and socio-cultural norm entails looking into various stakeholders' attitudes in the community and analysing the challenges faced by adolescents in accessing the SRH services.

3.0 METHODOLOGY

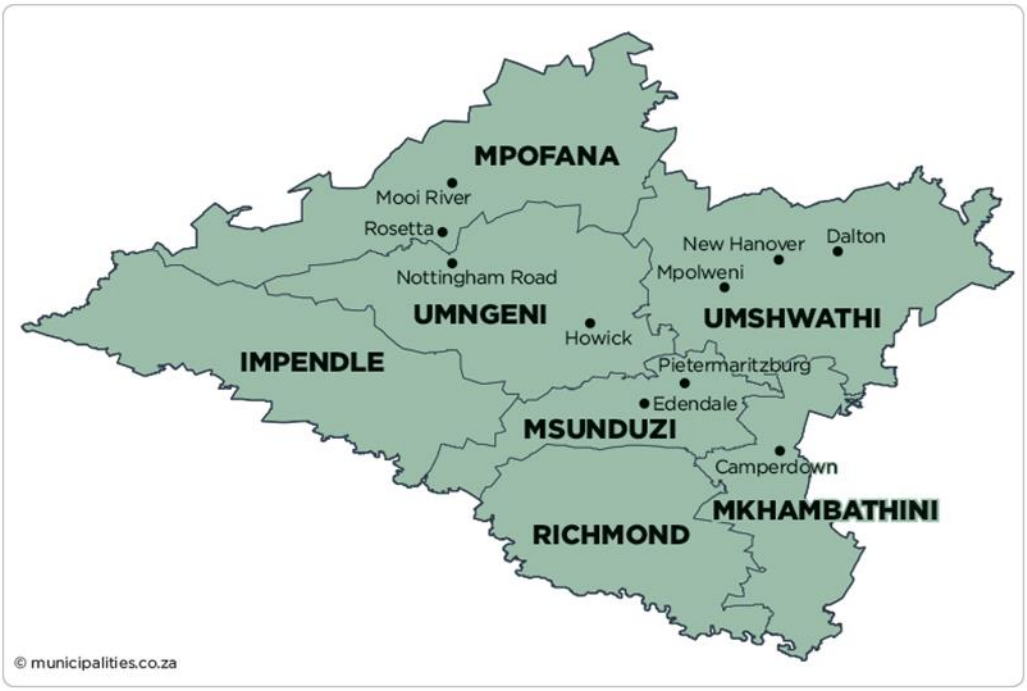
This chapter presents the research methodology that was used for the study. It also justifies the research methodology chosen by the researcher. It begins with describing and applying the research design, population sample, sampling procedures, validity, reliability, and ethical issues relevant to the study.

3.1 Research context

3.1.1 Area of research

The study area lies in Mkhambathini Municipality and is the second smallest municipality under Umgungundlovu District, South Africa, with around 917km2. Mkhambathini is located southwest of KwaZulu-Natal, 24.1 kilometers from Pietermaritzburg, the province's capital. Umgungundlovu is the province's most populous district, with a population of just over one million people (Bradford, 2016). The highest rate of HIV infection in the state is seen in this district.

Figure 3: Map of Umgungundlovu



Source: https://municipalities.co.za/map/1086/mkhambathini-local-municipality

3.1.2 Selection of Study area

The study area was chosen because HelpHer.Org, the commissioner of this study, is involved in outreach programmes in KwaZulu_Natal. The Mkhambathini Municipality's population is confronted with HIV/AIDS-related infections as well as high teenage pregnancies. There are two high schools in Esidadeni from which the majority of adolescent participants attend. However, a significant proportion do not complete school, be it primary or high school. Reasons vary from teenage pregnancies to drug abuse. The municipality has implemented several awareness campaigns. Measures like abstinence, education, and other applicable measures were accepted with active

engagement from various important community stakeholders. There are also two public clinics that offer their services to seven wards. The organisation wanted to identify priorities for community intervention and redesign programs to improve the accessibility of sexual and reproductive health services for adolescents in Esidadeni in Mkhambathini.

3.1.3 Description of the organisation

HelpHer.org, a women-led non-profit in the heart of Pietermaritzburg, is the research commissioner. The organization's mission statement is to restore women's dignity by providing sanitary packages containing pads, tampons, wipes, and fresh underwear to disadvantaged adolescent girls and homeless women in Pietermaritzburg, South Africa. The work and practice seek to enhance dignity in women and girls. The organisation is convinced that those who carry the burden of the problem must be part of the solution, which is why it contributes to structural changes in sexual and reproductive health, poverty, and inequality. Its projects focus on gender and HIV/AIDS, economic empowerment, female leadership, and participatory democracy. The contextual network and capacity building aims to train female leaders to make objective decisions on resources, strategies, and policies and become active and meaningful contributors to solving practical social problems. The organisation has joined forces with the Department of Health and other sister non-governmental organisations in promoting the health of an adolescent girl in KwaZulu-Natal.

3.1.4 The project implemented

HelpHer.org has a programme named Ziphosele inselelo which targets schools with a high teenage pregnancy rate, all issues resulting in adolescent girl vulnerability. The target schools are located in Umgungundlovu's sub-districts, including Mkhambathini. Improving the health and psychosocial well-being and access to education for adolescents is the programme's primary goal.

3.2 Research Design

For this study, a case study was used as the research design. The case study is a research technique that entails an empirical inquiry into a current phenomenon in its real-life setting; when the boundaries between phenomenon and context are blurred; and when numerous sources of information are used," explains (Yin 2009). The researcher used a case study design because it collected a lot of detail about enablers and barriers in accessing sexual and reproductive health services amongst adolescent boys and girls aged 12 to 19 in Esidadeni. The case study was used because it generated answers to ' why' and ' what' questions. In the present study, the (what)? questions on the topic in question were answered. During the wave of the Covid – 19 pandemic, data was obtained through the online internet platforms, ensuring the safety of everyone.

3.3 Research tools

Both secondary and primary data collection methods were employed in this study. Secondary data was collected through a desk study to review enablers and barriers to accessing sexual and reproductive health services for adolescents. On the other hand, primary data was explored through focus group discussions and semi-structured interviews.

Data collection procedures refer to the steps in administering the research instruments during data collection (Laws et al., 2013). A data collection plan enables the researcher to prepare all logistics and serve as a quality assurance strategy. Appointments with Key Informants were made through emails two weeks before conducting the interviews. Adolescents were conducted through Whatsapp messaging, confirming their availability. The researcher got a letter of permission from Help.Her.org, the commissioner. Copies of the letter were taken to village heads of Esidadini, Ngangezwe,

Ophokweni, and the District Administrator of Mkhambathini Municipality to notify them about the research study.

3.3.1 Secondary data

The researcher used newspapers, government publications, NGO reports to generate new insights from the previous analysis.

3.3.2 Primary source

The researcher conducted semi-structured interviews and Focus group discussions with the aid of the assistant researcher at venues desired by participants themselves. This was to ensure free and open communication. Before the beginning of each interview, the researcher explained in detail the purpose of the study and gave assurances of confidentiality. During the interviews and FGD, the research assistant translated the questions to Isizulu, the most spoken language in the community, although respondents tended to mix Isizulu and English languages.

Semi-structured interviews

Five sets of Semi-structured interviews were conducted with 12- 15-year-old adolescents and Key Informants. The Key Informants were all youth-serving professionals, including two school teachers, one health care worker, one representative from a local NGO. In addition, an official from the Department of Social Development was interviewed as well. The semi-Structured Interview guide consisted of open-ended questions with additional probing questions. The interview guide for adolescents was designed with a HelpHer.Org Youth Care Coordinator who worked with the Esidadeni teenage population. The method gave room to collect open-ended data and delved into personal and sometimes sensitive sentiments. During the interviews, the participants (teachers, health care workers, representatives from NGOs) explored their attitudes and experiences in providing SRH services to adolescents. Whereas adolescents unraveled the challenges, they face in accessing the SRH services and revealed how they access them (SRH). The researcher conducted the interviews with the aid of the research assistant, who used adolescents' vernacular language for clarity. All interviews were recorded.

WhatsApp call interviews

WhatsApp video calling or voice calls were used during the interview session with the key informants. Before calling the Key Informants, appointments were scheduled before the interview. The researcher did the interviews personally while recording and taking down notes. On the right hand side is a picture of a WhatsApp video call with KI 1.

Figure 4:Whatsapp video call

Source: Author (2021)

Focus Group Discussions

A local high school hosted all of the focus groups discussions. There were three focus group sessions. A checklist was used to guide the discussions in all focus group discussions. The moderator was the research assistant who conducted the discussion in Isizulu and was present among the participants while I was on a Whatsapp voice call, following the discussions and taking notes. I was also recording the discussions, though I was unable to observe nonverbal gestures. Each FGD lasted 50 to 90 minutes and had 6 to 10 participants. The first and second FGDs were held separately for boys and girls to allow free expression and views on potentially sensitive issues. Adolescents were between the ages of 16 and 19. The third FGD was for parents, and six women and four men attended. During FGD sessions, participants discussed the sexual and reproductive health services available to adolescents and the enablers and barriers to accessing those services. The checklists also included open-ended questions that encouraged everyone to speak up to elicit more information about the enablers and barriers to accessing sexual and reproductive health services among Esidadeni adolescents. During these focus group discussions, information about positive and negative sexual and reproductive health services strategies, issues in adolescent counselling, and recommendations for improving services were gathered.

Data in FGDs were gathered in bulk and all at once from diverse perspectives in a group setting. Since the discussion was open to parents of all age groups, it catered for the illiterate and literate, and participants enjoyed sharing their opinions. During the FGDs for adolescents, one reliable cellphone was used to connect the researcher to the meeting.

Figure 5: Online Focus Group Discussion

Source: Author (2021)

Illustrated in Figure 5 above was a focus group discussion held in a classroom with six 16 to 19-year adolescent girls. The researcher was on WhatsApp call while the assistant researcher was asking the questions in Zulu. The discussion took almost 60 minutes.

3.4 Sampling design

A non-probability sampling design for adolescents and key informants was applied. According to Laws et al. (2013), non-random sampling is a term used to describe all sampling methods that are not based on random selection. However, the study was not interested in counting how many people hold a particular view on enablers and barriers in accessing SRH services among adolescent girls but more in finding out their opinions.

3.5 Sampling Method

Laws et al. (2013) state that a sample can represent the larger group (population), which is essentially the universe of your units of analysis (such as people, villages, or regions) and will be indicated by your research purpose. All participants in this study were chosen using purposive sampling. According to Adelino (2012), in a purposive sample, the researcher selects the sample based on their knowledge of the population, its elements, and the study's objectives.

3.6 Sample size

Laws et al. (2013) defines a population as a complete set of cases about which generalisations are made. Twenty-four (24) adolescents (girls and boys) ranging in age from 12 to 19 years old were recruited from several Esidadeni schools for this study. Adolescents who dropped out of school were supposed to participate in the study, but they did not enroll. Gender equality was achieved by stratifying the sample by age (12 to 15 and 16 to 19 years) and sex. The assistant researcher distributed fliers at local clinics and the community hall to facilitate the recruitment of adolescents with the help of key informants, the local nurse, and two school teachers.

The key informants were chosen based on their experience with teenage sexual and reproductive health programmes. Two school teachers, a local nurse, one representative from a local NGO, and a representative from the Department of Social Development were all included in the study. For all of the Key Informants, a purposive sample was used.

Ten parents (of all ages, young and old, six female and four men) took part in the discussion, offering their thoughts on teenagers' access to sexual and reproductive health services. Parents of all ages were accommodated, which aided in analysing various points of view based on their personal experiences. Parents were recruited by speaking with the local chief, who then circulated the information to the rest of the population

Table 1:Operationalisation of the research questions

Questions	Method	Expected Information	Source of Information	How respondents were selected	Data processing
1. What are the sexual and reproductive health services currently available for adolescents in Esidadeni, Mkhambathini, South Africa?	Semi-structured Interviews	Sexual and reproductive health services currently available for adolescents in South Africa	Adolescents Teachers Nurse Government policy worker Ngo representative	Purposive sampling	Thematic content analysis
	Focus group discussions		Adolescents Parents	Purposive Sampling	Thematic content analysis
	Desk analysis		Reports Journals		Content analysis
2.What are the factors that influence the accessibility of sexual and reproductive services among adolescents 12-19 years in Esidadeni, Mkhambathini?	Focus group discussion	Factors that make sexual and reproductive services accessible to adolescents 12-19 years in Esidadeni	Adolescents Parents	Purposive sampling	Thematic content analysis
	Semi-structured Interviews		Adolescents Teachers Nurse Ngo Representative	Purposive sampling	Thematic content analysis
3. What are the current challenges faced by adolescents to access the sexual and reproductive health services in Esidadeni	Semi-structured Interviews	Challenges faced by adolescents to access the sexual and reproductive health services in Esidadeni	Adolescents Teachers Nurse Ngo Representative	Purposive sampling	Thematic content analysis
	Focus group Discussion		Adolescents Parents	Purposive sampling	Thematic content analysis
4. What are the attitudes to accessing sexual and reproductive health services by adolescents 12-19 years, community service providers of Esidadeni in Mkhambathini?	Semi-structured Interviews	-Attitude by family -Attitude of health care workers -Attitude of adolescents	Adolescents Teachers Nurse Ngo Representative	Purposive sampling	Thematic content analysis
	Focus group Discussion		Adolescents Parents	Purposive sampling	Thematic content analysis

Source: Author (2021)

3.7 Data analysis

The interviews and focus group discussions were conducted and recorded using a WhatsApp conversation. All transcriptions were checked against the recordings for accuracy. Interviews were conducted in IsiZulu and transcribed in English. The two researchers analysed the transcribed data to check for missing information and accuracy. The information was then organized into categories based on similar headings, data codes, and themes of responses to each of the interview questions. The flow of patterns, gaps, relationships, and contradictions were manually examined on a thematic level. This allowed the researcher to deduce what the data collected meant regarding the study's problem and topic. To develop conclusions and recommendations, the findings were compared to available data from the literature for any discrepancies and supporting material.

3.8 Ethical Considerations

Participants were told that their participation in the study would be kept private. They had to sign consent forms stating their desire to participate in the research. Before the study began, participants were also advised of their right to participate or not participate. They were told that the information gathered would only be used for this study. During the interview sessions, participants were asked not to reveal their true identities; instead, pseudonyms or codes were used throughout the study. Every adolescent was given an information sheet to keep for themselves and their parents.

3.9 Research limitation

Data collection was delayed for a few days due to violent riots in South Africa's KwaZulu-Natal area. All adolescent girls and boys are concerned about access to sexual and reproductive health care. Still, this study focussed on a specific age range of 12 to 19-year-olds, leaving out other adolescents. During FGDs, the researcher participated through WhatsApp calls, preventing the researcher from observing people’s non-verbal cues.

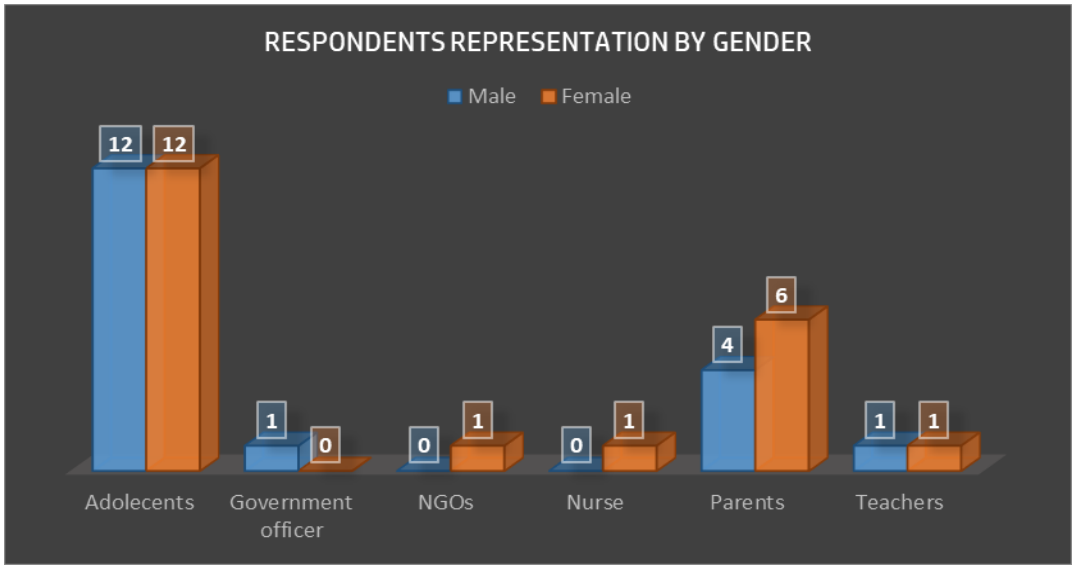
4.0 RESEARCH FINDINGS

This chapter will give an outline of the research findings from the data collected on enablers and barriers in accessing sexual and reproductive services in Esidadeni, Mkhambathini. The part looked at the opinions and perspectives of adolescents, teachers, nurses, a representative from a non-governmental organization, and parents in Esidadeni regarding the availability of sexual and reproductive health services for adolescents. How teenagers used services was influenced by their awareness, societal norms, structures and regulations, and resources. Twenty-four teenagers were questioned; three were in senior primary school, and the others were in secondary schools.

The majority of adolescent respondents expressed dissatisfaction with adult communication on sexual-related issues, lack of youth-specific health facilities, and concern about confidentiality, particularly with relationships that health care workers have with community members. In addition, condom distribution to younger teens was a source of concern for the parents.

Respondents profiling

Figure 6: Sex Composition; Total number of respondents



Source: Author, 2021

Figure 5 shows respondents' representation by gender. Purposive sampling was carried out for all respondents. Twenty-four adolescents ranging from 12 to 19 years participated in this study, with equal gender distribution. Twelve 12-15-year-old adolescents were interviewed. Ten parents, four fathers, and six mothers were present for the focus group discussion. The rest of the participants were Key Informants, one male government official, one female non-governmental organisation representative, one female nurse, and two teachers, a male and a female. In total, 39 participants provided important information to make this study feasible. However, except for two respondents, the Social Services District Officer and an NGO representative, all the other participants came from the Esidadeni community.

Ethical considerations were taken note of, as all interviewed respondents were given code names to protect their privacy.

4.1 Knowledge of sexual and reproductive health services

Being aware of sexual and reproductive health services is very important as people seek the services if they know what they are and how to get them. According to the findings, seven had little or no knowledge of sexual and reproductive health services available in the Esidadeni community of all the

twelve adolescents interviewed. However, they all knew only condoms as a contraceptive but barely gave examples of other contraceptive methods. From focus group discussions, adolescents aged 16 to 19 explained what is meant by sexually active and gave examples of various contraceptives methods and their use. The illustrations below depict some of the responses to what sexual and reproductive health entails.

"Sexually active is when one is participating in sex when a girl and boy become intimate with each other. Most of my friends are sexually active. Contraceptives are things used to avoid pregnancy such as condoms and pills. Pregnant women go to nearby clinics to deliver. And people from NGOs give pads to girls." (FGD- female)

"Sexually active is when a person wants to communicate with others and contraceptives are Condoms, to avoid pregnancy. I normally get them from shops." (Participant 2-male)

4.1.1 Availability of sexual and reproductive health services

In all focus group discussions, issues on sexual and reproductive health illnesses came out. From those issues, the FGD for parents were stressing the increase in sexually transmitted infections because children lack discipline; hence, they agreed that children have to be disciplined the way they were when they were growing up. Results from all interviews and FGD indicate that reproductive health services are available in Esidadeni. Adolescents stated that community outreach programmes offer girl talk discussions, though many do not attend to them. In addition, sexual and reproductive health education, particularly from local NGOs, counselling, and contraceptive provision is among them, explained Respondent 1. Except for abortion services, 16-19-year-old adolescents in FGD were aware of all other services, such as the provision of contraceptives, circumcision, sexual health talks, to mention only a few and how to access them.

"Adolescents normally get sanitary pads, treatment of STIs and provision of family planning such as loop or injection, but they attend teenagers who are pregnant at big hospitals." (adolescents FGD-female participant)

"There is a mobile clinic that makes rounds once a month offering free HIV test and counselling and other services. Also, there are organisations like Men's International Clinic in town which offers services that address all men's sexual health problems but for a fee." (adolescents FGD-male participant)

According to the findings of both the nurse and the government official in working for the Department of Social Development, all adolescents are offered free Human Immunodeficiency Viruses (HIV) testing, counselling, and treatment, as well as voluntary male circumcision, family planning, sexually transmitted infection screening, and testing, health education, and abortion services. However, KI3 mentioned how some adolescents are asked to fetch their parents for prescribed medication. Teachers were also concerned about the national school curriculum's lack of sexual education information. Noted below are some quotes from the respondents.

"We offer HIV testing and counselling, educating the negative population on pre-exposure prophylaxis, which prevents people who feel they are at risk of contracting the disease, The HIV positive population we link them to our partners so that they can start (ART) AntiRetroviral Therapy. We also offer family planning methods (IUD) Intra Uterine Device, oral pills which we do not advise adolescents to take because they forget. We screen for HIV/AIDS infection and STIs." (KI 3: Nurse)

"The national curriculum does not have adequate information on Sexual and reproductive health, we only teach about their bodies, bad touches, and abstinence." (KI 3: Teacher **α**)

4.1.2 Individual reasons for seeking services

The most common reason for seeking SRH services was to obtain information or advice. While some adolescents' interviewees, Respondent 3 and Respondent 6 described accessing testing or treatment

for STI and pregnancy, the primary value of SRH services was in the prevention of illness or unwanted pregnancy. KI-1 and KI-3 described the provision of services as a lifetime benefit for adolescents' health and future. Parents FGD, KI-3, and KI-5 agreed that adolescents seek services from clinics or hospitals, but KI-1, KI-2, and KI-4 reported that adolescents, particularly boys, seldom used mainstream services and that some adolescents boys from FGD said they would only attend if they were "very sick." Non-governmental organisations (NGOs) were singled out as important providers of SRH services to adolescents. From interviews, four adolescents girls and key informants (KI-1, KI-2, and KI-4) reported that they were more accessible than government facilities, owing to the perception that non-governmental service providers were more friendly and competent in dealing with adolescents.

"People from Ziphosele inselelo are more welcoming; in addition, they do not belong in this community, so I am free to talk to them about anything." (Respondent 2-female)

*"When we meet the girls, they are so free to discuss their issues with us, and we give them the platform" (*KI-4)

4.1.3 Implications for sexual and reproductive health services

Two sub-themes emerged from this theme and are presented as follows:

Unplanned pregnancies

Unwanted pregnancy, which leads to, high rates of unsafe abortion, is a result of unmet family planning needs. It turned out that four adolescent girls interviewed thought it prestigious to get pregnant around other adolescents because it indicates that the girl can conceive. All the six boys interviewed mentioned that a girl should have an abortion because both parents will still be in school.

"In case of an unexpected pregnancy, mostly the girl tells the boyfriend, or her friends or the parents. Among us girls we don't mind having a baby but sometimes our family's attitude forces us to abort. Some girls abort the baby through ladies who are secretly known as 'midwives.' Parents differ; if they are understanding they will be angry at first, then later on they will offer their support. Some parents chase you out of the house. The community will shame you." (Respondent 4- female)

However, some families are rigid when it comes to premarital sex, and female adolescents from those strict families elope to their boyfriends' homes, abort their babies or commit suicide if they become pregnant. The following is a quote from a female participant who was interviewed.

"I accompanied my friend to a lady who knows how to terminate the pregnancy, she uses traditional herbs, I am not sure whether she is a Sangoma. But we went in the evening because the lady said people must not see you coming." (Respondent 3)

To test their virility, three male adolescents from FGD also insist on having unprotected sex with girls, mostly their age mates. Another male adolescent from a focus group discussion also said:

"Many couples who fail to conceive end up being miserable or worst divorce, so it is better to have a child first before getting married to see whether you are fertile. And some families only get married to have children. As Zulu people, we believe we get married to enlarge our clan through having children, so it is important to check whether your girlfriend will be able to have children in future." (adolescent FGD- male)

Sexually Transmitted diseases

During interviews and FGDs, when asked about their sexual reproductive health problems in their community, many respondents mentioned sexually transmitted infections as one of them. All male adolescents interviewed said the STI called 'drops one that is common among adolescents boys. From the adolescent girl's interviews, three respondents mentioned itchy sensation in the vagina as the

common problem among girls. However, (sangomas) traditional healers were identified as a more accessible and less expensive sexual and reproductive health services providers. They supply "muthi" or concoctions for STI treatment or abortion at a lower cost, said one participant in the adolescent focus group discussion for boys. Comparing boys to girls, some adolescent boys said when they have an STI, they sought help from traditional healers or used herbs, whereas girls go to traditional for other issues, such as abortion services. This was reported in all two FGD, for the parents and for adolescent boys.

"I encourage my boys to use herbs more as I grew up using the same herbs and they worked!" (parent FGD-male participant)

"There are also herbalists that give traditional herbs for STIs like drop, the herbs are strong and the herbalists keeps confidentiality." (adolescent FGD-male participant)

From interviews, some adolescents expressed that, upon discovering that they had an STI, they were hesitant to seek treatment, when asked why they are hesitant, as one participant mentioned:

"My neighbour once had an STI and was embarrassed to seek medical help; by the time she went, it was late and had other complications." (Respondent 2)

4.2 Factors that influence accessibility

4.4.1 Enablers and Barriers

Information access

The adolescents' responses show that they have sufficient knowledge of the dangers of unprotected sex due to education and information. In addition, adolescents in Esidadeni have access to information on where to seek services due to improved communication on SRH issues through modern technology. Of the 12 adolescents who were interviewed 8 had android phones, and said they were on Facebook, Instagram and Whatsapp.

"I use Facebook a lot to connect with my friends and relatives, when I am going through Facebook I see adverts of sexual and reproductive health, and sometimes I end up liking the page to get more information and there is a platform to ask questions." (Respondent 7)

As revealed by FGD for male adolescents, they were in consensus that health information is essential and that SRH services protect them from diseases particularly sexually transmitted diseases, as illustrated in the quotation below

"You see that mobile clinic has served us a lot, we get circumcised there, serving us from going to the mountains, circumcision is good because it lowers chances of getting STI" (adolescent FGD-male participant)

Friends, parents, and teachers were recognised as the primary source of sexual and reproductive health information during adolescents' interviews and FGDs. 4 male adolescents were interviewed and depended heavily on their friends for sexual and reproductive health knowledge. They stated that their friends understood what they are going through. In addition, the findings revealed that parents were a valuable source of information, particularly to female respondents. 2 male adolescents and four female adolescents interviewed stated that their mothers support them with all the SRH information they need.

"My mother and I talk about everything, she tells me everything that I need to know about women issues, when I started my period, she was the first person I told." (Respondent 5)

Health care workers and social media appeared as two other significant sources of information for older adolescents, according to adolescents FGD participants. To highlight these points, below are some quotes from participants.

"I don't trust people at home, so I go to the clinic if I need any information about my sexual health." (Respondent 4-female)

"*I am free to talk to my friends because they might know a Sangoma who can help you."* (adolescent FGD-males)

Concerning confiding in someone in the case of sexual and reproductive health matters, there was a clear distinction as girls tend to confide in their mothers, unlike boys who mentioned their older brothers or friends as their trusted confidantes. Most of the adolescents interviewed came from homes where they stay with their mothers or maternal grandparents. Two participants responded as follows:

"I stay with my Gogo (grandmother) but I can not tell her anything because, she wants me to behave in certain, 'ancient ways', so I always talk to my mother on the phone about such issues, or when she comes during the monthend." (Respondent 5- female)

"I stay with mother and grandmother, I don't have a father, so if I want to know something about my sexual health, my neighbour (Umkhulu) welcomes me and gives me good advices." (Respondent 10-male)

In contrast, parents' focus group discussions recognised teachers as ideal individuals to discuss sexual and reproductive health topics with adolescents. The reason for their unwillingness to discuss sexual matters with their children was an embarrassment, and they also said it felt ethically wrong. Below is a quote to support this claim:

"I as the father is not culturally right to talk to my daughter about sexual matters; girls have to talk to my sister or their mother." (parents FGD-male)

Economic access

There are only two public clinics in the area where the study took place. Although the FGD of male adolescents revealed that the clinics' sexual and reproductive health services were not always adequate, some medical procedures are also not offered at those local clinics. As a result, they were occasionally referred to nearby hospitals, which were relatively expensive as they pay for transport costs.

"There is some reproductive health medication that you don't always find at the clinic, so sometimes they will refer you to Durban or Pietermaritzburg, which is quite expensive to travel." (Male adolescent-FGD)

Nurse KI-3 also commented this by saying:

Termination of pregnancy for pregnancy is mostly done at referral hospitals where doctors are found. At the clinic, there are nurses and the procedure can not be done without the doctor's supervision. So mostly the girls are refered to a nearby hospital if there is no doctor available.

Physical access

Interviews and focus group discussions with adolescents and Key Informants revealed that distance to health facilities was an obstacle. For example, some participants expressed that they have to wait for the mobile clinic which visit their ward once a month. This was highlighted in both methods used (SSI and FGD) to extract data; below are some of the statements which were reported:

"…there is also a mobile clinic that make rounds once a month offering free HIV test and counselling and other services, many of us use that one because clinics are far away" (adolescent FGD-male participant)

"We stay approximately 10km away from the clinic, I need R12 for a round trip, which is quite expensive because my mother is not employed." (Respondent 9)

Public policy access

There was a distinct conflict of responses among 3 Key Informants, the Social Development government official, teachers and a nurse. The table below present quotes from the Key Informants

Table 2: Contrasting views of Key Informants

KI_ Government Official Worker *"Seeing the high rates of teenage pregnancy, different departments have worked in collaboration with each other, for example, adolescents spend most of their time in school, therefore the government has seen it fit to incorporate comprehensive sexual education from senior primary phase."*	**KI1- Teacher** *"Only rights-related subjects (including gender rights); common diseases, HIV included; support and treatment of HIV-infected people; family; community and cultural values of sexual behaviour; abstinence; peer pressure; risks and repercussions of peer pressure, are the topics covered in the senior primary and the General Education and Training (GET) phases' school curriculum. Positive and negative relationships, pregnancy, contraception methods, STIs, dangers of many sexual partners, condoms, STI testing and community resources for reproductive health needs appear to be neglected in a National Curriculum and Assessment Policy Statement (CAPS)."*
KI_ Government Official Worker *"Many sexual health related projects have been implemented in communities especially our rural communities to address various sexual and reproductive health challenges. The government is working with many partners to alleviate or lessen the magnitude of HIV/AIDS, STIs and teenage pregnancies. There are various services which were approved for adolescents which include HIV testing at their own free will, male circumcision, contraceptives (including contraceptive counselling), and virginity testing at various periods before the age of 18, termination of pregnancy from the age of 12 onwards, and access to SRH treatment."*	**KI1- Nurse** *"The programmes which are there are mostly designed to cater for the girl child. Little is done for a boy child. Adolescents are permitted to have consensual sex from the age of 16, but when 12 olds come for contraceptives, we have to give them.*

Source: Author (2021)

The above quotations came from 4 interviews with the Key Informants. The KI 5- government worker from the Social Development department mentioned what was put in place by the government regarding sexual and reproductive health for adolescents. For instance, he said that comprehensive sexuality education was incorporated in the Life Orientation (LO)and Life Skills (LS) curriculum in 2015. In contrast, KI 1 and KI 2, both school teachers mentioned that LO and LS have sexual education, which

is not comprehensive. The curriculum leaves crucial sexual reproductive health information that is beneficial to adolescents. KI-5 also listed sexual reproductive health services that were approved and to be provided by the health department, but the nurse had opposite views as shown in the above quotes.

Focus group discussions for adolescent boys expressed their desire for the health sector to employ male staff who will assist adolescent males for easy interaction; they say it will suit their needs, ensuring accessibility, reliability, and efficiency of services. Some further suggested that the government should implement measures that enable young people to access the services without fear or hesitation, motivating and encouraging them. Here is what they had to say:

"There should be a department for solely males, not mixed with our female age mates, and the government should train and recruit more male nurses to treat us, not female nurses, because they are the ones who stigmatise and discriminate against us." (adolescent FGD-male)

4.3 Challenges faced by adolescents

Service provider's confidentiality

Adolescents also mentioned a lack of privacy as a hurdle. During interviews, eight adolescents participants and few females from adolescent FGD stated that privacy was violated during consultation. 1 Adolescent girl respondent who sought SRH services before mentioned being attended with more than two health workers during a consultation session. Another issue of confidentiality was the fact that adolescents were also concerned with health care workers who reveal information to the adolescents' parents or guardians about their interaction with adolescents who seek such services to their parents.

"I went to a clinic with an issue of virginal thrush; I was attended by a nurse who goes to the same church with us. The nurse met my grandmother after some few days, and she asked her whether I am taking my medication earnestly…. I never told anyone at home that I had visited the clinic!" (Respondent 5)

Information and privacy

Esidadeni parents demonstrated a relatively low awareness of adolescents' need for access to contraception and abortion services. Consequently, even though a significant minority of adolescent males admitted to having started engaging in intercourse, the parents do not believe condoms should be publicly available, nor do they believe HIV testing should be conducted without the parents' consent.

"I think it is not a good idea, as it encourages early sexual activities, especially 12-year-olds should not have access at all to condoms. They are still babies in primary school. I think abstinence talks should be emphasised instead." (parents FGD- Female)

A large number of participants appeared to relate this concept to the theme of factors that affect accessibility which was discussed previously.

Myths and misconceptions

Myths and misconceptions acted as impediments to using sexual and reproductive health services. For example, KI-1 stated that some parents believed that family planning causes infertility and that condoms cause cancer. As a result, they encourage their children not to use family planning methods while they are still young, such as when they are in school, as KI-1 mentioned:

"They believe that if you use contraceptives, especially condoms and pills before giving birth, particularly girls, they will cause infertility at a later stage in their lives."

Despite widespread awareness of the benefits of condom usage in preventing STIs and pregnancy, there remained some concerns and misconceptions about condom use. Condoms, for example, have holes, and female condoms are not made for virgins, according to responses from the adolescent girls' interviews. Other contraceptives such as "pills" and intra-uterine-device have been accused of destroying women's "eggs," resulting in infertility; respondent 6 reported this by saying:

"My sister used to use pills when she was in school, now she has been married for two years and she is failing to have kids."

In addition, two male participants from parents FGDs brought their opinions on how they enhanced their manhood through the use of herbs. One was quoted saying:

"Our traditional herbs work wonders, we give our children to chew the herbs when they reach puberty, especially that one…'Umvusankunzi', it helps when your manhood is becoming tired," (parents FGD-male participant)

Socio-cultural norms and taboos

Adolescents' reluctance to discuss SRH with providers was also influenced by cultural taboos prohibiting the discussion of sex and reproduction, anxiety about being asked sensitive questions, and fear of physical examination. During parents FGD, one father also mentioned that in Zulu culture a father cannot discuss sexual matters with his daughter, vice versa with mothers too. Providers also mentioned religious and custom as factors that prevented them from providing SRH advice or services to adolescents or made them uncomfortable discussing sex:

"In our Zulu culture, it is a sign of disrespect for a daughter to talk to me whilst looking straight into my eyes, let alone me talking to my girl children about their private parts; it is a taboo!" (parent FGD -male participant)

The SRH services for adolescents that KI3-nurse is supposed to deliver are sometimes in contrast with their own beliefs and values, according to this study. According to her, certain SRH service guidelines, which they must follow when delivering services to adolescents, appear to be in conflict with their own traditional, religious, or personal views. The nurse gave abortion services as an example, claiming that performing an abortion on a 12-year-old is inappropriate because she believes it encourages the teenager to engage in sexual activity while knowing that the pregnancy can be terminated. Respondent reported this by saying that,

"A colleague of mine belongs in a religion of the apostles' sect, performing abortion goes against her doctrine, so she only signs for duties that doesn't put her in that position. If she has no choice, she writes a referral letter for the adolescent girl to go at the nearest clinic." (KI-3, nurse)

During parents FG discussions, mothers tended to underestimate their 12 to 15-year-old children's sexual engagement. However, all mothers and fathers in the FGD agreed that their culture encourages girls to obey social norms and refrain from sexual activity until marriage.

It is wrong; according to our cultural traditions, children should wait to sleep around until marriage. (parent FGD-female)

Adolescent girls in interviews and FGDs have emphasised the condemnation of any sexual activity should pretend to keep their virginity so that their parents do not become embarrassed. For example, during interviews, a female adolescent, Respondent 3, responded by saying this:

"My parents value virginity that every year they send me to Emhlangeni for the reed dance where virgins meet to celebrate their virginity."

Gender

Furthermore, sexual and reproductive health is gender-specific as well as culturally specific. Various gender-specific factors, such as power and control relations are within, households, kin groups, and the symbolic value of fertility, can influence sexuality, fertility, reproduction and health decisions. Some of these factors were mentioned by adolescent participants after a question on, who initiate the use of a condom was asked. The responses are illustrated below:

"Girls are the ones who should negotiate condom use because they are the ones who fall pregnant. Though sometimes if a girl wants to say let us use protection, the boy may end up rapping the girl or hitting the girl for refusing to have sex." (Adolescents FGD- female participant)

Girls are the one who should because they are the ones that become pregnant and mostly take responsible of looking after the baby. Us men mostly we beg for sex so if they say they want protection then we will use condoms. (Respondent 9)

4.4 Attitudes

Attitudes of service providers

According to teachers and nurses interviewed for this study, having access to SRH information and services could reduce the number of female adolescents dropping out of school due to early pregnancy. The nurse also stated that some health care workers are hesitant to provide sexual and reproductive health services. They believe that giving adolescents contraceptives will encourage them to experiment with sex. Adolescent sexual activity will increase as access to abortion services improves. Adolescents from interviews and FG discussion believed that health care workers oppose abortion services because it interferes with their religious convictions. The following quotations back up the claims:

"Nurses in the public sector mostly have negative attitudes because they normally judge the adolescents and say derogatory remarks and this will stop the young people to go and seek for the services." (KI-3 nurse)

Furthermore, when it comes to accessing sexual and reproductive health services, all adolescent participants stated that they must first go through a counselling session with nurses or health care workers before receiving the services they require at the time. Counselling is the process of discussing and working through personal issues with a counsellor, who is in this case, a health care worker. A health care worker assists adolescents in dealing with problems in a positive manner by assisting them in clarifying issues, exploring options, developing strategies, and increasing self- awareness. As stated in the previous theme, some adolescents expressed dissatisfaction with some sessions because they were mostly held in the presence of a co-worker, making it difficult for them to ask questions. Participants in both focus group discussions made the following remarks:

"I once went to the clinic when I had drop, in the consultation room, there were two of them, the other nurse was a bit younger. The older nurse was giving me a talk on using condoms. I had a so many questions but I couldn't ask because I saw them giving each other disapproval looks…The nurse even asked how many girls I had slept with in the past month…How could I be honest when I knew they were going to talk about me the moment I leave the room?..." (FDG- male adolescent)

Attitudes of family

During a Focus group discussion, parents were asked their views on adolescents accessing contraceptives, all respondents showed disapproval, stating that it would be a way of encouraging their children to have sex at an early stage. When it came to adolescents' urge for friendship with people of the opposite sex, fathers were more permissive than mothers. This is possible owing to perceived gender-based social behaviour double standards, especially interaction with people of the opposite gender. Almost all the fathers in the room expressed a desire for their sons to have girlfriends, but the mothers saw it as delinquency.

"I have talks with my children- boys of course, to find out whether they are befriending girls. There reaches a time in life when boys start to chase girls, that way I will see that my child is growing well." (parent FGD- male participant)

Attitudes of adolescents

Although health care workers are trained to provide SRH services, during FGD, adolescents pointed out that they were reprimanded or labelled as "unruly boys and girls" when they sought the services. Some teenagers also believed that when seeking SRH services, the health care providers treated them unfairly. One respondent during interviews said she is less likely to use accessible services due to health workers' negative remarks.

"Those people (nurses) pretend as if they live a straight life, the other one asked me 'if I go to church?!' Really! I will never go to that clinic again"

The findings indicate that the community has an impact on adolescents who sought SRH services at health facilities. All adolescent interviewees and FGD participants were afraid of being seen at the health facilities. The adolescents who took part, both males and females, were afraid of being seen taking condoms because the community would label girls as "prostitutes" and boys as "ungovernable", according to one respondent:

"It may happen that you will go to the mobile clinic for SRH services and you get there only to see many people you know; you will then feel embarrassed to seek whatever you would have gone there for." (FGD-male participant)

Attitudes of the community

From the parents' focus group discussion, most responses welcomed the strategy of issuing condoms to older adolescents.

"The community support some of the provision of SRH services such as pads distribution and circumcision but they are sceptical on the issuing of condoms to young boys who are still below the age of 14 years."

In contrast to adolescents' responses, all adolescents interviewed, expressed how community members talk ill of adolescents who are seen buying condoms especially girls. The quote below gives a narrative of what adolescents go through in their community:

As an adolescent girl you cannot buy condoms freely in this community because most people know each other, it happens to another girl that went and buy condoms, the people who saw her went and told her father, and also started gossiping or talking about it in social gatherings (ek'phuzweni) (Respondent 4)

5.0 DISCUSSION OF THE RESULTS

This chapter provides insights into the results obtained from fieldwork in relation to relevant literature from chapter 2 of this report. The discussion is going to follow the outline of the gender at work framework.

5.1 Access to resources

The research revealed that sexual and reproductive health services were available in the Esidadeni community. The researcher identified several factors that enable or hinder adolescents from accessing the services available to them. Access to the services is hampered by service-related barriers. Information access, physical access, economic access, socio-cultural access, and structural access were the factors that lead to low numbers of adolescents accessing SRH services.

Adolescents in this study felt that the facilities which provide sexual and reproductive health services did not give them enough privacy. As a result, utilisation of sexual and reproductive services by adolescents in the Esidadeni community was lessened. According to, Kylleh et al. (2018), adolescents' reproductive health services outlets should be designed to provide adequate privacy. Because of their lack of confidentiality, judgemental attitudes, failure to take their patients' needs seriously, healthcare workers discourage adolescents from accessing services.

Furthermore, adolescents' access to services can be enabled or restricted due to economic and physical constraints. According to the respondents, physical distance is a contributing factor to the accessing of sexual and reproductive health services. In practical terms of Esidadeni dwellers, seeking services from registered health providers declines as distance increases. Public transport is available at all times, though concerns were on travel costs, further restricting movement to visit health facilities. There are only two clinics that serve seven wards in Mkhambathini. Hence physical access has different implications for different individuals depending on a persons' financial status, as supported by Probst, Parry, and Rehm (2016). They note that treatment centres are more accessible if they are close to the household and if transportation costs and spare time are affordable.

Friends, parents, family members, teachers, and health care workers all have an impact on adolescents' access to information and services (Morris and Rushwan, 2015). According to the data collected, most adolescents, particularly those under the age of 15, depended heavily on their friends and social media for sexual and reproductive health information. They are vulnerable to misleading information because of these sources. In that situation, people will make decisions based on inaccurate information, which would negatively impact them. Some older adolescents preferred health professionals, whereas parents opted for teachers as sources of information, indicating a desire for factually accurate information or a want to obtain it in a detached and professionally defined setting.

5.2 Formal rules and policies

Existing legislation, policies, strategies, and statistics on adolescent sexual and reproductive health behaviours worried some key informants in Esidadeni, highlighting irregularities in in-laws and regulations that make it difficult for adolescents to get confidential SRH services. For example, the age at which an adolescent is allowed to consent to sex frequently clashes with the age at which the adolescent is allowed to consent to medical care, according to WHO (2015). In South Africa, an adolescent can consent to contraceptives and get contraceptive counselling as early as the age of 12 (Strode and Essack, 2017). At the same time, prescribed drugs can be administered as early as the age of 14 (Children's Act of 2005). Therefore, different departments must collaborate to provide satisfactory SRH services to adolescents. As stated by a government official in policymaking, the Department of Social Development, in collaboration with the Departments of Education, Health, and Women, Youth, and Persons with Disabilities, supports community and national efforts in adolescent sexual and reproductive health. Several programs, including outreach programs, are also

implemented to bring services closer to the target group. In this case, a mobile clinic in Esidadeni that provides a variety of health services monthly.

5.3 Informal cultural norms and deep structures

Socio-cultural norms and religion govern many societies. It has been noted from the literature reviewed that communities hold a deeply embedded sense of disapproval of adolescent sexual activity, which is often demonstrated through the stigmatisation of sexual health concerns (Morris and Rushwan, 2015). According to the authors' findings, adolescents were less likely to discuss sexual and reproductive health with parents or health care workers, based on the health care workers' age and gender. One of the most influential and meaningful connections in the lives of adolescents is that between parents and their children (Horstman, Hays, and Malisk, 2016). Focus group discussions of parents also mentioned that in Zulu culture, a father could not discuss sexual matters with his daughter; the same applies to mothers with their sons. Igras et al. (2014) support the findings by arguing that parents are frequently unprepared to discuss sexuality and sexual health issues with their children. However, a few adolescents reported having SRH discussions with their mothers, while not statistically significant, and more girls reported having this discussion with their mothers than boys. Adolescents in Esidadeni do not find challenges of disapproval at home only but also at the health care facilities too.

In South Africa, past literature claims that health care professionals were particularly hostile to adolescents seeking obstetric services (WHO, 2010). The negative attitudes stemmed from community norms and health care workers' opinions about certain services, such as contraception and safe abortion. Certain SRH service guidelines which must be followed when delivering services to adolescents were identified by nurses in Esidadeni to conflict with their own traditional, religious, or personal views. When health care workers are put in a predicament position, they will do everything in their power to discourage adolescents from utilising SRH services, for instance conducting abortion services, as noted by some respondents.

Furthermore, in reviewed studies, widespread unequal gender norms and restrictive masculinities were found as barriers to condom usage among teenagers in Southern Africa, with some signs of shifting norms emerging (Moyo and Rusinga, 2017). Condoms were identified as the most well-known method of contraception. Interestingly, all adolescent participants in this study knew where condoms are found. However, adolescent girls reported so much stigma on girls who purchase condoms in the Esidadeni community and unequal gendered norms relating to sexual decision-making. In the Esidadeni community, purchasing condoms among adolescent girls was considered to be severely stigmatised and neither acceptable nor expected of young women of 'good' moral character, according to parents FGD. Müller et al. (2018) stated that adolescent sexuality is regarded as bad or immoral, exacerbated by taboos that shape people's beliefs in a community.

In contrast, adolescent boys believe that 'real men have to prove their fertility. The parents' attitude toward adolescent sexuality reflects a socio-cultural environment in which premarital sexual activity is socially sanctioned excessively against girls.

According to the issues that came out during adolescent girls' interviews, they stated that, if a girl is to become pregnant, they only not worry about parental judgement but also punishment for being pregnant, such as being kicked out of the house. Through societal and gendered norms about adolescent sexuality, interpersonal factors at the family level were linked to community influence (Erasmus, Knight, and Dutton, 2020). As a result, deviating from conventional norms regarding pregnancy timing has a negative impact on family morals. However, internalised societal and community standards alone cannot account for fear of punishment from family. Van Zyl et al. (2015) asserted that studies in the same setting have found that pregnant adolescents have been banished from their homes as a form of punishment.

5.4 Individual consciousness

Knowledge and autonomy contribute to increased contraceptive use, according to Phongluxa et al. (2020). Personal knowledge of available services was revealed to be an essential personal factor of adolescents' use of sexual and reproductive health services in Esidadeni. There were several ways in which adolescents became aware of the existing SRH services. Outreach programmes, school curriculum, social media, friends, health care workers all contributed to the SRH knowledge that the adolescents have. Though adolescents were not familiar with the term sexual and reproductive health services, almost everyone gave few examples of them upon hearing the word' contraceptives. Hence, it is essential to use the language that everyone better understands to realise goals. Obtaining information or advice was the main reason for seeking SRH services amongst adolescents in Esidadeni.

The South African educational coverage provides an optimal foundation for ensuring that most adolescents receive adequate sexual education, as revealed from the findings. Findings indicate that the South African school curriculum offers Comprehensive sexuality education (CSE). It is a curriculum that aims to equip children and adolescents with knowledge, skills, attitudes, and values that enable them to realize their sexual and reproductive health, well-being, and rights; develop healthy interpersonal relationships, and reflect on the impact of their choices (Wekesa et al. 2019). However, results from the study indicate that most of the sexuality education content in South Africa emphasises abstinence as the primary method of contraception. Other subjects covered in the curriculum include STIs and the prevention of unplanned pregnancies (Wekesa et al. 2019).

The findings in this study reported that adolescents are anxious and scared to utilise contraceptives due to the negative attitudes towards the use of contraceptives. While all the participants for this study recognise the need for contraception in preventing unwanted pregnancy, a fraction believes hormonal contraceptives and condoms are harmful to the health of adolescent girls, particularly those who have never given birth. Other studies have found that contraception by young girls was not approved by community members or health care providers since it was thought to influence the fertility of young females (Godia et al., 2014). In addition, some adolescent girls felt they will never seek SRH services ever due to the hostile reception they get from health care workers. Fear of people finding out, embarrassment, and lack of knowledge were limitations to seeking SRH services.

Abortion is one of the controversial topics met with mixed reactions in South Africa. The study findings show that a significant percentage of adolescents believed abortion to be a "life-threatening" procedure or knew someone who has died as a result of abortion, implied that their understanding of safe, legal procedures is restricted. Their remarks on the subject also highlight the high level of stigma in the community around abortion services and alternative dangerous backdoor services even though termination of pregnancy is permitted by law in South Africa.

5.5 Reflection of the researcher

Research process and methodology

It all started when the Research methods and design module was introduced to us. The content was a lot but so detailed. The exercises, writing a mini-research, and research methodology prepared me for practical and theoretical ways of conducting the research.

We were tasked with doing a research topic for the proposal. It was a daunting experience as I changed topics countless times with the notion of doing something challenging, a concept that has never been researched in my research area. The concept I was interested in was investigating the link between risky sexual behaviours and depression among adolescent girls. However I did not defend it so well, but in my future like I am going to do it.

I ended up doing the topic that seemed interesting, but unfortunately, I did not do thorough research on it, and it was not in line with my Organisation’s mission. During the defense of my proposal, I was given a red for fail. My world came crumbling down, and I had to find myself up after remembering

the words from my theory classes that research is an iterative process. Not overlooking the support I got from my supervisor, she encouraged me to think through and took one step at a time.

On my second attempt, I came up with a topic on looking into enablers and barriers in accessing sexual and reproductive services among adolescents. After receiving some criticism on my background and literature review, I reflected, and I was glad to move on to the following data collection stage.

Data collection was the most daunting experience that I endured during the research. Participants for my study included adolescents, both boys and girls, teachers, and other Key Informants. When we were released to go for data collection, schools in South Africa were closed for a winter break. I used the method of flyers to select the adolescents purposively. I got in touch with the Mkhambathini municipality administrator to provide a database of where I could get the workplaces of my desired key informants. I prepared my interview guides and some checklists for FGDs. As I was about to start my fieldwork with the help of my research assistant, the area of research got into some riots, people looting, and burning shops. Although I emailed all my Key Informants to arrange meetings to explain my study entails, they all said they were not in the right frame of mind that I had to wait. I was doing my data collection online. After a fortnight, they were responding one by one. I had difficulties getting in touch with a representative from the office of Social Development who deals with the welfare of adolescents. Since her schedule was always busy, she assigned someone to attended to me. I eventually scheduled appointments with key informants.

As Salmons (2011) previously stated, a researcher is the instrument of data collection, which implies that the relationship established with participants requires a level of trust, intimacy, and proximity to access personal and nuanced data, as well as to instill a level of credibility in the research findings. This is so true. I had challenges extracting data from 12-to 15-year-olds adolescents because there was no familiarity, worse distance stood as a barrier. I had to take my first interviews as a pilot, as the adolescents gave a one-word answer or said they did not understand me. The pilot process did not reveal that the questions were difficult for adolescent respondents to comprehend. Still, I saw it necessary to rephrase most sensitive questions to eliminate ambiguity and incorrect responses. That is when I decided to seek aid from a research assistant. I decided that the research assistant had to use Isizulu for effective communication. Compared to boys, adolescent girls found it difficult to engage in a productive dialogue about their sexuality, and just a few gave detailed answers.

Luckily, this was not the case with all Focus group discussions, and I conducted FGD through WhatsApp calls; since there was a problem with the network, we could not do a video call because the connection kept on breaking. This deprived me of observing people's facial gestures when they were giving their responses. The discussions were interesting and insightful, some of the input they brought forward was not included in my interview guide, but they added value to my research. For instance, the FGD for parents discussed how they addressed sexual and reproductive health issues when they were growing up. The FGDs evoked some emotions in me, realising how much the girl child is undermined in the Esidadeni community. I had to read the concept of reflexivity and looked into my own biases to remain as objective as possible.

While interviews and FGDs were taking place, I recorded every session and also took down some notes of what I noticed during each session (diary entry). It helped me to reflect and asking myself a question like " were my questions answered?", "what needs to be improved?". At the end of each interview day, I transcribed all the recorded responses to get a verbatim version of what people actually said. While listening to the recordings, I noticed not all information was relevant. Nevertheless, I typed everything down, intending to sift the data during analysis.

Data analysis proved to be tedious and time-consuming. The process of data coding and entry was challenging. This required concentration as I had challenges sorting the categories and putting my data into themes. In addition, some responses were similar, and I wondered how to organise them because they applied to different contexts or themes though the responses were identical. Finally, I used the

theoretical framework- gender at work to discuss my findings. In sum, it would seem like there is repetition when presenting my findings.

Finally, throughout the journey of data collection, I realised that for research to be more interesting, the researcher has to be on the ground, in the field. There is a huge difference when asking people to do things on your behalf and doing it yourself. The research assistant and the driver had their schedules, so I had to follow their timetables which inconvenienced my planning, though I had paid them handsomely for their services.

Overall, I enjoyed the journey and have grown as a person as a result of the research. I have also improved my research skills by gaining insight from people's stories and analysing them without bias. What is left is figuring out how to best begin the implementation journey now that I've explored these issues.

6 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In conclusion, this research sought insights into enablers and barriers to accessing sexual and reproductive health services among adolescents in Esidadeni. Overall, several barriers emerged through discussions and interviews. Therefore, the conclusion is based on the sub-questions.

- What are the sexual and reproductive health services currently available for adolescents in Esidadeni, Mkhambathini?

All participants confirmed that sexual and reproductive services were provided by the two local clinics and a non-governmental organisation. There is provision for sanitary pads for girls, making it easier for girls from impoverished backgrounds. Condoms are easily accessible for free in clinics and for a small price in shops.

- What are the factors that influence the accessibility of sexual and reproductive health services among adolescents 12-19 years in Esidadeni, Mkhambathini?

Distance to health care facilities and financial constraints are among the factors that influence adolescents' access to SRH services. The further the distance to the health care facilities, the expensive it becomes and less affordable for adolescents to go and seek services.

The laws and policies are not aligned with reality. For example, it is difficult for adolescents to access services such as abortion. This is because the age of consensual sex is 16, yet at 12, a girl has the right to abort. Furthermore, the education curriculum lacks essential information, focusing on abstinence rather than on contraception topics. In addition, adolescents have difficulty accessing health services since the facilities are not conducive to their needs.

- What are the current challenges faced by adolescents to access the sexual and reproductive health services in Esidadeni?

Despite having little knowledge, adolescents are hesitant to discuss their sexual health with their parents and health care workers. They identified as sexually active prevented them from purchasing condoms freely or never buying them at all. Judgement by the family, community and health care workers also stood in the way of adolescents accessing SRH services.

- Attitudes to accessing sexual and reproductive health services.

Socio-cultural barriers inhibit the access of services since a lack of openness about sexual matters affects people of all generations. There is a connection between adolescents' primary source of information and people they confide in. Technically, those that provide adolescents with information tended to be the people whom they confide in.

According to the findings, service providers have negative attitudes toward adolescents, so the adolescents become reluctant to use the services available. Both adolescents and health care workers reported having a negative attitude. Community norms and health care workers' opinions about specific services, such as contraception and safe abortion, contributed to this negative attitude.

Boys and girls are socialised in a biased way that maintained gender-based myths about sexual matters. The research findings reveal that adolescents opt for traditional herbs to address their sexual and reproductive health challenges with the notion that privacy and confidentiality are obeyed at the traditional healer's point of service.

6.2 Recommendations

- Because myths and misconceptions hamper the adolescents' decision to utilise sexual and reproduction services, it is advised that HelpHer.Org works in collaboration with the Department of Arts and Culture in designing programmes that sensitise the community on contraception use and sexual and reproductive health matters
- Based on the findings, the facilities where the adolescents go-to for services do not provide enough privacy. It is recommended that The Department Of Health provide specific rooms in the health care premises to prevent adolescents from mingling with adults, working with HelpHer.Org to provide counselling since they are free to talk to strangers.
- Based on the findings, adolescents are only exposed to a small amount of information on SRH services. Therefore, it is recommended that HelpHer.Org develop programmes to help adolescents grasp the value of the information in terms of their current actions and future decisions.
- Based on the findings, parental control over adolescent girls' sexuality, the stigma of a girl's sexuality within the family were identified; it is advised that HelpHer.Org design sexual and reproductive health promotion programmes that target parents.

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APPENDICES

Appendix 1: Code names for Respondents

Female Adolescents	Male Adolescents	Key Informants
Respondent 1	Respondent 7	Teacher 1 – KI-1
Respondent 2	Respondent 8	Teacher 2 – KI-2
Respondent 3	Respondent 9	Nurse KI-3
Respondent 4	Respondent 10	Ngo rep KI-4
Respondent 5	Respondent 12	Government official KI-5
Respondent 6	Respondent 13	

Appendix 2: Permission Letter

HELP HER.

Restoring the dignity of women one pad at a time!

27 July 2021

RE: DATA COLLECTION NOTIFICATION FOR WINFRIDA MASUNDA'S RESEARCH PROJECT

To whom it may concern.

Winfrida Masunda is a Master's student currently pursuing her studies in Management of Development (Social Inclusion Gender, and Youth) at Van Hall Larenstein University of Applied Sciences. With your permission, she would like to conduct a research on Enablers and barriers in accessing sexual and reproductive health services among adolescents 12-19 years of age, through her assistant researcher Anele Sokhela.

Your support will be greatly appreciated.

Fikile Mbambo

Project Manager

HelpHer.org
31 Golf Rd, Scottsville
Pietermaritzburg. 3201
(+27) 33 387 2259

Appendix 3: Semi-Structured Interview Guides for Adolescent Girls

QUESTIONNAIRE FOR FEMALE ADOLESCENTS (12-15-year-olds)

My name is Winfrida Masunda. I am a masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Masters of Development in Social Inclusion, Gender, and Youth. I am researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini in South Africa. The interview will take approximately 30 minutes to complete.

All responses will be kept anonymous.

Please tick the box on questions where boxes are provided

1. What do you understand by "being sexually active"?

2. Are your friends sexually active? **Y** ☐ **N** ☐

3. In case a teenager becomes pregnant, what does the girl do?
   What do their parents/ guardians do in such instances?
   What are the community views on teenage pregnancies
   In case of an unwanted/unplanned pregnancy, what do girls do?

4. Are there any sexual health problems that girls your age face in this community?
   If yes, briefly explain.
5. What do you understand by term contraceptives?
6. Which women's reproductive health services have you heard that are available to you in Esidadeni or Mkhambathini?

7. Sources of information on women's reproductive health services?

   ☐ Friends ☐ Social media ☐ Teachers

   ☐ Parents ☐ Churches

   ☐ Others (specify)_____

Section B: Factors that make influence accessibility

1. If you need contraceptives (or SRH services), where do you get them from?
   Which type of contraception do you use?
   Is it easy to access them? How do you access them?
2. Are there costs involved in obtaining contraceptives, STI treatment, pregnancy-related services, or getting circumcised?
   If yes, do you have payment methods for the required services?
3. From where you stay, how far is it to the health centres?

Section C: Challenges

1. Are there any challenges you encounter in accessing the women's reproductive health services in Esidadeni?
   If the answer is yes, give a brief explanation of the challenges encountered.

Section D: Attitudes

1. Have you ever visited a health facility to receive reproductive health services or information on contraception, pregnancy, abortion, or sexually transmitted diseases?

2. In the last six months, how many times have you sought services mentioned in question 1 or information from health care workers	Number of times ☐ Did not seek any services ☐

3. Think of your last meeting with a health worker, at which facilities?	Government clinic ☐ Government hospital ☐ Private doctor ☐ Other (specify)_____

4. Besides seeking reproductive health services from the above-stated facilities, do you have other means to address reproductive health problems?
5. What are your views on abortion?

6. When you last saw the health care worker, what was the reason for going?	SRH counselling services ☐ Contraception ☐ STD treatment ☐ Gynaecological exam ☐ Termination of pregnancy ☐ Circumcision ☐ Other (specify)_____ _____

7. Did you see any posters on contraception at the facility you identified in question 6.
   What was the information on the posters?
8. Were you given counselling on men's sexual health matters?
   What counselling advise did you receive?
   Were you comfortable asking questions?
   Were you satisfied with the answers to the questions you asked?
   Were you satisfied with the counselling session? Explain why you were not satisfied/ or why you were satisfied?
   Was there anyone else in the room during the meeting?

9. Do your parents'/ guardians' accept the use of contraceptives by you as their child?
   What are your parents'/guardians' views on the use of contraceptives?
10. Do you belong to any religious sect?
    What does your religion say about the provision of contraceptives to people of your age group?
11. What are the activities done by people of your age group during leisure time in your community?
12. Are there programmes in your community designed to promote reproductive health for people of your age group?
    What activities are carried out by the programmes?
    Do you attend to such programmes?
13. What are your community's views on the provision of contraceptives to people of your age group?

Appendix 4: Semi-Structured Interview Guides for Adolescent Boys

My name is Winfrida Masunda. I am a Masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Master of Development in Social Inclusion, Gender, and Youth. I am researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini in South Africa. The interview will take approximately 30 minutes to complete.

All responses will be kept anonymous.

1. What do you understand by "being sexually active"?
2. Are your friends sexually active?
3. What is circumcision?

   Where do boys your age go if they want to get circumcised?

   Who is in charge of doing the circumcision procedure?
4. What do you understand by term contraceptives?
5. If you need condoms (or SRH services), where do you get them from?

   Is it easy to access them? How do you access them?
6. Are there costs involved in obtaining condoms, STI treatment, or getting circumcised?

   If yes, do you have payment methods for the required services?
7. From where you stay, how far is it to the health centres?

   Which mode of transport do you use to get to the health centres?
8. Where do you get information on men's sexual health services?

Friends ☐ Social media ☐ Teachers ☐

Parents ☐ Churches ☐

Others (specify)_____

9. Do you have men's sexual health services available to you in Esidadeni or Mkhambathini?
10. Are there any challenges you encounter in accessing the men's sexual health services in Esidadeni?

    If the answer is yes, give a brief explanation of the challenges encountered.
11. Whom do you confide in for support when you need men's sexual health services? Why?

12. Have you ever visited a health facility to receive men's sexual health services or information on contraception, circumcision, or sexually transmitted infections?

13. If YES or NO to question 12- why?

14. Think of your last meeting with a health worker; which facilities did you go to?	Government clinic ☐ Government hospital ☐ Private doctor ☐ Other (specify)_____

15. Besides seeking sexual health services from the above-stated facilities, do you have other means to address sexual health problems?

16. Did you see any posters on men's sexual health at the facility you identified in question 15.
    What was the information on the posters?

17. Were you given counselling on men's sexual health matters?
    What counselling advice did you receive?
    Were you comfortable asking questions?
    Were you satisfied with the answers to the questions you asked?
    Were you satisfied with the counselling session? Explain why you were not happy/ or why you were satisfied?
    Was there anyone else in the room during the meeting?

18. Do your parents'/ guardians' accept the use of contraceptives by you as their child?
    What are your parents'/guardians' views on the use of contraceptives?

19. Do you belong to any religious sect?
    What does your religion say about the provision of contraceptives to people of your age group?

20. What are the activities done by people of your age group during leisure time in your community?

21. Are there programmes in your community designed to promote reproductive health for people of your age group?
    What activities are carried out by the programmes?
    Do you attend such programmes?

22. What are your community's views on the provision of contraceptives to people of your age group?

Appendix 5: Semi-Structured Interview Guide: School teachers

All responses will be kept anonymous.

1. What is your role as a teacher concerning sexual and reproductive health services for adolescents?
2. Besides the government curriculum (LO), does your school have programmes designed to promote sexual and reproductive health besides the government curriculum (LO)?
   Specify
3. When adolescents have an urgent need for SRH services, are they comfortable discussing them with teachers?
4. From your point of view, are there any challenges adolescents face in accessing sexual and reproductive health services in this community?

   For instance, are there any beliefs that stand in the way of adolescents to utilise SRH services?

Appendix 6: Semi-Structured Interview Guide: Health Care Worker-Nurse

All responses will be kept anonymous.

1. What is your opinion on providing sexual reproductive services to adolescents of 12 to 19 years?
2. What are the services currently available for adolescents provided by your organisation, that is, Dept of Health?
3. Does your clinic have programmes designed for adolescents?
   Which services does the facility provide for girls?
   Which services does the facility provide for boys?
4. From your observation, which gender comes often to seek SRH services at your facility?
   What could be the reasons for the disparities?
5. How do you feel about providing sexual and reproductive health services to adolescents?
   And why do you feel that way?
6. From your point of view, are there any challenges adolescents face in accessing sexual and reproductive health services in this community?
   For instance, in your opinion, are there any beliefs that stand in the way of adolescents to utilise SRH services?

Appendix 7: Semi-Structured Interview Guide for Key Informant: Non-governmental Organisation Reps

My name is Winfrida Masunda. I a Masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Masters of Development in Social Inclusion, Gender, and Youth. I am currently researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini, in South Africa.

All responses will be kept anonymous.

1. What kind of sexual and reproductive health services do you provide to adolescents in this area?
2. How often do you offer the services you mentioned, to adolescents?
3. Are your services meant for both genders?
   Give some reasons?
4. Do you have special site/facilities or location from which you offer your services?
   Is your location within reach of your target population (adolescents)?
   How is the overall attendance of adolescents to your programmes?
   Which gender is more present? What could be the reason for that?
   Does your setting offer privacy for adolescents?
5. How do you feel about providing sexual and reproductive health services to adolescents?
   And why do you feel that way?
6. From your point of view, are there any challenges faced by adolescents in accessing sexual and reproductive health services in this community?

Appendix 8

Semi-Structured Interview Guide for Key Informant: Department of Social Development Official

My name is Winfrida Masunda. I a masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Masters of Development in Social Inclusion, Gender, and Youth. I am currently researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini, in South Africa.

All responses will be kept anonymous.

1. What are the sexual and reproductive health services currently available for adolescents?
2. Is there a way adolescents communicate their sexual and reproductive health services concerns to the department?
3. From your point of view, are there any challenges adolescents face in accessing sexual and reproductive health services in this community?
4. What does the Department of Social Development do to address the challenges faced by adolescents?

Appendix: 9 Focus Group Discussion Guide for adolescents. (16-19-year-olds)

My name is Winfrida Masunda. I a masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Masters of Development in Social Inclusion, Gender and Youth. I am currently researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini in South Africa.

All responses will be kept anonymous.

1. What do you think about pre-marital sex?
2. What are your views on fertility?
3. What do you understand by sexual health or reproductive health services? Or contraceptives?
   Give examples of sexual health services you know?
4. Which of these services are available to people of age group here in Esidadeni?
5. Do you think you should access SRH services?
   Where do you seek these services here in Esidadeni?
   How do you access them (contraceptives, STI treatment or termination of pregnancy?
6. Are there any challenges you encounter in accessing these SRH services?
7. Whom do you discuss sexual and reproductive health issues?
   Why do you discuss this with them?
8. What are the general views in your community on the provision of sexual health services to adolescents?

Checklist: Conducting focus group

☐ Find a suitable location for the group- a location desired by the participants- somewhere quiet and comfortable.

☐ Put people at ease with an informal, open approach- ensure they do not feel they are under scrutiny.

☐ Make sure everyone gets a fair chance to speak.

☐ Encourage interaction between group members, but keep them on the subject.

☐ Prevent group members from pressuring others to agree with them.

☐ Do not rely on one focus group to represent a whole group of people's point of view- do more to guard against a 'rogue' group going off at a tangent.

☐ Remember the data collected relate to the group, not the individuals in it.

☐ Invite enough people: sometimes it is a good idea to overbook, especially when you expect some of them not to show up. There is a window within the ideal number of participants of about six to 12.

Appendix 10:

Focus Group Discussion Guide for Parents.

My name is Winfrida Masunda. I a masters' student at Van Hall Larenstein University of Applied Sciences. I am doing Masters of Development in Social Inclusion, Gender, and Youth. I am currently researching enablers and barriers in accessing sexual and reproductive health services amongst adolescents aged 12-19 years in Esidadeni, Mkhambathini, in South Africa.

All responses will be kept anonymous.

1. What do you think about pre-marital sex?
2. What do you understand by sexual and reproductive services?
   Give examples of SRH services you know?
3. What are your views on adolescents accessing contraceptives?
   Why?
4. Do you have any cultural practices that may influence the utilisation of sexual and reproductive services among adolescents?
5. Do you discuss sexual and reproductive health issues with your children?
6. Where do you think is the best place for your children to get sexual health information?

Checklist: Conducting focus group

☐ Find a suitable location for the group- a location desired by the participants- somewhere quiet and comfortable.

☐ Put people at ease with an informal, open approach- ensure they do not feel they are under scrutiny.

☐ Make sure everyone gets a fair chance to speak.

☐ Encourage interaction between group members, but keep them on the subject.

☐ Prevent group members from pressuring others to agree with them.

☐ Do not rely on one focus group to represent a whole group of people's point of view- do more to guard against a 'rogue' group going off at a tangent.

☐ Remember the data collected relate to the group, not the individuals in it.

☐ Invite enough people: sometimes it is a good idea to overbook, especially when you expect some of them not to show up. There is a window within the ideal number of participants of about six to 12.