ACCESS AND UTILIZATION OF ADOLESCENT YOUTH FRIENDLY HEALTHCARE SERVICES IN EKURHULENI SOUTH DISTRICT, GAUTENG

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Date:

Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

29 March 2022

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Abstract

Background- The Adult Youth Friendly Health Service (AYFHS) programme has been fragmented in the healthcare system. Regardless of youth healthcare being a priority, the inequalities within the implementation and sustenance of this service, there has been unmet health needs of many youth and adolescents within the community of Ekurhuleni in the South district of Gauteng. This study has therefore found it necessary to explore the youth perspectives in accessing and utilising adolescent/youth friendly health services within the community.

Aim of the study-The aim of the study was to explore the perspectives of adolescents regarding their access and utilization of AYFHS in Primary Health Care clinics in the Ekurhuleni South District, Gauteng Province.

Methodology- The study utilised a qualitative, explorative, descriptive approach where data was gathered through individual interviews from a study population based in the Ekurhuleni South District in Gauteng province and selected through a purposive sampling technique. The analysis and interpretation of the data revealed emerging themes which discussed and formed the core of the research findings.

Conclusion- Access and utilisation of AYFHS in the Ekurhuleni South District, noted that several barriers existed. From the perspective of the youth that have been interviewed, it was noted that a lack of knowledge regarding the AYFHS programme was prevalent. Youth healthcare is the centre of priority in the healthcare system and AYFHS should be the programme of focus as it encapsulates the burden of disease holistically amongst the youth population. Provision of accessible, available, equitable and appropriate youth healthcare services are required at healthcare facilities in the Ekurhuleni South District.

Recommendations- Policy makers and those in authority should routinely assess and evaluate healthcare facilities to ensure that the essential package of the AYFHS programme is implemented at all healthcare facilities and quality healthcare services are provided to the youth population. This study recommends that all aspects of quality service delivery, such as adequate infrastructure, human and

material resources and operating hours of the healthcare facility need to be improved to meet the needs of the community. Education and training of staff and the community regarding AYFHS is required as matter of urgency. Strategies to improve satisfaction of healthcare services should be targeted and retaining the youth population within the healthcare facility must be given priority.

Key words: Adolescent Youth Friendly Health Services, Access, Utilisation, Clinic Initiative.

Dedication

I dedicate this dissertation to our Lord and Saviour Jesus Christ; through whose abundant grace and faith I have been able to complete this research study. A heartfelt dedication to my husband and daughter, who have been my support, my strength and my encouraging force and to all the youth/adolescents of Palmridge.

"Faith is being sure of what we hope for and certain of what we do not see" …Hebrews 11.1

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To my precious daughter Tyresse for assisting me and being my inspiration.

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To all the youth and adolescents of Palmridge community.

Table of contents

List of tables

List of figures

Appendices

Glossary of terms

Access-Access to health services means the timely use of health services to achieve the best health outcomes (Burger and Christian. 2018: 1-2) defined access as the potential or the actual entry of an individual or population group into the health care system, and further highlighted that 'having access' denotes potential utilization of a service when required.

AYFHS- Youth Friendly services are services that all adolescents are able to obtain and these amenities should meet adolescents' expectations and needs thus improve their health. The WHO identifies 5 key dimensions of YFS -Equitable, Accessible, Acceptable, Appropriate and Effective. The National Adolescent &Youth Health policy further supports this definition, describing AYFHS as a standard driven health approach to improve quality of health for adolescent and youth. AYFHS is interchangeably used as AYFS or YFS.

Primary Health Care Service- Is an essential health care method, that is scientifically sound, practical and socially acceptable system, made universally accessible to individuals and families in the community. PHC services is known as the first point of contact that focuses on the comprehensive and integrated aspects of physical, mental and social health and well-being of an individual (WHO 2019: 1).

Youth-Is a period of life between childhood and adulthood, time of experimentation within roles and identities, still void of the burden of social norms, obligations and preparing youngster for society (Henze 2015: 5).

Utilisation-Utilisation of services is usually measured using indicators which are used to access and utilize services and influence the type of health outcomes that a person may receive.

Acronyms

Acronym	Full word/sentence
AYFHS	Adolescent Youth Friendly Healthcare Service
OVID 19	Corona virus disease
DOH	Department of health
HIV	Human Immunodeficiency Virus
KZN	KwaZulu Natal
NAFCI	National Adolescent Friendly Clinic Initiative
NAYHP	National Adolescent Youth Health Policy
MDGs	Millennium Development Goals
TB	Tuberculosis
SDGs	Sustainable developmental Goals
STI	Sexually Transmitted Infection
SA	South Africa
WHO	World Health Organisation
UNICEF	United Nations International Children's Fund
UESCO	United Nations Educational Scientific and Cultural Organization

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The (YFHS) Youth Friendly Health Service initiative began in early 1999 as a collaborative project among various multi-disciplinary teams which were involved in the re-organization of the National Adolescent Friendly Clinic Initiative. Members from the Reproductive Health Research Unit of the University of Witwatersrand, Chris Hani Baragwanath Hospital, and Lovelife (South Africa's (SA) largest national HIV preventative enterprise for young people), collaborated to form an integral part of the programme. The aim of the (NAFCI) National Adolescent Friendly Clinic Initiative is still entrusted to ensure that health care services would be accessible and acceptable to adolescents (James *et al*. 2018: 1).

In 2006, due to cessation of funding, the National Adolescent Friendly Clinic Initiative (NAFCI) was succeeded by a simplified (YFHS) Youth Friendly Health Service programme, and further developed by the World Health Organization (WHO) in 2002 to address the specific health needs of adolescents aged 10-24 years. Research has shown that in many countries in Africa, young people face significant barriers to receiving health services, resulting in the underutilization of the service. Poor access and low use of health services by adolescents have been attributed to insufficient available services, lack of knowledge about the available services, and social and cultural stigmatization. According to Beksinka (2014: 676), forbidding access to sexual and reproductive or other health services, is a significant challenge that continues to threaten its implementation and is further compounded by opposition from religious organizations and conservative political interest groups. These extremist groups believe that sexuality and HIV education encourage children and young people to experiment with sexual activity (UNESCO 2019: 1-18). Thus, these cultural and religious contexts result in poor access and utilization of adolescent health services allowing this category of the population to be inadequately informed about health and

sexuality matters, as they rely on their peers for information and often are exposed to incorrect information and myths.

Access to health care is central in the performance of health care systems around the world and access to effective care is at the center of the discourse on how to achieve the health-related Millennium Developmental Goals (MDGs) and Sustainable Developmental Goals (SDGs) by 2030 (United Nations General Assembly, 2000). The SDG Goal No.3, is Good Health and Well-being. Boerma and Mathers *(*2015: 92*)* emphasizes that many adolescents are exposed to a variety of health risks such as HIV/AIDs, tuberculosis, sexually transmitted diseases, mental health issues as well as drug and alcohol abuse. While mortality rates are low compared to other age groups, most causes of death among adolescents are preventable and adolescent health behavior patterns which are adopted during this phase of life, have a lasting impact on health through the course of life (WHO: 2021).

Despite the government's commitment to youth health care such as the implementation of the AYFHS, the unmet needs of young people and their experiences are widely documented (Cooper, De Lannoy and Rule 2017: 60-66). The same study adds that this is compounded by other challenges such as lack of information and awareness, access and availability of services to the youth and poor skills amongst service providers. There is also compelling international evidence of the strong relationship between health care provision to adolescents and improved health outcomes (Mtwesi 2014: 38).

The Ekurhuleni Metropolitan Municipality (EMM) lies within the Gauteng Province, and is one of three municipalities in the Gauteng Metropolitan region of the Gauteng Province in South Africa. According to Mogakwe, Ally and Magobe (2020: 1), the Ekurhuleni health services is divided according to three categories of function namely preventative, curative and rehabilitative. Evaluation of services has shown a disproportionate spread of successful and failed services. It has been a long-term goal to ensure a responsive public health service to all citizens including youth. Discussions regarding the burden of disease and social pathologies has shown HIV/AIDS, tuberculosis, teenage pregnancies, sexually transmitted diseases, substance abuse and mental health issues within the Gauteng Province has escalated amongst the

vulnerable groups especially the youth and adolescents (Health Statistics Report Gauteng 2018). Mogakwe, Ally and Magobe (2020: 3) have further indicated the need for further studies to be undertaken exploring Public Health Care (PHC) services in the Ekurhuleni area, with special reference to youth health friendly services.

The current COVID-19 pandemic has overwhelmed the entire world, demonstrating the urgent need for healthcare and infrastructure, as a result of the increasing burden of disease. This global catastrophe has reshaped the landscape of health systems across nations (WHO 2020). Given the current health challenges faced by the Gauteng population, the province itself has encountered a large number of COVID-19 infections and fatalities (Stats SA 2020). The researcher, who is a specialist PHC nurse, practising in the Ekurhuleni South District, Gauteng Province, feels that there is a need to understand and explore the health challenges encountered by the adolescents as the findings may influence access to and utilization of AYFHS in this region. The global unpreparedness of the current health crises such as the COVID-19 pandemic, has caused disruption to health care systems worldwide, allowing many countries to rethink their PHC strategies.

Exploring the access and utilization of AYHFS is not only an important component for the health transformation process in South Africa, but makes it imperative for a reengineering of PHC services in SA to meet the needs of the vulnerable youth especially in times of a crisis situation. The researcher therefore, incorporated the principles of the conceptual framework by Aday and Anderson's (1974: 208) Model of Health Care Access Health Services Research in this study to illustrate how these principles, when applied to the topic of inquiry, would advance and benefit youth health care needs in accessing and utilizing the PHC services.

1.2 RESEARCH PROBLEM

Since 1994, South Africa has tried to abide by a comprehensive and progressive policy framework governing its provision of adolescent and youth friendly health services. However, many healthcare facilities have encountered challenges with delivery of such services. Cooper, De Lannoy and Rule (2017: 60-66) and Mtwesi (2014: 38) have noted that critics of the National Adolescent Youth Health Policy-NAYHP (2017), have expressed concern about failure of current policies and programmes that address the quality-of-life issues for youth in SA, which poses a barrier to their development and improved health. The same study noted that the National Adolescent Youth Health Policy (NAYHP) development has been unable to apply effective influence over PHC service delivery and enforcing of relevant public policies. This has consequently affected the access and utilization of health services by adolescents in SA.

Notably, adolescents need access to AYFHS in helping to prevent adverse sexual, reproductive and general health outcomes, which is also necessary for protecting future generations from negative health consequences. However, youth appear to be also influenced by their social and cultural norms, forbidding them access to these services. Nmadu, Mohamed and Usman (2020: 3) reported cultural taboos which has also prevented adolescents from openly discussing sexual and reproductive health issues. Within certain cultural groups, adolescents do not normally talk freely about contraceptives as it is not culturally acceptable. These beliefs make adolescents feel guilty when engaging in sexual activity and as a result, accessing such health care services is a problem. Several other research studies emphasized that access to sexual reproductive health services have determinants associated with utilization of such services (Shabani, Moleki and Thupayagale-Tshweneagae 2018: 11)

BMC Health Services Research (2018: 16) reported that risk behaviors in adolescence contributed substantially to the global burden of disease and it has been recognized that over the past years, there has been minimal improvement in adolescent health. Like many other countries, SA has been experiencing a great health transition which has impacted on adolescents. The overall debated concerns are about poor mental health, substance abuse, accidental injuries, poor nutrition, obesity, infectious

diseases and sexual reproductive health issues. Unemployment and lack of education notably contribute to the challenges that adolescents and youth face on a daily basis.

Studies for example (James *et al*. 2018: 1-16) found that the AYFS lacked infrastructure, material and human resources and skilled staffing. This study also recommended assessment of adolescent's perceptions of AYFHS. Hence, the present study will explore the above researchers' recommendation.

Despite availability of PHC services in the Ekurhuleni South District, Gauteng Province, the researcher has observed poor access and low usage of AYFHS by adolescents residing in the Ekurhuleni South District. Therefore, it should be noted that, a greater understanding of the service provider (AYFHS) from the consumer perspective such as the adolescents, regarding access to and utilization of AYFHS in PHC clinics in this region, will provide and raise awareness of the fact that provision of comprehensive, quality care to youth at PHC level is a vital method of promoting basic health care.

1.3 AIM OF THE STUDY

This study aimed at exploring the perspectives of adolescents regarding their access and utilization of AYFHS in Primary Health Care clinics in the Ekurhuleni South District, Gauteng Province.

1.4 OBJECTIVES OF THE STUDY

1. Explore the current health challenges encountered by the adolescents from the Ekurhuleni South District.

2. Determine the barriers to access and utilisation of AYFHS by adolescents from the Ekurhuleni South District.

3. Determine the facilitators of access and utilisation of AYFHS by adolescents from the Ekurhuleni South District.

1.5 RESEARCH QUESTIONS

This study plans to answer the following research questions.

1. What are the views of adolescents regarding the AYFHS?

2. How is this PHC service accessed and utilized in the Ekurhuleni South District?

3. What are the reasons that contribute to AYFHS services being under-utilised?

4. What practices can be instituted, to allow for better access and utilization of AYFHS in the region?

1.6 SIGNIFICANCE OF STUDY

The youth in South Africa have been facing health challenges especially with the increased burden of disease such as HIV and AIDS, tuberculosis (TB) and Sexually Transmitted Diseases (STI) together with the high prevalence of teenage pregnancies in South Africa (Hoopes and Venkatraman 2014: 1-5). A core aim of the SDGs is to provide all people throughout the world with equal, unbiased access to health care and ensure that measures are in place to enable utilisation of basic services such as the AYFHS. Not only is it a cost-effective measure, but its focus on prevention and promotion is increasingly relevant to the upward trend of acute and chronic diseases amongst youth (UNESCO 2019: 1-18).

A literature search yielded evidence of the strong relationship between AYFHS provision and improved health outcomes of youth (MDG Report 2015; Boerma and Mathers (2015). Therefore, effective utilisation of the service would not only enhance the efficiency of the overall South African health care system, especially in the face of the current pandemic, but would assist in the health promotion of rural populations, for whom it was sometimes impossible for the government, to provide full-scale health care services. Considering the current disaster management response, policies and protocol that had restructured the PHC system of SA due to the COVID19 pandemic, the findings of this study would endeavour to inform South African policy makers and help strategize PHC services for safe and attainable health

transformation. This would further reduce the challenges of access and utilisation of AYFHS allowing for better management of the increasing infection and chronic disease burden in the country and provide a more efficient use of available resources.

1.7 OUTLINE OF THE DISSERTATION

Table 1.1 below provides the outline of this thesis**.**

CHAPTER	TITLE	OUTLINE
1	Overview of the study	Introduces and provides an overview of the study by identifying the topic of enquiry, research questions, and study aims. Background information on AYFHS from a global and national perspective is provided in order to highlight the importance of the topic and justify this study.
2	Theoretical framework	Presents the theoretical framework that guides this study.
3	Research methodology.	Provides a detailed description of the study methodology. The study population, sample, data collection and data analysis methods are described in order that the reader may appreciate the intricacies of study design and the potential for research findings.
4	Presentation of findings	Presents the results of qualitative data using thematic analysis. Key findings include and elaborate on the themes and sub themes.
5	Discussion of findings.	Discusses the findings of the study in relation to the access and utilisation of AYFHS by reviewing and interpreting data obtained from the participants.
6	Conclusions, limitations recommendations	Conclusions drawn from the findings are presented and the limitations and strengths of the study are identified in this chapter. Recommendations are made in relation to the key findings of the study.

1.8 CONCLUSION

This chapter provides an overview of the study, introduction and background of AYFHS. The problem statement was clearly identified. The purpose of the study was notably emphasized and the significance of the study explained. The objectives outlined, were aligned to the research questions. The following chapter concentrates on significant literature reviews linked to the above research topic.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is an organized written presentation of what has been published on a topic by scholars. The objective of the review is to describe to the reader what is currently known regarding the research topic. The review should be organized into sections that present themes or identify trends. The author is required to critically analyze the available literature of the research topic, as it creates a foundation for the research study and also encourages further research (Pilot and Beck 2015: 88-91). It is accredited scholarly and research work published on related topics (Grove, Burns and Gray 2013: 97) that have to be consulted. This chapter provides an overview of literature to give clear direction to the research study. According to Burns and Grove (2017: 81-82), perusing articles on the research study are necessary for refining problem areas and determining what is already known, verses what is needed further to be known.

PubMed and Cumulative Index to Nursing were searched for articles using the following terms: access, accessibility, utilization of health services, PHC, AYFHS, Textbooks, and National Health Policies in the field of Public health and PHC related to access of health care services. Google scholar was also one of the search engines which was used to retrieve documents and publications related to the conceptualization of access.

This chapter presents a literature review of national and international authors and researchers pertaining to research directed at AYFHS. Various sources of literature were reviewed and studied, using NDoh, National Adolescent & Youth Health Policy 2017, Google Scholar and PubMed. Further literature was perused for improved understanding of adolescent/youth behavior in the present day as well as health issues and challenges they face in our current society. With increased health pandemics and the burden of disease, many youth face daily and health challenges therefore a holistic approached was adopted to source information that was linked to adolescents and

youth. Factors influencing access and utilization of AYFS in PHC facilities globally, was also reviewed.

2.2 ACCESS TO HEALTH CARE

Access to health care is central to the performance of health care systems around the world (Levesque and Sutherland 2017: 1-9). Access to healthcare services means timely use of health care services to achieve the best health outcome (Abaerei, Ncayayani and Levin 2017: 1-49). The globalization of public health has important implications for access and utilization of healthcare services. The Constitution of the Republic of South Africa (1996) section 27(1) (a), emphasizes that all citizens are granted the right to access health care services. Differences in access to health care services and the resulting adverse health outcomes are major public health priorities. Moreover, the high quality of health care, easy accessibility of health services and reduction of health disparities depend on diversifying the health work force in terms of education, as they provide services to different populations (Williams *et al.* 2014: 33).

Access to health care is defined as having the opportunity to use healthcare. Good access to healthcare means that healthcare is available, affordable and acceptable. There is a difference between primary care and primary health care: Primary care is the first point of contact between a patient and the health care system, whilst primary health care is broader and focuses on how the provision of health services, prevention and health promotion is delivered (Burger *et al.* 2018: 43-55).

One of the health services would be the Adolescents and Youth Friendly service which would be described as services that is based on a comprehensive understanding and respect for young people's right to health care. These services are further described as a place that they trust and one that provides a supportive environment. For a service to be considered as adolescent friendly health services, young people should be able to obtain health services that are available, acceptable and suitable to their age group. Equitable service means adolescents and youth should be able to obtain health services that are not for selected groups. Appropriate health services to the youth and adolescents are services that should be effective and make a positive contribution to the adolescent health needs (UNFPA 2017: 12-14).

The YFHS has previously been recognized as a successful model for implementing youth friendly health services within the public sector. However, an evaluation of this programme indicated a focus on pre-defined standards related to services provided, policies supporting adolescents' rights and the clinic environment. According to global health organizations such as the International Conference on Population and Development Plan of Action, WHO together with Maputo Plan of Action, the need for development of YFHS was emphasized.

In reference to UNFPA report (2018: 158), the Reproductive Health Services in Zimbabwe and Kenya has increased attention to improving youth friendly services. The surveys carried out in these areas were analyzed and important issues of lack of confidentiality and long waiting periods where some of the problems highlighted. The findings for improvement of health care services even in the most resource-poor settings indicated that they are in a position to improve their level of youth friendly service.

Internationally, SA is recognized as having a scaled up AYFHS programme compared to other international YFHS programmes (Mazur. *et al*. 2018: 116). In South Africa, the constitution provides for the right of access to health care services. According to Section 24 of the constitution, every person has the right to an environment that is not harmful to their health or well-being. The National Department's 2030 plan, centre's on building a better future for the South African youth. According to James *et al.* (2018: 1-16), improvement is still required and necessary in YFHS programmes, to influence the youth of South Africa to access and utilize AYFHS.

HIV amongst South African youth remains relatively high, especially in the recent years. The antenatal survey carried out by Bhengu (2018: 1-7) states that South Africa remains challenged by persistently high levels of maternal and perinatal mortality rates. Geary (2015: 1) adds that the health facilities providing the YFS programme does not always deliver a positive experience to the youth when providing the programme. The burden of TB among youth and adolescents has been subjected to an increase especially among those youths with co-infection of HIV/Aids. With

reference to TB Statistics South Africa (2020), SA is one of the countries with highest rate of TB. Francis (2018: 1-13) also adds that the prevalence of sexually transmitted infections among young people in South Africa has been rapidly increasing with HIV/Aids and poor reproductive and sexual health. According to Peltzer and Mafuya (2018: 1-6), the use of illicit drugs amongst South African youth is very prevalent while youth and adolescents face several mental health issues (Baldwin-Ragaven *et al*. 2018: 17-18; Gauteng DOH- Annual Report 2016/2017).

These compounding problems noted in the literature search, has raised questions and stimulated dialogue as to how AYFHS in PHC clinics in the Ekurhuleni South District, Gauteng Province is accessed and utilized.

2.3 FOUNDATION OF ADOLESCENT YOUTH FRIENDLY SERVICES

Lovelife is a non-profit organization that interacts nationwide with the community's outreach and support programmes to promote healthy living among South African Youth. The focus of the organization is on HIV preventative initiatives for young people. The National Adolescent Friendly clinic was founded in 1999 by various organizations namely the Reproductive Health Research Unit of University of Witwatersrand, Chris Hani Baragwanath Hospital and the Lovelife organization (James *et al*. 2018: 2).

In 2002, the World Health Organisation developed the Adolescent Friendly Health Services model which focused on providing health services that addressed specific health needs of adolescents (13-19 years). The package was broadened to include the health needs of young people aged (10-24 years) and is called YFHS. This programme addresses complex issues such as substance abuse, obesity, violence, and psychosocial support in addition to sexual and reproductive health services that is set to target young people. The framework consists of equitable, accessible and acceptable ways for youth to access health services, but the plague of poor coverage, inadequate implementation and lengthy follow-up periods has disrupted effective access and utilization of this youth service (Koon, Goudge and Norris 2014: 1-5).

In 2006, the Lovelife organization's funding ceased and the Department of Health (DOH) took over the YSF programme. In 2010, the National Department of Health (NDOH) set up a programme to assess and evaluate the YFHS. The aim of the programme was to holistically meet the health needs of the youth. The target population group were youth between 10-24 years of age, unemployed men and women, teenage mothers, HIV infected people, destitute youth and scholars in need of health assessment.

The promotion of Adolescent and Youth Friendly Services in South Africa by the National Department of Health took effect in 2010. This served as a means of standardizing the quality of health services in the country (James *et al*. 2018: 2-16). As the burden of disease increases globally, the youth and adolescents are at a growing risk of health transitions. Concerns around adolescent health are poor nutrition, obesity, teenage diabetes, mental health issues, substance/drug abuse, sexually transmitted infections, HIV/Aids, TB and teenage pregnancies (UNICEF 2019: 16; Miller *et al*. 2017: 2).

In South Africa, the Lovelife non-governmental organization together with other consortiums, developed and implemented the NAFCI. The vision of NAFCI is to provide services for adolescents that address the barriers of health services, attitudes of health care providers, inadequate information, and lack of equipment and accessibility of services (Greathead, Devenish and Funnell 1998: 6). According to the quality improvement plan, AYFS was adopted and ensured healthcare providers would deliver quality health care services which could be measured against fixed standards and criteria (James and Pisa 2018: 2). Figure 2.1 illustrates the functions of NAFCI in providing accurate information for youth and adolescents, so that they would be able to make informed decisions about their health needs. The illustration also shows the Adolescent Friendly Services (AFS) in the center which serves as an anchor in the programme.

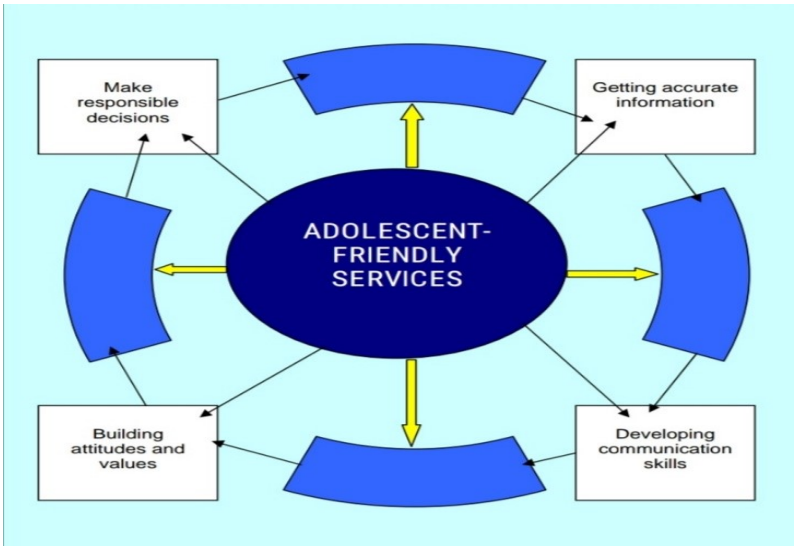

Figure 2.1 Functions of the NAFCI and AFS (Adapted from Greathead, Devenish and Funnell (1998:6)

2.4 GLOBAL TRENDS OF AYFHS

The United Nations Population Fund (UNFPA) supported adolescent health rights by means of access to comprehensive sexuality education, services to prevent, diagnose and treat STI's and counselling on family planning. This was to empower youth to exercise their rights including the right to delay marriage and the right to refuse unwanted sexual advances. UNFPA together with other ministries including NGO's also advocate and support the efficient delivery of a holistic, youth friendly health care ensuring the following: universal access to accurate sexual and reproductive health information and contraceptives, sensitive counselling, quality obstetric and antenatal care for all pregnant women and girls as well as prevention and management of sexually transmitted infections, including HIV (Maputo Plan of Action 2016-2030: 6-7; UNFPA 2014).

2.5 AYFS IN AFRICA

The Reproductive Health Services in Zimbabwe and Kenya has increased attention to improving youth friendly services. The focus on adolescent reproductive health is said to be a new phenomenon because previously, programmes focused on parents, teachers, and adults but now the emphasis has been prioritized for youth programmes.

Previous studies have revealed that adolescents were not well received or comfortable in mainstream family planning clinics. Young people felt judged and criticized in some facilities (Mazur, Brindis and Decker 2018: 2); Koon, Goudge and Norris, (2014: 1-5).

Studies in several African countries revealed that providers-imposed age restrictions on providing family planning methods, including condoms. In a study done in Tanzania, more than a third of the providers placed restrictions on condom provision based on age. Condoms are the most accessible and suitable to the sporadic nature of adolescent sexual behavior as well as reducing the risk of HIV infection.

In Ghana and Nigeria, young clients were not treated with same level of respect as older clients nor were, they given detailed information as compared to youth in Zimbabwe. Zimbabwe preferred a stand-alone youth friendly health service, for reasons pertaining to privacy and respectful youth care (Mazur *et al.* 2018: 2-97). In Uganda, youth requested that the current services be upgraded to accommodate the youth rather than a separate facility and they emphasized confidentiality, accessibility and cost (Onukwugha *et al*. 2019: 134-144).

Malawi also integrated YFHS programmes into their health care system. The YFHS was initiated in 2000 and in 2007 the Ministry of Reproductive Health developed Youth Friendly Health Service standards to improve the overall services to young people. A follow up evaluation was conducted in 2014 by stake holders, USAID, Centre of Social Research at the University of Malawi and MOH-RHD. The quality of YFHS in comparison to the existing health standards in relation to the health care needs of the youth of Malawi was assessed and according to the evaluation assessment, better insights were obtained with regards to the sexual reproductive health knowledge, behavior and health service needs of the Malawian youth. The need for improvement of YFHS program according to the changing health needs of the youth was noted as well as the need for improvement of services in response to the youth. The need for adherence to the YFHS National Standards was a key priority in many institutes.

Stakeholders further promoted interventions to strengthen YFHS in Malawi (USAID 2015; Barden *et al.* 2020: 344).

As cited by Barden *et al. (*2020: 1-344), youth advocate Msiska argued that young people in Malawi are having sex at young age, resulting in high number of adolescent pregnancies. In an interview with Msiska, the importance of youth policy and young people's sexual reproductive health rights were discussed. Further probing resulted in findings that the majority of youth lack understanding of sex and sexuality. The promotion of youth health and information regarding youth sexual and reproductive health to encourage healthy sexual behaviors that allows youth to make improved decisions about their health was given priority. This informed health information would allow youth to make better choices thus helping young people to interact and participate in the community and promote rights, choices and gender equality (Barden *et al.* 2020: 343).

Msiska 2012 (as cited in Barden *et al.* 2020: 344) supported the implementation of the YFHS program evaluation, because he felt that the results of the evaluation would definitely impact the strategy for adolescent Sexual Reproductive Health Rights (SRH). He claimed that this would further uplift and support adolescent SRH issues and the YFHS. Other campaigns such as legal age of marriage, adolescent pregnancy, girls' rights and access to reproductive health services, the 'Condomize Malawi' campaign would be strengthened in view of effective youth friendly health services and this would effectively be advocated throughout the African continent (Barden *et al*. 2020: 1-344).

The importance of an effective policy was needed to serve as a framework for attaining sustainable AYFS, thus ensuring that quality is not compromised when services are being offered. Youth inclusiveness and decision making empowers youth leaders to build a strong foundation to advocate for their rights and fulfil their responsibilities with regards to their health (Barden *et al.* 2020: 1-344).

According to literature regarding strategies promoting YFHS, Chinele (2017) describes "Clubs" promoting YFHS for example the youth of a traditional authority in a remote area in Kawinga attend a health center in Malawi. It is mentioned that it is a privilege to have an YFHS in the area as the youth are able to access information and also

contraceptives without being judged. The YFHS of Kawinga Health Centre promote good nutrition, HIV testing and counselling, sexually transmitted infections screening and treatment, health education and peer education. The YFHS coordinator verbalized that every Wednesday from 2-4pm, youth flock to the facility as it is a special time for the youth. They have also engaged in activities such as football, netball, and chess which kept the youth engaged. The existence of youth clubs promoted the YFHS in the area. Chitetezo Youth Club in Kawinga has 21 members, 10 Male and 11 Females. On a negative note, the Kawinga Health Centre had been lacking in meeting the demands of the youth because of lack of medication and shortage of trained staff.

Following the evaluation of AYFHS in 2014, the standards of services being provided was noted as medium. Implementation action plans to improve quality service delivery in alignment with National Health standards was highlighted. Managing the performance of AYFHS is said to be a method of safeguarding young people's transition into adulthood and improving indicators of health in Malawi (Self *et al*., 2018: 15; Ministry of Health Malawi- National Youth Friendly Health Services strategy 2015-2020). Rosenburg (2018: 456-458) reasoned that integrated YFHS had led to substantial improvement in the uptake of HIV testing, condoms use and hormonal contraceptives among adolescent girls and young women in Malawi.

Diverse clubs and projects such as Empowering Young People, Youth Net and Counselling (YONECO), Education Expertise Development Foundation (EEDF), Aidsfonds and Edukans, with funding from DFID implemented this project in districts of Mangochi and Chikwawa. The aim of this project was to engage in wider community involvement in YFHS initiatives, targeting gate keepers and power holders like traditional and religious leaders and encouraging intergenerational discussions such as taboo subjects, breakdown of stigma and discriminatory attitudes towards youth (James *et a*l. 2018: 2-10). Parents within the community recognized the need for YFHS so that the youth could access the necessary health care required (Schriver *et al*. 2014: 625).

2.5.1 The overall view of YFHS in Malawi

The focus is on the use of culturally sensitive approaches to community-based youth friendly health services programming and using existing structure and yielding positive outcomes. Interventions are centered on community power such as, traditional /religious leaders as custodians of culture and motivating key to successful youth friendly health service initiatives. Improved knowledge of SRHR among youth in schools and the community is encouraged. There is a transitioning towards positive shifts in cultural norms and encouraging parents' participation in youth related initiatives. The use of different youth clubs and youth driven projects highlight YFHS. There is an ongoing need for evaluation and improvement of YFHS as the youth trends change with regards to new diseases and need to access health care. A commitment from the Malawi Department of Health to youth driven quality health care and policy updates and reviews by stakeholders was noted. Youth involvement and empowering youth advocacy with regards to health-related issues was encouraged (Ministry of Health Malawi-National Youth Friendly Health Services strategy 2015-2020; Barden *et al*. 2020: 1-344; UNFPA Report 2018: 15-158).

The above methods and strategies can be used by many other YFHS initiatives as a benchmark to be adopted and implemented to advance the YFHS thus encouraging access and utilization of health care services. This would advance SDG 3 "Good Health and Well-being" and the Adolescent Youth Health Policy 2017

According to the above literature, Zimbabwe and Kenya still require some major improvement to implementation as compared to Malawi. Malawi has some positive AYFS benefits that influence the quality improvement plans for Zimbabwe and Kenya. Benchmarking the positive influences of Malawi AYFS can impact on the health care of Zimbabwean and Kenyan youth and how they receive the improved AYFS.

2.6 AYFS IN SOUTH AFRICA

The South African Department of Health adopted and scaled up the Love Life's Youth Friendly Services initiative in 2006, a National policy to improve youth utilization of health programmes by strengthening community response and counselling services. This approach was promoted as a means of standardizing the quality of adolescent health services in the country. The heightened challenges of inequity of this service with no thorough knowledge of the programmes purpose or activities has been widely documented (Schiver 2014: 625). According to Geary (2015: 1) few youth friendly health services worldwide have been evaluated from youth perspectives. This research study explores the youth/adolescent's experiences when accessing and utilizing AYFHS.

In 2010, the first evaluation undertaken by the South African National Department of Health determined that the AYFS programme was not implemented at the selected facilities because of inadequate accommodation for AYFS and lack of trained staff. The youth verbalized lack of resources, staff attitude and overall poor quality of care. Renewed quality improvement plans were initiated but no follow up took place to date. Further research follow-up will be addressed in this study.

Although, Internationally SA has a scaled up AYFHS programme compared to other international YFHS programmes, improvement is required and necessary in YFHS programmes to function effectively in a capacity to be influential to the youth of South Africa accessing and utilizing AYFHS. The institutes that are not practicing AYFHS programmes are not operating according to National Core standards by failing in maintaining MDG, Ideal Clinic initiative policies, National Adolescent & Youth Health Policy 2017, all of which has been set as a priority by the Minister of Health and other stakeholders. (James and Pisa 2018: 1-16).

This research study focuses on the vulnerable target population within the youth and adolescents assessing access and utilization of AYFHS within PHC facilities. The study further explores the barriers experienced by youth and adolescents and probes the youth involvement to improve access and utilization of AYFHS within PHC facilities to meet their healthcare needs.

2.6.1 Adolescent and Youth health challenges

The following information provides an overview of the health challenges many of the youth face on a daily basis. The overview highlights the burden of different types of diseases and infections that could be prevented through the promotion of AYFHS. As noted in documented literature worldwide, youth and adolescents are faced by greater health risks; physical, psychological and sexual abuse; gender-based violence and health challenges such as HIV/Aids that is increasing in many households. Sexually transmitted diseases, unwanted pregnancies and other related complications are among the risks that many youth face (United Nations 2018).

According to Statistics South Africa (WHO 2020), morbidity and mortality patterns of youth has highlighted that the Youth and Adolescent Health Policy is aimed at improving long-term health outcomes of South African youth. The policy advocates for the long-term health commitment to improve the health care needs of the youth and prioritize health in relation to diseases such as HIV/Aids, tuberculosis. chronic diseases, sexual and reproductive health (DOH 2018: 3-30).

Youth/adolescents want a place of acceptance without prejudice and if we as healthcare practitioners together with other stakeholders would ensure an effective implementation of AYFS, then the burden of diseases would rapidly decrease. This would impact positively on the quality of health care amongst the youth as compared to previous studies.

2.6.2 Youth and Reproductive Health

Snyder (2014: 1-9) commented that a review of Children and Youth Service indicated the prevalence of HIV amongst South African youth remains relatively high especially in the recent years. The Antenatal survey carried out in 2011 found a 14% prevalence of HIV in youth 15-19 years, which increased among the 20-24 age group with a prevalence of 27%. The burden of disease has trended overtime and the need for intervention to prevent new infections among the youth is a priority. South African

youth are at risk according to behavioral research which indicated that sexual activity is initiated at an early age in South Africa and young people have multiple partners and condoms are used inconsistently (Snyder 2014: 1-9).

2.6.3 Youth and the burden of HIV

According to Jaspen *et al.* (2019: 4) and Mathews *et al*. (2018: 7), USAID, in their 2011 announcement report, recommended support groups as a measure to meet psychological needs of HIV infected adolescents in Africa. SA National Strategic Plan for 2012-2016 prioritizes the strengthening of youth friendly health services and programs linked to HIV adherence and care (Jaspen *et al.* 2019: 4 and Mathews *et al.* 2018: 7). The burden of disease was further acknowledged by authors Kharsany and Karim (2016:34-48) who mentioned that in 2013 the youth population in Africa was the center of the HIV/Aids epidemic, with 74% of AIDS related deaths. Youth within the age group of 15-24 contributed to 42% of new HIV infections.

Geary (2015: 1) researched 15 PHC clinics in Soweto, Gauteng, and investigated youth experiences of using sexual and reproductive health services by YFS programmes and this was compared to those clinics where YFS programmes were non-existent. The outcome of the study showed that the health facilities providing the YFS programme did not deliver a more positive experience to the youth than those not providing the programme. The lack of privacy, inadequate information and negative experiences was noted by youth when they had to show soiled sanitary products to obtain contraceptives. On a positive note, it was reported that health care staff were friendly, respectful, staff knew how to address youth and appeared to value the fact that youth seek health information. The recommendations of this research in conclusion mentioned that the provision and impact of the YFS programme is limited thus future research should explore limitations, regular training and monitoring so that health care professionals would meet the needs of the growing youth (Geary 2015: 1; Koon *et al.* 2014: 1-5).

2.6.4 Sexually transmitted infections amongst youth today

In reference to Francis *et al. (*2018: 1-13), the prevalence of sexually transmitted infections among young people in South Africa has been rapidly increasing with HIV/Aids, poor reproductive and sexual health. According to statistics in 2012, a total of 286 million people aged 12-24 years live in Africa. This accounted for 18% of the global youth population. It has been presumed that by 2040, the projected youth in Africa would increase to 60%. Therefore, health interventions are vital for current and future youth generations for Africa and globally. It is said that in low and middle-income countries (LMICS), symptomatic STI's is treated by syndromic management. The concern is that asymptomatic STI's can go unnoticed and untreated and both symptomatic and asymptomatic STIs can cause serious morbidity such as pregnancy complications, infertility, cancer and HIV transmission. Highlights of young people with increased prevalence of STIs has been observed globally and the critical need for NDOH to improve sexual and reproductive healthcare is needed on a continued basis. The WHO Global Health Sector Strategy on Sexually Transmitted Infections (2016-2021) has set out goals and targets for global STI prevention and control.

One of the highlighted targets are the key population most at risk for STIs, which is the youth and adolescents. This is when the youth ability to access and utilize AYFHS comes into effective and the influence of this service would definitely have a positive influence on the healthcare of youth. There is a decrease of the burden of current and new diseases and overall health of the youth population. It would be a milestone achieved in health care if the AYFS programme operated effectively and the youth adopted the services as a basis where every youth should be encouraged to have a health assessment (Francis *et al.* 2018: 1-13).

2.6.5 TB-increase ailment amongst youth

The burden of TB among youth and adolescents has been subjected to an evident increase especially among those youths with co-infection of HIV/Aids. With reference to TB Statistics South Africa, SA is one of the countries with highest rate of TB. The WHO statistics showed an estimated incidence of 322 000 cases of active TB in 2007,

compared to 2011 with an estimated incidence of 500 000. From the estimated cases of 322 000, 60% (193,000) are HIV positive. TB is noted as the leading causes of death in SA (Stats South Africa 2018).

A survey held in the Western Cape Province, South Africa, stated that new TB notifications in 2013 was 18%. HIV prevalence among TB patients was 10.9% in 10-14year old's, 8.8% in 15-19- age group and young adults 20-24 years with HIV coinfections had poor treatment outcomes, 15.6% discontinued treatment prematurely and 4.0% died. Young people in the Western Cape had a high risk of treatment discontinuation and furthermore the substantial rate of TB-HIV co-infection was on the increase (Snow, Hesseling and Naidoo 2017: 651-657).

In more recent research studies, it has been reported that there was a significant decrease in TB rates among adolescents in the Western Cape Province. HIV coinfection impacts on TB disease rates among the youth population, and since the HIV programme has substantially improved, the testing and screening process has significantly aided the youth health care with regard to early diagnosis and treatment. Notification of TB cases amongst the youth population has seen evidence of a change within the TB programme. The strengthening of the TB health management information system which impacted the electronic notification of TB patients was introduced. The DOTS programme has supported tracing and treating of patients with TB. Measures such as universal HIV testing, active case findings notification and also assessment of contacts, impact on the decline of TB amongst the youth population in South Africa (Bunyasi. *et al*. 2020: 1).

2.6.6 High prevalence of substance abuse

According to Peltzer and Mafuya (2018: 1-6), the use of illicit drugs amongst South African youth has increased drastically. Africa News (2017) confirms that the use of drugs has taken a toll on communities in the country and many youths in the country are easily getting caught up with drugs, alcohol and gang life (Health24: (2018). A report by the South African Community Epidemiology Network on Drug Use

(SACENDU) stated that there has been an increase in the number of people treated for drug abuse in 2017. Since 2016, there has been a 10 047-increase included in the numbers, many are adolescents, especially males 17-20 years old. The risk of alcohol and drug abuse increases the risky sexual behavior and poor judgement thus increasing chances of STI, HIV, neurological and memory disorders. Psychiatric disorders have also been linked to abuse of drugs. The association of drug abuse and how this is linked to health care needs amongst the youth, is highlighted so the AYFHS are prepared to receive such cases within the facilities (Parker, Streck, and Sigmon 2018: 167-170; Peltzer and Mafuya 2018: 1-6).

2.6.7 Mental health and how youth are affected

According to SA Federation for Mental Health, “Young People and Mental Health in a Changing World- snapshots and solutions” (2018) states that youth and adolescents within today’s society face several mental health issues. The aim is to raise awareness of mental health issues amongst the youth especially in a changing world with evolving trends. Every person is unique and everyone handles challenges differently. SAFMH focuses on key issues such as social media pressure, suicide amongst youth, substance abuse, poverty, HIV/Aids and crime amongst other challenges and how this impact on the health of today’s youth. Young people are a vulnerable demographic with mental health as a risk. The awareness of mental health issues is exposed so that priority of integration with regards to this health care need is addressed and adopted into the AYFHS, thus exploring availability to access and utilization the services (SA Federation for Mental Health 2018: 1-54).

According to UNICEF (2018), the impact of COVID 19 on mental health of adolescents and the youth is having a significant crisis. Despite facing great difficulties, many adolescents and young people have found different ways to face new challenges and cope with their emotions. While some have chosen to distract themselves by getting involved in community projects to help during the pandemic, others have chosen to read and write down how they are feeling. Those who do not have the same possibilities to maintain their physical and emotional well-being, have reached out for help.

The spread of the COVID-19 virus worldwide, resulted in closure of schools in many countries. The implications of school closure has led to exposure of many adolescents to potential social vices and health risk behaviors. Recent evidence amidst the COVID 19 pandemic, has revealed a rise in interpersonal violence amongst adolescents in Sub-Saharan Africa during school closure. This has been exacerbated by a spike in gender-based violence, sexual exploitation, rape and teenage pregnancy reported in Nigeria and Kenya. Youth and adolescents with co-morbidities have been at greater risk during the pandemic. Some have succumbed to the disease. There is an urgent need for public health interventions that support youth and adolescents to equip them during the COVID 19 pandemic to avoid preventable death over fear of COVID 19 infections (Addae 2020: 219-222).

AYFHS programmes plays a prodigious role during the pandemic in supporting the vulnerable youth and adolescent within the community. Hence this research study will explore the significant views of youth and adolescents on accessing and utilizing the AYFHS within the community.

2.7 AYFHS IN EKURHULENI SOUTH DISTRICT

Figure 2.2 Ekurhuleni South District (Ekurhuleni AYFHS Mission Statement: 2018).

A study by Basu (2018: 17-18) described integration of adolescent youth friendly services into PHC structures within the 3 Medical Outpatient Units and PHC facilities within the Ekurhuleni District Gauteng.

The Ekurhuleni South District consists of 33 health care facilities. Only 20 professional nurses within this district have been trained with regards to AYFS. The only facilities that have been recognized as effectively operating AYFS are Katlehong North clinic and Dawn Park clinic. Dawn Park clinic has a stream dedicated for youth between the ages of 10-24years.

The AYFS Programme is designed to influence change in outlook, overall values and attitude in health care provider to understand and accept young people's rights in accessing and obtaining quality health services. It also initiates change of attitude and how we accept and approach young people (Ekurhuleni AYFHS Mission Statement: 2018).

2.7.1 Where is the service currently available?

AYFS services are provided by all public clinics on a different scale depending on whether the clinic had just started the roll out service, whether the clinic was already recognized for meeting the 5 prescribed minimum standards and whether the clinic is fully accredited for implementing and meeting all the 10 standards (Basu 2018: 17; Gauteng DOH- Annual Report 2016).

The above reports noted that variable levels of implementation had been utilized in the various sectors of health facilities, so it is imperative and timeous that this study explore the variable levels of access and utilization of services by the youth population.

Table 2.1 Advantages/Disadvantages of AYFHS in Ekurhuleni

Advantages	**Disadvantages**
1. 33 PHC Facilities in Ekurhuleni South District	1. Only 2 PHC Facilities fully effective AYFS
2. 20 Trained AYFS Professional Nurses	2. Inadequate number of trained personnel, other categories
3. Available Policies/Guidelines, National Adolescent & Youth policy, MDG, Core standards, Vision/Mission	3. Many Facilities did not meet National standard guidelines
4. Ideal Clinic	4. Facilities that followed Ideal Clinic Initiative, lacked staff, influx of clients…
5. AYFS Programme MX, Coordinator's, AYFS Trainers etc. Management level	5. Lack of support from Management to ensure effective AYFS
6. Lovelife organization still active in Ekurhuleni South District- supporting AYFS	6. Due to lack of funding which has impacted negatively on Lovelife organization foundation

2.8 CONCLUSION

This chapter discussed the literature review of AYFS global trends namely national, international trends and local perspectives of AYFS, its advantages and disadvantages and utilization. The following chapter will discuss the chosen theoretical framework that was used to guide the current study and the application of its various constructs to the topic of inquiry.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

THEORETICAL FRAMEWORK USED TO GUIDE THE STUDY

A theoretical framework, is an abstract, logical structure of meaning, guiding the development and organisation of the study (Burns and Grove 2017: 139). In order to answer the research question and draw a link between the topic of inquiry and the study's objectives, the researcher adopted Aday and Anderson's model of Healthcare Access to explore the factors that influence adolescents' access to and use of AYFHS in Primary Health Care clinics.

3.2 THEORETICAL FRAMEWORK USED TO GUIDE THE STUDY

Aday and Anderson "Access to Medical Care" model was used to guide the study. This model was developed and used since the late 1960's. This framework is further described as an integrated model that reviews health policies, characteristics of health care delivery system, characteristics of target risk population, utilization of health services and the consumer satisfaction (Aday and Anderson 1974: 208).

3.3 ACCESS TO MEDICAL CARE FRAMEWORK

The ongoing revision of the framework through research studies has strengthened and reinforced access to health services, decreased health disparities and increased utilization of health care services in order to achieve health equity by satisfying customers (Anderson and Newman 1973: 1; Aday and Andersen:1974: 208); Anderson 1995: 1). The above theoretical framework intricately flows through the problem, purpose, significance and also the questions of the current research study. A deep understanding of the framework was established and an integrated link emerged as to how this could be suitable to the research topic. The researcher's understanding of this particular framework and the appropriateness was enhanced through the five elements which holistically explores the research problem, the

purpose of the research, the significance and also the questions laid out in chapter one.

ADAY AND ANDERSON'S MODEL OF HEALTHCARE ACCESS

Developed by Aday and Andersen in 1974, this is a comprehensive framework that defines access as dimensions which describe the potential and actual entry of a given population group to the health care delivery system. The framework also demonstrates the interdependence of health service dimensions and how they act synergistically, to promote or impede health care access. Three key beliefs are the core of the framework as follows:

1. Health care is a human right
2. Health care resources are limited
3. Health care policy must allocate these resources equitably

The following model (Figure 3.1) seeks to explain the interplay between health policy, the health-care system, populations at risk and their effects on health-care access. (Aday and Anderson 1974: 208).

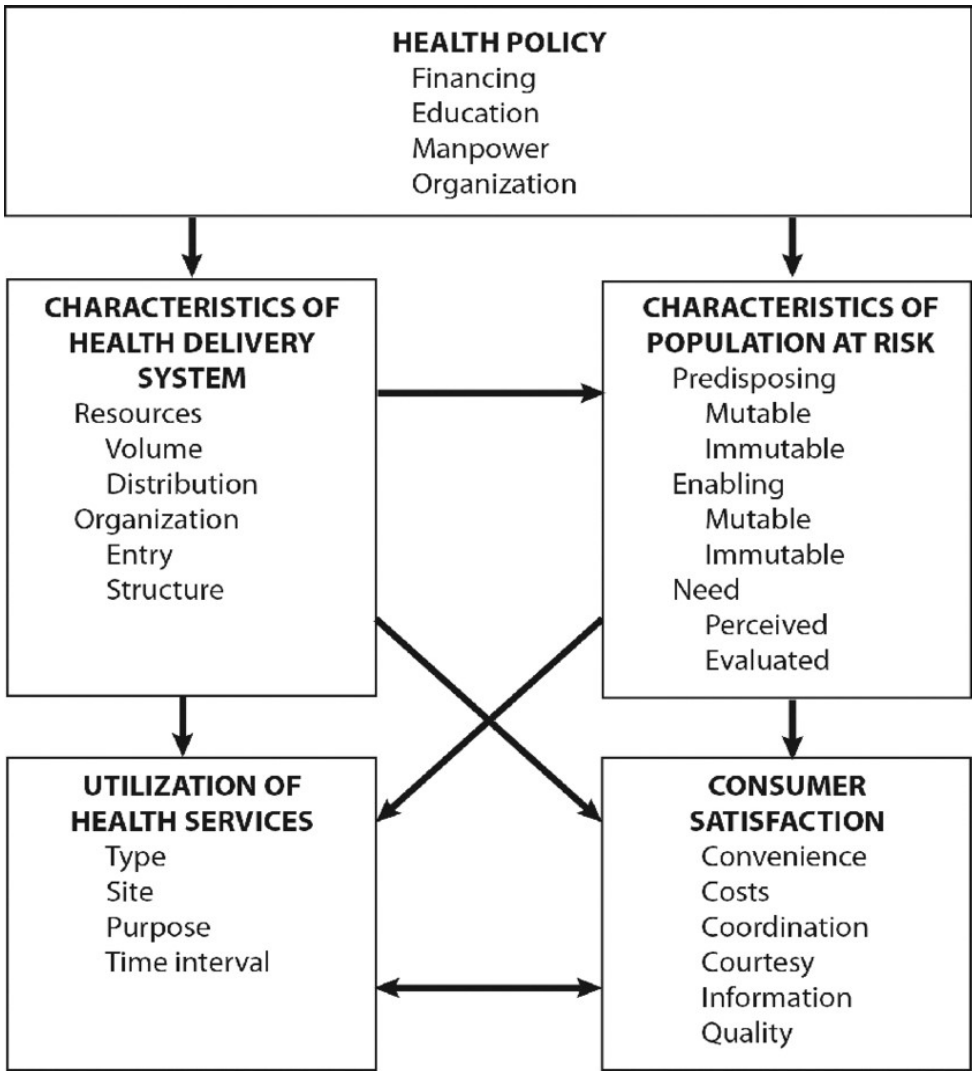

Figure 3.1 Aday and Anderson's model of Healthcare Access (Aday and Anderson 1974: 212).

THE FOLLOWING 5 COMPONENTS OF THE THEORETICAL FRAMEWORK ARE DESCRIBED AND SUMMARIZED AS FOLLOWS:

COMPONENT 1- Health care policy: Health Policies have been strategized to increase and improve access to health care services although the challenges that exist in implementing primary health care services are clearly understood.

COMPONENT 2- Characteristics of health delivery system: The delivery system consists of fundamentals such as resources, which is made up of volume, distribution and organization, which is made up of entry and structure. Organisation is described as the process which is used to utilize resources, access as the process a client uses to gain entry to the health care system, whilst structure determines how the health facility is structured to ensure that the client receives health care.

COMPONENT 3- Characteristics of the population at risk: There are three characteristics of the population at risk namely: predisposition (age, race, and religion), enabling (availability of facilities and health care providers) and need factors (individual's ability to perceive his or her health care needs).

COMPONENT 4- Utilisation of health care services: Utilisation of health care services may be evaluated in terms of its type namely; site, purpose and the time interval (from arrival at a health facility until being treated).

COMPONENT 5- Consumer satisfaction: Consumer/customer satisfaction is referred to as the measurement of customer experiences, regarding a product or services provided by a company or organization (Sokhela 2013: 23).

3.4 APPLICATION OF THEORETICAL FRAMEWORK TO THE STUDY

COMPONENT 1- Health care policy

Access in this context refers to having the organizational and governmental support that integrates finance, education, human resources/manpower and organization programmes which assist in implementing and guiding policy makers and health planners. It is therefore used to determine the adherence of AYFS policies by adolescents and review practices that can improve health care access and utilization.

COMPONENT 2- Characteristics of health delivery system

Within the context of this study, it is important to note that, if any barriers such as waiting time at a PHC facility or adequacy of resources influence service delivery, this will pose hindrances to access and utilization of healthcare services and client satisfaction. In this study, the target group facing this challenge would be the youth population.

COMPONENT 3- Characteristics of the population at risk

The researcher in this study uses this component to support the finding that young people who constitute a fifth of the global population, are burdened by disease and predisposing factors such as young people's risk-taking behavior which influences their health risks (UNICEF 2011; Van Zyl 2013: 281). Therefore, enabling factors such as challenges with regards to access and utilization of AYFHS can cause harm to the youth and the "*need* factor", may sometimes be established at a later stage, when the health condition has deteriorated.

COMPONENT 4- Utilisation of health care services

In this study adolescents/youth utilizing health services, are the end users or the consumers of health care services. The researcher used the aspects of characteristics of the population at risk (type, site, purpose and time interval), in addressing the objectives of the study and for a clearer understanding of the range of challenges that exist in the implementation of AYFHS in the Ekurhuleni district.

COMPONENT 5- Consumer satisfaction

Consumer satisfaction in this study explores the experiences of adolescents in accessing and utilizing health care services. Consumer satisfaction is used to measure any occurrence experienced by individuals and barriers hindering health care services and thus measures client outcome. The outcome of customer satisfaction further impacts on evaluation of Adolescent Youth Health Policy 2017 and success of SDG 3 “Good health & well-being”.

3.5 CONCLUSION

The framework discussed in this chapter was used to guide the study and aid the researcher to conceptualize the synthesis of literature in chapter 2, whilst linking the theoretical framework to the problem, purpose, objectives, significance and intent of the study as outlined in chapter 1. The application of the framework allowed the researcher to explore the link between the 5 components and how this impacted on the use of AYFHS. The following chapter will detail the research methodology of the study.

CHAPTER 4: DESIGN AND RESEARCH METHODOLOGY

4.1 INTRODUCTION

The following chapter consists of a systemic method that was used for gathering data and information which was further analyzed for advancement of knowledge and improving the specific study area. Chapter 4 follows the theoretical framework which guided the study. The research design, setting, sampling process, data collection, data analysis, validity/reliability and ethical consideration will be discussed in this section.

4.2 RESEARCH DESIGN

A research design is a blueprint for the comportment of the study which exploits factors that influenced the desired outcome of the study. Designs have been developed to meet the unique research needs that occur (Burns and Grove 2012). The purpose of a design was to achieve control of the study and thus improving the validity of problem being studied.

4.2.1 Descriptive research

According the Burns and Grove (2017: 200) a descriptive design was conducted in a natural setting, to answer a research question related to incidence, prevalence or frequency of existence of a phenomenon interest and its features. A descriptive research provided an accurate portrayal or account of characteristics of a particular individual, situation or a group.

4.2.2 Exploratory descriptive

The use of exploratory descriptive studies was to facilitate a greater understanding of the target populations' needs, in order to assist in the development of specific interventions that might alleviate the problem (Burns and Grove 2017: 29,678). Information gathered from the target population- youth and adolescent and nursing personnel within the health care facilities, was used to explore and describe access to and utilization of AYFHS. The objective of using a descriptive research design was to illustrate the reality of problems experienced in the setting described in the study and it was a legitimate method of research (Burns and Grove 2017: 69-70).

This study explored access to and use of AYFHS by adolescents' in PHC clinics in the Ekurhuleni South District, Gauteng Province and drew on the principles of the theoretical framework by Aday and Anderson's Model of Health Care Access (1974: 212).

4.3 RESEARCH DESIGN USED IN THE STUDY

The study used a qualitative research design, with an exploratory descriptive approach. It has been noted by Grove, Burns and Gray (2012: 23), that exploratory descriptive qualitative studies usually explore and describe a problem that was in need of a solution. The researcher chose this approach to explore the perspectives of adolescents regarding access to and use of AYFHS and considered this approach appropriate to gain the information from the proposed participants.

Qualitative research was appropriate because the researcher wanted to examine the experiences of human beings in the natural environment. The description of qualitative research is further argued by Grove, Burns and Gray (2012: 25), that this type of research is conducted to explore, describe and promote understanding of human experiences, situations, events and cultures over time. Exploratory research is designed to increase the knowledge of a field of study (Grove, Burns and Gray 2012: 25). The study was conducted in the real world setting where the participants resided and their perspectives or feedback on the access and utilisation of AYFHS were described in their own words. This facilitated a greater understanding of the target populations' needs, in order to assist in the development of specific interventions that might alleviate the problem.

The objective of using a descriptive research design was to illustrate the reality of problems experienced in the setting described in the study and it was a legitimate method of research (Burns and Grove 2016: 69-70).Therefore the use of a qualitative, exploratory descriptive method in this study provided a systematic, interactive, subjective, naturalistic and scholarly approach used to describe life experiences, cultures, and social processes from the perspective of persons that were actually involved (Marshall and Rossman, 2016).

4.4 STUDY SETTING

A setting in a research study uses the environment or surrounding from where the researcher collects data for the study (Burns and Grove 2016: 329-331). The setting used for this study was the Ekurhuleni South district in the Gauteng Province. The City of Ekurhuleni emerged approximately 17 years ago as a key Metropolitan Municipality in Gauteng with a population density of 513 people per km in Gauteng. This well-established community has a youth and adolescent population of approximately 48000 youth and adolescents. It consists of thirty-three PHC (33) clinics that service a population of 2.5 million people, with a youth population aged between 15-24 years of age (Ekurhuleni Profile, 2016). The Primary Health Care (PHC) facilities in this district are divided into provincial and municipality lead clinics, with the PHC clinics being responsible for the offering of AYFHS. Reports show that only two (2) PHC facilities in the Ekurhuleni South District are currently operational (National Adolescent and Youth Health Policy Report, 2017).

4.5 STUDY POPULATION

A population refers to a set of individuals with common characteristics that the researcher wished to study (Polit and Beck 2012: 61). Qualitative studies lend meaning and realities to a target population. The target population for this study included the population of youth or adolescents residing in the Ekurhuleni South
District.

4.6 SAMPLING

Involves selecting a group of people, events, behavior or other elements with which to conduct a research study (Grove 2017: 329). Sampling allows the researcher to clearly define the target population, select a sampling framework, choose a sampling technique, determine the sample size, collect data and assess the response rate (Taherdoost 2020: 19).

4.6.1 Sampling process

Sampling was noted as a portion of the study population that represented the full population (Polit and Beck 2012: 742). For the purpose of the study, the researcher used a non-probability convenience sampling method, which is frequently used in qualitative research to select the research sample. This sampling method was considered appropriate in qualitative research as researchers choose a group of people that had the potential to answer the research questions that guide the study (Burns and Grove 2016: 345-346).

This study planned to sample adolescents between the ages of 18 to 24 years from the Ekurhuleni South district. Using a non-probability convenience sampling technique, the researcher does not know in advance how many participants are required (Grove, Burns and Gray 2017: 342-343). Data will therefore be generated through voluntary participation and guided by data saturation.

Data saturation is known to guide the data collection process in qualitative research methodology and means that sampling was conducted to the point at which no new information was obtained from the participants. The study was therefore guided by data saturation which was achieved when no new information is expected to emerge from participants related to access and utilisation of AYHFS. The desired minimum number of participants selected from the site as a sample, would be approximately 20 adolescent participants to ensure that data saturation is reached.

4.6.2 Recruitment of research sample

Following ethical clearance, the researcher used a snowballing technique to gather data. According to Grove, Burns and Gray (2017: 345-346), snowballing is a technique whereby participants refer the researcher to other prospective participants who meet the inclusion criteria. This sampling technique is also known as the chain method and was noted to be efficient and cost effective to access people who would otherwise be very difficult for the researcher to access. The main aim of the researcher was to contextualise the meaning of human experience rather than generalise (Polit and Beck

2012: 524). It must be noted that in this type of sampling, the participants highly benefit a study (Polit and Beck 2012: 517). Hence, the researcher was able to identify suitable participants from a hard-to-reach population (Polit and Beck 2012: 766). Furthermore, with an introduction from the referring person, researcher had an easier time establishing a trusting relationship with the new participant. This was an effective strategy for identifying participants who know other potential participants who can provide greater insight and information for the study (Burns and Grove 2017: 346) Snowball sampling grows at an exponential rate, from a conveniently available pool of respondents. Convenience sampling was simple to the rule, cost effective and time beneficial therefore information and data was gathered successfully.

In this study, the researcher asked the first few participants whom she has made contact with via social networking and had selected through convenience sampling, if they knew of any adolescents that form part of the inclusion criteria, who were willing to take part in the research. This sampling technique was also chosen ideally to manage data once saturation had been achieved and according to Browne (2005: 4760), this sampling technique may not require gatekeeper permission.

According to Mendez (2017: 1-19), there is legitimate grounds for excluding gatekeeper permission when research is not being conducted on the physical premises of a specified organisation and when participants are recruited without any physical or electronic violation of the physical boundaries of an organisation. Singh and Wassenaar (2016: 42-46), noted that gatekeepers can only provide access permission and they do not provide consent for the study. Consent is only obtained from the individual participants. In view of this, the researcher, planned to collect data only after Institutional ethics approval and informed consent from participants was gained (see Appendix 1, 2b, 3b).

4.7 INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria

- The participants included were all adolescents from all race-groups between the ages of 18-24 years, of male and female gender, and who resided in the Ekurhuleni South district. These participants were included as they are of legal age and consented to participate in the study.

Exclusion criteria

- Participants that reside in other Gauteng districts
- All adolescents below the age of 18 years or above 24 years were excluded.

4.8 DATA COLLECTION

The data collection process began from before the first participant's data was obtained and ended as the last participant's data was obtained. During the interview process, the study variables were measured through a system of questions, and the interview was recorded systemically for each participant. The researcher obtained an ethics research training certificate prior to collecting data (Burns and Grove 2016: 55).

The data collection process included all participants who met the desired inclusion criteria for the study. Data was collected by means of in-depth semi-structured interviews, using an interview guide that entailed a grand tour question and a few probing or guided tour questions that helped to facilitate the discussion. In view of the COVID-19 guidelines, the researcher conducted interviews telephonically and via online platforms such as Microsoft TEAMS, Skype, WhatsApp and Zoom. Consent was obtained from the participants to have the research assistant present during the interview sessions and to have the interview recorded. The presence of the research assistant during the interview sessions was to aid the discussion by interpreting any questions or answers for the researcher or the participant. An interview guide, available in English and IsiZulu (see Appendices 4a and 4b), was used to conduct the interviews, as IsiZulu is the local language used in the area. Participants were informed about the study and given an opportunity to read the information letter provided.

Written consent to participate in the study prior to commencement of the interview was obtained. The researcher accepted the written consent to be emailed or a screenshot via WhatsApp.

The study demographic data was collected using a short questionnaire with regard to gender, age, and race, level of education and place of residence. This was done after participants signed the consent to participate. All participants were told that they have a right to withdraw from the study at any time and the number of participants interviewed was to be guided by data saturation. The participants' names were known only to the researcher and codes were used to identify participants. All the interviews were recorded on audio to provide a precise record of all the participants' comments. All interviews were planned to last for 20-30 minutes a session and also occurred at a time suitable and convenient to the participant. The list of participants and other field notes or records of the recorded interviews would be kept in a computer locked with a password only known to a researcher. No other person would have access to the raw data to prevent breach of confidentiality.

4.9 DATA ANALYSIS

According to Burns and Grove 2016: 269-270), the purpose of data analysis was to logically organise and generate meaning from data collected. The authors added that data collection and analysis in qualitative study often occur concurrently rather than after all data has been collected, which can increase validity and trustworthiness of the study. Identifying and organising important thoughts and ideas stemming from the participant findings began from the moment that data collection was commenced. In this study the audio recordings of interviews were carefully listened to, immediately following data collection. This was done to verify collected data and to determine if improvements were needed in the subsequent interviewing processes (Polit and Beck 2021: 516). Transcriptions of collected data was important in preparing for data analysis as it added credibility to the research findings (Polit and Beck 2021: 531). In the study, the researcher together with the help of the research assistant, read and understood the collected data in order to sort and organise the data according to Creswell's six steps of qualitative data analysis (Creswell 2009: 185). The analysis and

interpretation of the data gave an explanation of emerging themes which formed the core of the research findings.

THERE ARE SIX PHASES IN THEMATIC ANALYSIS PROPOSED BY BRAUN & CLARKE (2006) THAT WAS FOLLOWED BY THE RESEARCHER WHEN ANALYSING DATA:

Phase 1: Organising and preparing data

The researcher went through the collected data by transcribing the interviews and scanning the material to arrange and sort the data.

Phase 2: Read through all the data

The researcher then acquired a general sense of the information and reflected on its meaning and general ideas of what the participants were saying. Notes were made on the side of the margins. The researcher was then able to start recording thoughts about the data.

Phase 3: Coding the data

Once the researcher was acquainted with the data for qualitative research, the coding commenced and a list of codes were generated. The codes were used to identify a component of the data of particular interest to the researcher by giving labels. Manual coding was used whereby written notes on the printed transcripts were documented.

Phase 4: Description involves detailed information

The themes were consolidated to generate a small number of themes or categories and the themes refined the findings. This then constituted the headings and subheadings in data analysis chapter.

Phase 5: Interrelated Themes

The core of each theme was identified from the data and conveyed through the narrative findings. A detailed description was completed through identified themes, categories and subcategories.

Phase 6: Constructing the report

The data finding was combined into a concise, logical and non-repetitive report which was justified and supported by the relevant literature. This allowed for a deeper understanding of the meaning to the description.

4.10. RESEARCH RIGOUR AND TRUSTWORTHINESS

Rigour, according to Polit and Beck (2012: 62) was motivation for good qualitative research which encompassed trustworthiness thorough quality scientific research methods and accuracy of the data. This ensured the validity and reliability of the data. Trustworthiness was established since the nature of research study is qualitative. The four principles as defined by Lincoln and Guba's strategies of credibility, transferability, dependability and conformability was used (Lincoln and Guba 1985: 290-294).

4.10.1 Credibility

Credibility refers to the truthfulness of the data collected and the understanding thereof (Polit and Beck 2012: 239). To ensure credibility of the data collected, notes were written during the interview. Thereafter, a summary was written immediately after each interview to clarify the obtained data. Audio recordings were also used to assist the researcher when reviewing data.

4.10.2 Dependability

Dependability according to Polit and Beck (2012: 239) is the provision of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar. To ensure dependability, the methodology and data gathering process, were part of a detailed research report.

4.10.3 Transferability

Transferability according to Polit and Beck (2012: 285) stated that the extent of the findings conveyed and applied to other groups or settings in order for the study to be meaningful. The researcher provided a detailed comprehensive description of the research setting and data process for other researchers to make a comparison.

4.10.4 Conformability

This referred to accurate reporting of the real meaning of data as provided by the participants Polit and Beck (2012: 285). The interviews for this study were voice recorded for the interview (WhatsApp, Teams, Zoom, Skype) so that the information provided by the participants is accurate and truthful.

4.11 ETHICAL CONSIDERATIONS

According to Polit and Beck (2012: 150-151), the researcher followed the processes of ethical clearance by meeting the professional, legal and social requirements when conducting the inquiry and ethics was the part of philosophy that deals with morality. Burns and Grove (2017: 170-171) asserts that with a qualitative research study, issues such as confidentiality, anonymity, risk of harm and deception may arise during the research process. This makes ethical considerations to be an integral part of any research.

Therefore, the researcher planned to commence with data collection only after full ethical clearance was granted by the DUT Institutional Research Ethics Committee (IREC). Informed consent (see Appendix 2b and 3b) was obtained from the participants. They were not coerced into participating in the study and it was emphasised that they can withdraw from the study at any time. Furthermore, the identity of the participants was protected by using a coding system, to ensure anonymity and no financial compensation was received or given by the researcher when conducting the study.

4.11.1 Beneficence

Beneficence is one of the most important ethical principles in research (Burns and Grove 2013: 162). The researcher did ensure that no harm came to the participants during the data collection. Participants were debriefed and if they showed signs of distress, the researcher in her personal capacity as a professional PHC nurse was able to make appropriate referrals.

4.11.2 Respect for human dignity

The principle of human dignity according to Polit and Beck 2012: 154-155) encompasses the right to autonomy, and the right to full disclosure by the researcher. During the course of data collection, participants were assured that the data they provided to the researcher would be kept in strict confidence and that they had the right to speak freely without any cohesion from the researcher.

4.11.3 Informed consent

Participants were given adequate information regarding the study that they had participated in (see Appendix 2b and 3b). The researcher did ensure that the information given to the participants was understood and participation was voluntary. According to Polit and Beck (2012: 13), participants are given a written consent form that highlights the purpose of the study, participants' expectations, time and any costs or benefits.

4.11.4 Confidentiality

Confidentiality measures were taken by the researcher to ensure that confidentiality was maintained by using a coding system instead of using participant's names thereby ensuring that the identity of the participants were kept confidential (Polit and Beck 2012: 13). The participants' names would be known only to the researcher by codes that was used to identify them. The list of participants and their codes would be kept under lock and key. Records of the recoded interviews would be kept on a computer locked with a password only known to the researcher. No healthcare worker or any parties would have access to the raw data to prevent breach of confidentiality.

4.12 CONCLUSION

This chapter reflected the research methodology, the theoretical framework and ethical considerations used in the study. The following chapter presents the results of the study.

CHAPTER 5: PRESENTATION OF RESULTS

5.1 INTRODUCTION

In the previous chapter, the research methodology was discussed. This chapter presented the results of the study as obtained from the data that was collected from the semi-structured interviews. This chapter also includes a detailed analysis of the findings obtained and was presented with actual excerpts and statements from participants. Data was analysed after in-depth interviews with the participants who provided their personal thoughts and perspectives on the topic of inquiry. Using a thematic analysis, findings were thereafter categorised as they emerged and consolidated into themes and sub-themes as noted in Table 5.1. The chapter was also aligned to the aim of the study which explored the perspectives of adolescents regarding their access and utilization of AYFHS in Primary Health Care clinics in the Ekurhuleni South District, Gauteng Province. Notably, the presentation of the results was significant to the three objectives of the current study as outlined in chapter one. This chapter further links the components of the chosen theoretical framework that guided the study to the themes that emerged during data analysis.

5.2 SAMPLE REALISATION

Data was collected through the snowballing technique using social media because of social distancing norms and in keeping with the lockdown level three (3), which was in place at the time when data was gathered. As discussed in chapter 4, a sample of 20 participants was interviewed to adequately represent the population to be studied. However, data was collected, telephonically and interviews were conducted on WhatsApp interviews and data saturation was reached after 17 interviews were conducted.

5.3. DEMOGRAPHIC DATA

All participants ranged between the ages of 18-24 years, with the majority being unmarried. A total of 12 females and 5 male's participants verbalized their perspectives with regard to access and utilization of AYFHS at their local Primary Health Care Facility. Majority of the participants completed matric but due to financial constraints did not pursue study at tertiary level. Unemployment amongst the youth was noted with a history of 7 participants who expressed their frustrations about difficulties in obtaining employment in the industry. All 17 interviews were conducted telephonically, guided by a semi-structured interview questionnaire guide. All 17 participants had no knowledge or information regarding AYFHS, they vented their frustration and annoyance about not being offered or able to access and utilize this service at their local clinic. Table 5.1 provides the demographic information of participants.

Table 5.1 Demographic Data of the participants

Participant	Age	Gender	Marital status	Level of education	Occupation
P 1	19	F	S	Completed Matric	Unemployed
P 2	23	F	S	Completed Matric	Small Business Entrepreneur
P 3	23	F	S	Matriculated	Unemployed
P 4	23	F	S	Matriculated	Unemployed
P 5	18	F	S	Matriculant	Scholar
P 6	18	F	S	Matriculant	Scholar
P 7	19	F	S	Matriculant	Scholar
P 8	20	F	S	Completed Matric	Unemployed
P 9	18	F	S	Matriculant	Scholar
P 10	24	F	S	Completed Matric	Temporary Employment
P 11	23	M	In a relationship	Completed Matric	Employed
P 12	19	M	S	Matriculated	Unemployed
P 13	19	M	S	Completed Grade 10	Unemployed
P 14	18	M	S	Currently in Gr 11	Scholar
P 15	24	M	In a relationship	Completed Matric	Employed
P 16	24	F	In a relationship	Completed Gr 11	Unemployed
P 17	23	F	In a relationship	Completed Matric	Unemployed

Key: M- Married / S-single F- Female/ M-Male

5.4. PRESENTATION OF RESULTS

On completion of the data analysis, four main themes emerged relating to participant perspectives regarding access and utilization of AYFHS in Primary Health Care clinics in the Ekurhuleni South District.

MAJOR THEMES

Theme 1- Availability of human and material resources

Theme 2- Youth behavior and attitude towards health needs

Theme 3- Information received at the health care facility regarding AYFHS

Theme 4- Experiences of youth/adolescent in accessing and utilizing health care services.

A summary of these themes along with their sub-themes that emerged are outlined in Table 5.2. The themes and sub-themes that have emerged, are evidenced with direct quotes provided from the interview transcripts to corroborate the results.

Table 5.2 Major Themes and Sub-Themes that emerged data analysis

Major Themes	Sub-Themes
Theme 1- Availability of human and material resources	Availability of staff at the health care facility Availability of medication and supplies Availability of infrastructure at health care facility Operating hours/ waiting period of health care facility/ Health care needs
Theme 2- Youth behavior and attitude towards health needs	Health care needs Influence of traditional norms and beliefs Fear of COVID 19 Unemployment and financial difficulties of youth/adolescents
Theme 3- Information received at the health care facility regarding AYFHS	Knowledge and information about AYFHS Staff participation/involvement in providing awareness of AYFHS to the community Waiting period at the health care facility
Theme 4- Experiences of youth/adolescent in accessing and utilizing health care services	Respectful and supportive environment at health care facility for youth and adolescents Community and staff attitude toward youth /adolescents Quality of youth health care at facility- Satisfaction/Dissatisfaction

5.5 FINDINGS OF THEMES AND SUB-THEMES

5.5.1 Major theme 1- Availability of human and material resources

Amongst the 17 participants, majority revealed that the health care facility lacked human and material resources. The lack of infrastructure to accommodate a specialized service to accommodate the health care needs of youth and adolescents within the facility was not available. Shortage of basic medication, files and health care resources hindered the health care needs of youth and adolescents being met. Shortage of nursing staff delayed the consulting time at the facility, waiting periods were long and exhausting. The shortage of staff contributed to the lengthy waiting period which was apparent in the dissatisfaction and frustrated voices of the participants. High levels of dissatisfaction were noted.

5.5.1.1 Sub-theme 1- Availability of staff at the health care facility

Participants mentioned that the shortage of staff was a major challenge and this may have contributed to the long and exhausting waiting times at the clinic. Also, the lack of awareness and information regarding AYFHS could be due to the shortage of staff.

(Participant 3)- "The waiting times at the clinic are long and exhausting and there's always shortage of staff". "We have to suffer because the government doesn't want to employ more nurse".

5.5.1.2 Sub-theme 2- Availability of medication and supplies

Quality health care can only be provided if there's access and availability of essential resources for diverse programmes at the health care facility.

Participants mentioned their concern regarding the clinic having lack or unavailable resources at the clinic. Basic supply of medication and even supplies to do dressings was not accessible.

(Participant 4)- "*I am tired of going to the clinic and waiting the whole day just to be told by the nurses that they don't have some medication". "Sometimes the nurse will tell you to come back to collect the medication the following day".*

5.5.1.3 Sub-theme 3- Availability of infrastructure at health care facility

Participants mentioned that the health care facility did not have a separate building or infrastructure to accommodate the youth and adolescent. Many of the participants suggested that the health care facility provide a separate infrastructure specially to provide a service for their age group.

(Participant 11)- "*My suggestion is that the youth have a separated building for this service, because we don't want to follow the queue that our grandmothers and older people from our community follow".*

(Participant 1)- "People *from the community recognize us and lay judgement on us, this makes me feel uncomfortable to go to the clinic".*

In this finding, it is evident that the youth experience a sense of discomfort at the health care facility and follow the same queue as adults within the community and judgement from the community is a challenge. The youth should never feel ashamed and disrespected when taking responsibility for accessing services for their health care needs. Participants explained that the bad experiences they had at the clinic was a deterrent to visiting the clinic again.

5.5.1.4 Sub-theme 4- Operating hours/ waiting period of health care facility

Participants stated that the health care facility in the area was inaccessible due to the limited operating hours. The health care facility only operated from Monday-Friday, from 8 am-4.30 pm. Participants mentioned the exhausting and long waiting periods at the clinic was an issue. Most youth are available during the weekend for example scholars and youth who are off from work during the weekend. Participants alluded that the operating days and times of the health care facility did not cater for the communities working class and scholars. Findings from the study showed that the health care facility lacked in offering services to the local community after hours and over weekends. This was further attested in the participant's statements below.

(Participant 11)- "*I wish that the clinic was open after hours and weekends, because that's the only time I can go to the clinic, it's difficult to take time off work during the week day". "I would like to attend the clinic over the weekend with my partner". "The*

queues are also very long during the week days and I cannot afford to take time off work because my hours will be cut and I will get less pay".

(Participant 17)- vented her frustration- "*Waiting makes people upset and they can leave before they are attended to, and end up falling pregnant because maybe you are rushing to work, you can get fired for late coming". "The Sisters take long even when giving us our repeat family planning treatment therefore, one may decide to leave if the queue is not fast".*

5.5.2 Major theme 2- Youth behavior and attitude towards health needs

Most youth are taking responsibility for their health care needs. The evidence from the study revealed that every participant had visited a health care facility at some stage. Behavior and attitude are key roles that establish whether a person may access health care services. A mixed variation of positive and negative behavior and attitude could be a result of the experiences that the youth/adolescents encountered when they have visited the health care facility.

5.5.2.1 Sub-theme 1- Health care needs

Youth and adolescents need age-appropriate information to grow and develop in good health and access to health care services that are accessible, acceptable, equitable, effective, safe and supportive to meet their health needs. "Good Health and Wellbeing" SDG goal no 3. The health care needs of youth and adolescents are changing daily with increased health risks and burden of disease.

(*Participant 13)- "I would like to suggest a separate space for us youth, somewhere that we can get respect and support". "We need to be among our own* age group and for nurses not to judge us, nurses who understand our situation and who can give us help".

5.5.2.2 Sub-theme 2- Influence of traditional norms and beliefs

Traditional norms and beliefs are alternatives that the participants seek when availability of health care facility whether over weekends or after hours. Participants reported that the influence of cultural/traditional norms exist within the community and the unavailability of access to health care services after hours and over weekends forces them to seek alternatives. Many visit the traditional healer from within the

community, as this is a reliable source unlike the health care facility that does not operate after hours and over weekends.

(Participant 11)- *Verbalized- "I go to the traditional healer when the clinic is not open over the weekend* ".

(Participant 11, Participant 12, Participant 13)- also agreed in suggesting that availability of the health care facility over weekend and after hours would be helpful as it is a financial burden to go to the traditional healer whereas the clinic is free.

(Participant 14)- Supported the extension of operating hours, as this would be less of a burden to sort out money to travel to another clinic which is far.

5.5.2.3 Sub-theme 3- Fear of COVID 19

The Covid-19 coronavirus has affected the entire world and the fear surrounding this pandemic has been emotionally overwhelming. The strong emotions of fear amongst people, young and old has been distressing. The impact of the pandemic has affected the daily life activities of youth and many have lost family members due to Covid 19. Families have been disrupted, youth have become orphans, and some have taken the role of their parents to support the family because of a parent losing their lives due to COVID 19.

(Participant 6)- Substantiated fear surrounding COVID 19 – "*The queues are long at the clinic and when we go to the clinic early in the morning, we all stand in one queue". "There's no social distancing*".

5.5.2.4 Sub-theme 4- Unemployment and financial difficulties of youth/adolescents

According to a literature review, Health Statistics Report Gauteng (2018) revealed an unemployment rate of 49.4% and youth poverty of 41.8%. Further evidence from this study supported unemployment and financial difficulties of youth and adolescents with only 4/17 of the youth who participated in the study having employment. Majority of the youth that participated in the study were unemployed and dependent on other sources for support. Financial issues were compounded for most of the participants who could not afford the cost of transportation to other Health Care Facilities after

hours or over the weekend because of their financial status of being unemployed or earning a low income and simply could not afford the burden.

(Participants 12 and Participant 13)- mentioned that they did not have money to travel to another clinic in the area.

Participant 8) - "*I am unemployed and I live with my grandmother". My grandmother supports us with her pension".*

5.5.3 Major theme 3- Information received at the health care facility regarding AYFHS

It is evident from comments made by participants indicated that they were not aware of AYFHS. They had no idea that such a service existed, no one gave them information regarding this service.

5.5.3.1 Sub-theme 1- Knowledge and information about AYFHS

Participants lacked knowledge and information regarding AYFHS. Despite government's Adolescent & Youth Health Policy supporting health and well-being of young people, the effectiveness of this programme is not evident especially with the youth not being aware of such a service. The information gathered from the study showed that the participants were unaware of an AYFHS. The lack of communication, community awareness and transparency of service delivery within the local Health Care Facility was highlighted through the interviews from participants.

All 17 participants had no knowledge nor information with regards to AYFHS at their local health care facility.

(Participant 5)- "*No, I am not given any information of this service".*

(Participant 7)- Statement also supported the above statement- "*When we enter the clinic and ask the nurses for some information, they do not provide this to us and their tone of voice is sometimes not pleasant".*

(Participant 10)- commented, "*No, I am not aware of this service".*

(Participant 11)- "*No information has been shared about this adolescent, youth friendly service".*

5.5.3.2 Sub-theme 2- Staff participation/involvement in providing awareness of AYFHS to the community

The findings of the research study revealed that the youth were unaware of AYFHS and no information was given by nurses regarding such a service.

(Participant 1)- "*I have not been given any information regarding Youth Friendly Health Services".*

(Participant 5) suggestion, "*We want to be differentiated and not mixed with every one and the sister can give us information that is youth related".*

(Participant 6)- "*The nurses at the clinic are sometimes rude to us and scold us". "I have not heard of such a service".*

(Participant 12)- agreed that such a service would help the youth in the community and more information regarding the AYFHS to be provided and made accessible to the community.

5.5.3.3 Sub-theme 3- Waiting period at the health care facility

The research gives an overview of the waiting period at the health care facility posing a challenge for the youth and adolescents. Many come from a low-income background and the fact that they wait at the clinic for long periods of time to be seen is very unfavourable to them. Some complained that they get exhausted and hungry. Others mentioned the dissatisfaction of long waiting times and unavailability of treatment at the health care facility was a challenge.

(Participant 1)- "*The long waiting times at the clinic makes me feel uncomfortable". "I get hungry and exhausted".*

(Participant 6)- The interview supported the above participants statement- "*We go to the clinic very early and wait there the whole day but we don't get the treatment we need". "The Sister at the clinic tells us there are short of treatment and we must come to collect the treatment". "I don't have time to come back and spend the whole day at the clinic, I have to be at school".*

(Participant 4)- "*The challenges are long waiting times sometimes I wait for 4 hours at the clinic and I become irritated and annoyed". "Some nurses are rude towards us".*

(Participant 5)- Also stated, "*When we complain that we are waiting for a long period of time to be seen, the nurses become rude".*

5.5.4 Major theme 4- Experiences of youth/adolescents in accessing and utilizing health care services

The literature review exposed the challenges youth and adolescents face globally in accessing and utilizing health care services. The previous research studies done showed that health care facilities failed to uphold the National Youth/Adolescent Policy priority to meet the health care needs of youth and adolescents and after several years the challenge still exists. This is evident with the experiences relayed by the youth and adolescents accessing and utilizing health care services in this particular community. The voices of the youth and adolescents need to be heard, it is a cry for help that is being ignored. Access to health care is central in the performance of health care systems.

5.5.4.1 Sub-theme 1- Respectful and supportive environment at health care facility for youth and adolescents

Majority of the participants wanted a separate building or space within the health care facility that provided services for their age group. They verbalized that they wanted a non-judgmental, respectful and supportive environment. They also voiced that they needed information and awareness of health care topics that they can relate to, amongst people of their age group, as they felt discomfort being in the same queue as adults within their community.

(Participant 5)- Suggestion, "*we want the youth to put aside in a separate queue and not follow the elders, we want privacy because the elders recognize us from the community". "We want to be differentiated and not mixed with every one and the sister can give us information that is youth relate".*

(Participant 10) supported the above statement with the following suggestion- "*I am an asthmatic patient and it is very stressful for me as a young person to be following the long queues". "It would be nice option if there were separate queues for teenagers and adult".*

5.5.4.2 Sub-theme 2- Community and staff attitude toward youth /adolescents

Participants mentioned incidence of rudeness and being scolded by staff members. Staff members judged them especially if they had to access family planning services or even Anti-Natal Care (ANC) as they are young.

Community judgement came when they had to follow the same queue as the adults and most community members know one another and they talk to others and gossip within the community. This brings a sense of discomfort towards the youth and adolescents.

5.5.4.3 Sub-theme 3- Quality of youth health care at facility-Satisfaction/Dissatisfaction

According to statements made by the participants, 16 of the participants were dissatisfied with services at the health care facility and suggested that more information be provided regarding AYFHS. The youth and adolescents concurred that a separated building space and nursing staff to provide services to meet their health care needs. The youth and adolescent supported AYFHS and said that it is respectful, supportive, non-judgmental, and safe environment that was easily accessible for them to utilize.

Participant 9 was the only participant that was happy with the health care services and had no challenges. But her statement contradicted the fact that she was unaware of information regarding AYFHS.

(Participant 9)- "*No, I have not heard about youth friendly services and I have not been given any information from the clinic"." I am happy with the services at the clinic, I don't have a problem".*

5.6 CONCLUSION

This chapter presented the results of the study. The themes and sub-themes that emerged from the analysis revealed from the study was supported by the precise and robust statements of the participants. The next chapter involves a discussion of the results.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1 INTRODUCTION

This chapter represents the discussion of the findings and data analyzed in the previous chapter. The chapter represents the results of the study through an interview process with 17 participants. This discussion was guided by objectives of the study and the theoretical frame work by Aday and Anderson's Model of healthcare access.

The objectives of the study were as follows to:

1. Explore the current health challenges encountered by the adolescents from the Ekurhuleni South District.
2. Determine the barriers to access and utilization of AYFHS by adolescents from the Ekurhuleni South District.
3. Determine the facilitators of access and utilization of AYFHS by adolescents from the Ekurhuleni South District.

6.1.1 The following Questions were used to achieve the objectives of the study.

1. What are the views of adolescents regarding the AYFHS?
2. How is this PHC service accessed and utilized in the Ekurhuleni South District?
3. What are the reasons that contribute to AYFHS services being underutilised?
4. What practices can be instituted to allow for better access and utilization of AYFHS in the region?

6.2 DEMOGRAPHIC INFORMATION IN RELATION TO THE CURRENT STUDY

The participants were selected according to their demographic location within the Ekurhuleni District, Palmridge area. The demographic data gathered from the participants were, age, gender, marital status, employment status. The ages of the participants ranged between 18-24 years. Majority female participants-12 and the Male participants range was 5.

6.3 OVERVIEW OF THE DISCUSSION OF THE FINDINGS

The discussion of the findings is presented in two sections:

1. Section1-The discussion of the findings in relation to the objectives of the study.
2. Section 2-Link between the major themes, sub themes to the elements of the theoretical framework.

6.3.1 Section1- Discussion of the findings in relation to the objectives of the study.

The discussion in this section aimed at describing the accomplishment of the aims and objectives of the study. The aim of the study was explored the perspectives of adolescents regarding their access and utilization of AYFHS in Primary Health Care clinics in the Ekurhuleni South District, Gauteng Province. The objectives were used to achieve the aim of determining the youth's perspective in accessing and utilizing AYFHS at the local clinic.

6.3.2 Section 2- Link between major themes and sub themes to the elements of the theoretical framework.

Four major themes emerged with supporting sub- themes that were discussed in this section linked to the elements of the theoretical framework. The discussion was further strengthened by relevant literature.

Table 6.1 Major themes, Sub-themes and link to the elements of the theoretical framework

ELEMENTS	MAJOR-THEMES	SUB-THEMES
Characteristics of health care delivery system Resources/structure Organisation/entry	Availability of human and material resources	Availability of staff at the health care facility Availability of medication and supplies Availability of infrastructure at health care facility Operating hours/ waiting period of health care facility
Characteristics of Population at risk Predisposing Attitudes Beliefs Enabling means/resources Needs-perceived/evaluated	Youth behavior and attitude towards health needs	Health care needs Influence of traditional norms and beliefs Fear of COVID 19 Unemployment and financial difficulties of youth/adolescents
Utilization of health system Type Site	Information received at the health care facility regarding AYFHS	Knowledge and information about AYFHS Staff participation/involvement in

Purpose Time interval		providing awareness of AYFHS to the community Waiting period at the health care facility
Consumer satisfaction Convenience Cost Coordination Courtesy Information Quality	Experiences of youth/adolescent in accessing and utilizing health care services	Respectful and supportive environment at health care facility for youth and adolescents Community and staff attitude toward youth /adolescents Quality of youth health care at facility- Satisfaction/Dissatisfaction

Major theme 1- Availability of human and material resources

The first theme that emerged was the challenge with the availability of human and material resources. All 17 Participants concurred that the shortage of basic supplies, infrastructure to provide for an AYFHS was not accessible. The shortage of staff gave rise to long and frustrating waiting periods at the Health care facility. The lack of staff was due to nurses resigning and their posts not being filled, also community health care workers (CHW), who play a key role in the health care facility have been removed due to end of contracts and they have not been suitably replaced at Health care facilities. The shortage of healthcare workers has been noted as a crisis, with major disparities between the public and private health system, with a shortage of 16 000 professional nurses needed to fill the gap to reach the equity target by 2025 (Cleary and Low. 2020. News). According to authors Thomas, Buch *et al. (*2021: 2-11) a study took place in the Ekurhuleni health district, Gauteng between 2011-2012 were 1108 CHW who studied within their teams, provided services of health education, tracing, referrals to health care facility. These CHW that were provided, were very effective during the pilot study with Ekurhuleni reaching a

25% population coverage in March 2019. In 2018-2019 there was a reduction performance of CHW team activities this was due to the fact that this programme was a district pilot study and the hesitation of CHW becoming permanent. As a result, this has affected key role player's contributions at Health Care Facilities (Thomas, Buch *et al.* 2021: 211).

Sub-theme 1- Availability of staff at the health care facility

The above sub theme covered in major theme 1, showed a lack of human resources.

This was an important factor that influenced the health care of the youth. According to discussions around this theme, participants emphasized that the lack of staff contributed to extended waiting periods at the Health care facility and on various occasions many clients left without being consulted.

The lack of staff at Health care facilities has evidently compromised the quality of health care. The negative impact has resulted in a decline of quality health care and furthermore this has caused the public to lose trust in the healthcare system in South Africa (Maphumulo and Bhengu. 2019: 42). In further discussion of the findings related to the above sub theme, participants verbalized their frustration and the incidence of leaving the healthcare facility without being consultation has proven the lack of trust the youth have towards the health care system. Authors Maphumulo and Bhengu (2019: 42) and Thomas, Buch *et al.* (2021: 2-11) discussed the different categories health care workers in the health care system and the major impact each role player had on the delivery of health care towards the community. To ensure quality health care these role players are dependent on each other in the cycle of health care demands and when these individuals are lacking it impacted on the entire health care system.

Sub-theme 2- Availability of medication and supplies

The second sub theme that emerged was a further elaboration of major theme 1. Findings of this sub theme impacted on the quality of health care received by the youth population attending the Health care facility. Quality of health care was compromised or unmet due lack of basic resources. Participants attested that the lack of medication and basic supplies for dressing were some off the supplies that were not available at the local Health care facility.

The challenges of medication shortages in SA were documented by authors Modisakeng, Matlala *et al* (2020: 234) although South Africa strives for universal health it cannot be compared to the developed countries. The determinants of availability of medicines included delay in

supplier payments, delivery, procurement of medicine and supplies challenges, and shortage of (APIs) Active pharmaceutical ingredients. The authors stressed the need for ongoing support and monitoring towards pharmacy staff for proper and effective inventory would improve medicine and supply availability.

Sub-theme 3- Availability of infrastructure at health care facility

Sub theme 3 highlighted a personal sense of discomfort for many participants and this was mainly due to the Health care facility not providing a separate infrastructure to accommodate services for the youth, as a result people from the community judged them.

Ageing infrastructure, lack of isolation facilities, overcrowding at healthcare facilities has been argued by authors Dramowski and Whitelaw. (2017: 194) as healthcare associated infections which contributed to the morbidity and mortality rate in public sector health facilities in South Africa. An estimated one in seven clients entering SA hospitals were at risk of acquiring (HAI) Healthcare Associated infection because of poor infection prevention and control measures (Maphumulo and Bhengu. 2019: 42)

Sub-theme 4- Operating hours/ waiting period of health care facility

The constraints of Health care facilities operating hours and waiting period at the facility for consultations hindered majority of the participants from accessing appropriate health care services. The findings on this theme exposed by the participants revealed that the health care facility within the topic of inquiry did not operate after hours and on weekends. The suggestions made by the participants was availability to access the Health care facility after hour and weekends to accommodate scholars and the youth population that work. The issue of long waiting period was an issue highlighted by all participants.

Amoako, Doku *et al.* (2020: 42-58) agreed that the operating days, times and the waiting period was not convenient for the community, thus hindering access and utilization of services.

Major theme 2- Youth behavior and attitude towards health needs

Youth behavior and attitudes towards health needs contributed greatly towards their eagerness to seek proper health care services. The encounters at health care facilities determined if the client would return or not. Many clients fail to return because of their negative experiences encountered and mainly how they were received at the Health care facility.

In reference to Jonas *et al.* (2018: 2-13), the author argued that whilst adolescents sexual and reproductive healthcare needs have been a priority globally, several of these needs are unmet.

However, many adolescents underutilize these services particularly in Sub-Saharan Africa, due to factors of unfavourable behaviors and attitudes of healthcare workers towards the youth seeking the services. A youth friendly service environment with effective provision to access and utilize would reduce the rate of burden of disease that many youth faces.

Sub-theme 1- Health care needs

All the participants interviewed had at some stage, visited a Health care facility. Findings from this sub theme was confirmation that participants did take responsibility for their health care needs by visiting a Health care facility. However, the challenge of access to YFHS remained. This resulted in many participants' health care needs not being met and this negatively impacted on youths' access and utilization of AYFHS.

The burden of disease and youth health care challenges are documented in chapter 2 literature review, authors Jaspen *et al.* (2019: 4); Mathew (*et al.* 2018: 7); Geary (2015:1); Koon *et al.* (2014: 1-5) and Francis *et al. (2018*: 1-13), have highlighted the problems related to healthcare and disease amongst the exposed youth and adolescents in South Africa.

Recent studies have shown a more positive link of youth behavior towards their healthcare needs. Optimism is an important trait that has notably influenced development in youth taking more responsibility towards their health and well-being (Malinowska-Cieslik *et al.* 2019: 1).

Sub-theme 2- Influence of traditional norms and beliefs

The association of traditional norms and beliefs were personal factors that influenced youth attitude and motivation on health behavior. It was vital that the health of young people was considered holistically, physical, mental, social, and cultural aspect to be viewed (Hamzah *et al.* 2018: 149-159).

In view of this sub-theme, participants related incidents of seeking out traditional treatment from healers within the community because they were unable to access and utilize the services at the local healthcare facility-due to the fact that the health facility not operating after hours and weekends.

Sub-theme 3- Fear of COVID 19

The COVID 19 pandemic has induced a considerable amount of fear and anxiety to global communities. The need for an improvement in adolescents' access to health services such as mental health support during the current crisis is deemed necessary. The pandemic has caused many long-term consequences to many vulnerable youth and adolescents. Health related issues, unemployment, poverty, emotional stress, loss of family members, delayed education was some of the detriments of Covid 19. There was an urgent need for public health interventions that support youth and adolescents should be made available to equip the youth during the COVID 19 pandemic to avoid preventable death over fear of COVID 19 infections (Addae 2020: 219-222; Singh *et al*. 2020: 29).

Sub-theme 4- Unemployment and financial difficulties of youth/adolescents

Discussions surrounding this sub-theme was evident from the interviews and data gathered, 4 of the 17 participants were the only individuals employed and many were dependent on social benefits such as grants. Many participants verbalized that transportation costs were an issue and could not afford to travel to outlying hospitals and health facilities especially when the local healthcare facility was not accessible due to specified operating days and hours. The participants further reflected on the shortage of medication and supplies at local healthcare facility, and they could not afford to purchase medication even though there was a pharmacy available within the area. According to the International Labour Organization (2020: 1-3), the challenge with Africa is that although the economy has grown it has not created sufficient jobs for the young people of Africa. The impact of the current pandemic had affected employment in South Africa, many industries have closed down and as a result major job loss, retrenchment has occurred. Although unemployment rate had been persistently high in South Africa, it has further escalated by 30.8% during the third quarter of 2020 (Bohlmann *et al*. 2021: 1)

Major theme 3- Information received at the health care facility regarding AYFHS

Information is the knowledge to something new or already known. It allows the person gaining the information to make decisive decisions with the knowledge gained. This study described the lack of information regarding AYFHS and how this hindered majority of the youth from accessing and utilizing this service.

Sub-theme 1- Knowledge and information about AYFHS

All participants lacked knowledge and information regarding adolescent's youth friendly services. Participants clearly verbalized that they were unable to access or utilize the service simply because they were not aware of the provision of such a service at their local health care facility. According to James (2018: 2-10) who agreed with the standard tools developed for service and management systems: 1. Provision of relevant information, education and communication promoting behavior change and consistent with YFS package, the comments made by the participants demonstrates that this standards tool was not active.

Sub-theme 2- Staff participation/involvement in providing awareness of AYFHS to the community

Participant's interviews collaborated as they mentioned that No information regarding AYFHS was provided by nurses. In support this study findings, there appeared to be no staff involvement in providing awareness of AYFHS to the community. According to researcher James *et al.* (2018: 1-11) a survey carried out in 2 Provinces in South Africa showed evidence of zero information educational material at 10 healthcare facilities, this is evidence that staff participation in providing awareness to the community is very poor.

Sub-theme 3- Waiting period at the health care facility

The challenge of waiting period was a repeated theme discussed in the findings of the study. Waiting period at the healthcare facility was notably a disadvantage to majority of the people as it interfered with exhausting, frustrating hours at the clinic, many clients lost interest and left before receiving proper healthcare. Factors that contributed to the long waiting periods at the healthcare facility was shortage of staff, high volume healthcare facility, and no separation of queues-no provision of AYFHS. Waiting time was an important indicator of the quality of services offered at the healthcare facility. The National Policy on management of patient waiting time in outpatient departments (2015: 8), mentions a 3-hour waiting period in Primary Healthcare Facilities, but this was not in keeping with reflections by the participants. The waiting times at the local healthcare facility exceeded 3 hours on many visits.

Major theme 4- Experiences of youth/adolescents in accessing and utilizing health care services

16 Participants mentioned their dissatisfaction with experiences at the health care facility. The lack of awareness of the service contributed to many aspects of not accessing and utilizing a service that should be provided for them. Author Nyblade *et al.* (2020: 1-15) acknowledged the experiences of shame and embarrassment because of the stigma they encounter in seeking information and services at healthcare facilities. The apparent experiences of many youth/adolescents seeking AYFHS was dissatisfying.

Sub-theme 1- Respectful and supportive environment at health care facility for youth and adolescents

In the suggestions provided by the participant's majority responded by wanting a separate programme for their age group, a respectful, non-judgmental services. The service provides to understand their health care needs. Moridi *et al.* (2020: 1-12) mentions respectful maternity care was a complex process which requires interpersonal skills of providers.

Sub-theme 2- Community and staff attitude toward youth /adolescents

Discussions on these sub-theme findings were not permissible at any healthcare facility especially staff attitude towards the youth/adolescents. Staff were governed by code of conduct which is based on respect, dignity, kindness to individual's healthcare in this circumstance the youth. Community awareness of a programme associated with youth health care services would allow an understanding and support of this service. The negative attitude of health provider's impacts on the services provided for sexual reproductive healthcare and the misconceptions are critical in improving utilization among youth (Nyblade *et al*. 2020: 1-15)

Sub-theme 3- Quality of youth health care at Facility-Satisfaction/Dissatisfaction

Satisfaction of services was noted by only one participant. The other 16 participants shared similar thoughts of dissatisfaction with services. The participants' experiences and challenges greatly influenced access and utilization of services. The dissatisfaction noted, was lack of knowledge of the existence of such a service. This hindered the youth in accessing this service as they were not informed of the service nor given provision of this service. Other contributing findings for further discussion were the staff attitude, shortage of staff, lack of resource, and the overburden of challenges. These factors have led to dissatisfaction and this affected quality of

youth health care at the facility. Nair (2015: 288-298) agrees that the challenges of accessing and utilizing health care services were related to the process of delivery. This included the judgmental, uncaring, disrespectful attitudes of providers which influenced the perceptions of adolescents about the quality of care and further increased distrust on health care provision

6.4 DISCUSSION OF FINDINGS BASED ON THE THEMES AND SUB-THEMES IN COMPARISON TO THE CHOSEN THEORETICAL FRAMEWORK

The themes and sub-themes that emerged from the study were linked to the elements of the theoretical framework, which was the Model of Healthcare Access by Aday and Anderson (1974: 208-220), as outlined in detail in Chapter 3. The components of the theoretical framework in comparison to its application in the study exposed the link to the experiences of the participants and how the model of healthcare access was used extensively in the discussion of the findings. In the findings it has been noted that model links the themes and subthemes and further discusses the effects on youth/adolescents accessing and utilizing youth friendly services.

A brief summary of the impact of the 5 elements on AYFHS- each element was explored further through the major themes and sub-themes that emerged from the interview process. The use of the theoretical framework was appropriate to the study and this was evident in the following:

Element 1- Healthcare policy-During the interview process participants were aggrieved by the many challenges with regards to lack of infrastructure, shortage of human resources/material resources, mostly that they had No information regarding the existence of such a service. Educational information from staff and IEC material regarding the adolescent/youth friendly service was not provided.

Element 2- Characteristics of healthcare delivery system- Participants vented their dissatisfaction with long waiting times at the healthcare facility.

Element 3- Characteristics of the population at risk- The youth population and in general the community health needs were not met because the operating hours of the healthcare facility was not appropriate to the needs of the community.

Element 4- Utilization of healthcare services- Although the youth did make use of the healthcare facility, they were not satisfied with many issues such as lack of confidentiality, judgement, no

separation of queues, long waiting period and most importantly the lack of knowledge regarding AYFHS and provision of this services at the local health facility.

Element 5- Consumer satisfaction- Only 1 participant was satisfied with the services at the healthcare facility and the statement made by the participant was contradictory, although the participant was satisfied with the services, the participant had no information of AYFHS. The dissatisfaction of all the other participants were noted in their tone of voice, frustration and these challenges hindered the quality of healthcare needs appropriate to the youth population.

All 5 elements integrated into the study exposed the youths' perspectives of the AYFHS in the Ekurhuleni South District.

6.5 RELEVANCE OF THE STUDY FINDINGS TO THE STUDY OBJECTIVES AND RESEARCH QUESTIONS

The objectives of the study have been met, the health challenges of the youth were explored through the interview process, the barriers to access and utilization of AYFHS were identified as the participants vocalized their perspectives, the facilitators of access and utilization of AYFHS in the Ekurhuleni South District were determined and highlighted challenges within the healthcare system, this was supported by the interview process of 17 participants, supporting literature, and the use of the theoretical frame work which guided the study.

6.6 CONCLUSION

This chapter discussed the findings presented in the study. The relevance to the elements of the theoretical framework, study objectives and research questions were discussed and supported by relevant literature. The next chapter entails the conclusion, limitations of the study, and recommendations.

CHAPTER 7: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This chapter presents the summary of the findings, limitations, recommendations, and conclusion of this study. The discussion of the findings was summarized in this chapter following the finding and conclusions highlighted in chapter 6.

7.2 OVER VIEW OF THE FINDINGS

The information gathered from the data collection and interview process highlights the youth's perspectives when accessing and utilizing AYFHS in Ekurhuleni South District, Gauteng Province. All participants concurred that they were unaware of the AYFHS and no information was provided to them regarding such a service. There were a number of factors that hindered youth and adolescents from accessing and utilizing the services at the local healthcare facility. These factors included, lack of material supplies and resources, lack of infrastructure, the influence of traditional norms and beliefs and the fear of the COVID -19 pandemic.

Additional challenges were stated as being, shortages of staff, and lack of information regarding AYFHS at the local health facility, displeasing waiting times at healthcare facility, financial constraints, community/staff attitude and behavior. These factors contributed immensely to youth and adolescents accessing and utilizing AYFHS at the local healthcare facility. This significantly impacted on the healthcare needs of youth and adolescents not being met.

7.3 Limitations of the study

The study was conducted in the Ekurhuleni South District, Palmridge and therefore the study cannot be generalized in other Gauteng Districts.

7.4 Recommendations of the study

7.4.1 Legislation, development and implementation of policy

- Advance recommendation for District Health Services to formulate a facility assessment policy to evaluate if the Healthcare facility is operating in line with the essential package of AYFHS. Proper infrastructure-supportive respectful environment, adequately trained staff,

access to medication /supplies/information, availability of services-operating times/days, a youth friendly service should be included in the assessment and implementation policy.

- Operating hours and days of Palmridge Community healthcare facility to suit the needs of the community. This would improve the healthcare of youth/adolescents within the community and progress in quality of care. This strategy should be included as part of the operational plan of the healthcare facilities in the Ekurhuleni District.
- Strengthen strategies to improve access and utilization of AYFHS, involve the community and other stake holders within the area. Policy makers and those in power within the organization to be actively involved in the implementation and ongoing evaluation of AYFHS. The Palmridge Community healthcare facility should include the leaders within the community, healthcare policy makers, and other stake holders to support the strategies to improve access and utilization of AYHFS.

7.4.2 Institutional management and practice

- The Department of Health to organize and sustain training and development of healthcare workers, in respect to the AYFHS implementation and delivery.

- Healthcare facility managers to ensure that ongoing training is provided for healthcare workers with regards to adolescent health care and revised information, policies to be sustained.
- Health care facilities to practice separation of queues, as this would allow youth/adolescents to follow a different stream that provides information and services appropriate to their age group. This also gains the trust of the youth community by providing a supportive, respectful healthcare service that meets their needs. It would also make the youth feel much more comfortable to be in a queue that is age appropriate, decrease the perception of judgement. The health care facilities would also be able to retain the youth within the community to their local health care facilities.
- All health care facilities should implement a strategy to monitor and evaluate the standard of healthcare delivered to youth/adolescents at AYFHS points. This would improve understanding of youth/adolescent's healthcare needs, as this is important to ensure that healthcare facilities provide the necessary services for youth/adolescents and retain them in care.

7.4.3 Community education programme and healthcare

- District Health services to support facilities to provide systems to inform youth/adolescents and community regarding AYFHS, and how to access and utilize this service.
- Palmridge Community health care facility to encourage outreach programmes to facilitate community involvement, in order to gain input from the community. This would improve access to information, assessing the needs of youth within the community and also client satisfaction.
- Health education programmes should be implemented at Palmridge Community health care facility, local schools, library, taking into consideration the values, beliefs and traditions within the community.

7.4.4 Future research

- Future research study involving different Primary healthcare clinics within the Gauteng Province, is recommended to gain a comprehensive perspective regarding access and utilization of adolescent youth friendly services.

7.5 Conclusion

Access and utilization of Adolescent/Youth friendly healthcare services is the center of priority in youth healthcare. This study was specifically targeted to the youth population within the community to have a platform to voice their challenges and suggestions regarding matters affecting their healthcare. Authors agree that the availability to access and utilize AYFHS would decrease the burden of disease amongst the young people within the country. Evidence offered in the study highlighted the need for AYFHS to be accessible, acceptable, equitable, appropriate and effectively utilized, a contextual surveillance of youth healthcare at Primary healthcare clinics to be monitored and evaluated.

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Appendix 1. Ethics approval letter

DUT
DURBAN UNIVERSITY OF TECHNOLOGY

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
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Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
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http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

15 December 2020

Mrs R Naicker
No. 9 Nik Street
Brackendowns
Alberton

Dear Mrs Naicker

Access and utilization of adolescent youth friendly services in the Ekurhuleni South District, Gauteng Province

I am pleased to inform you that Full Approval has been granted to your proposal.

The Proposal has been allocated the following Ethical Clearance number **IREC 164/20**. Please use this number in all communication with this office.

Approval has been granted for a period of **ONE YEAR**, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Professor J K Adam
Chairperson: IREC

2020 -12- 15

INSTITUTIONAL RESEARCH ETHICS CO.
P O BOX 1334 DURBAN 4000 SOUTH

Appendix 2a- Letter of information –English

Thank you for agreeing to participate in this study.

Title of the Research Study: Access and utilization of adolescent youth friendly health services in the Ekurhuleni South District, Gauteng Province.

Principal Investigator/s/researcher: Mrs Reshna Naicker, (MHSc: Nursing – student)

Co-Investigator/s/supervisor: Dr V Naidoo, D Nursing (Supervisor), Mrs M Moonsamy, Mrs A Mavundla (Co-supervisors)

Brief Introduction and Purpose of the Study: The proposed study aims at describing the experiences of adolescents/youth and professional nurses with regards to access and utilization of adolescent youth friendly health care services in the Ekurhuleni South District, Gauteng Province.

Outline of the Procedures: You are kindly requested to participate in an interview. The interview questions focus on access and utilization of adolescent youth friendly health services. The interview will be conducted by the researcher, in both English and IsiZulu. It will be a telephonic interview. The interview session will take between 20 minutes to 30 minutes. Permission is sought to record the interview for record purposes.

Risks or Discomforts to the Participant: The study does not involve any physical risk or cause physical discomfort to participants.

Benefits: The proposed study intends making recommendations to improve the access and utilization of adolescent youth friendly health services to meet the health needs of the youth within the community. It aims to also improve the body of knowledge training in

public health domain to improve adolescent youth friendly health service delivery to benefit users, decision-makers, policy-makers and practitioners.

Reasons as to why the Participant May Be Withdrawn from the Study: Contribution will be voluntary and as a participant you can withdraw at any given time without any opposing consequence

Remuneration: There is no remuneration for participating in the study.

Costs of the Study: There are no costs involved by participating in this study.

Confidentiality: The information provided will be kept strictly confidential and will remain anonymous. The interview does not comprise names and any personal identification details; instead, codes will be used.

Research-related Injury: There are no identified or foreseen risks and discomforts related to you in this study, nevertheless, if so, no compensation will be presented.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher Reshna Naicker. 084 400 7639, my supervisor's Dr V Naidoo. 031 373 2748, Mrs M Moonsamy 033 845 8000, Mrs A Mavundla 033 845 9017 Or the Institutional Research Ethics administrator on 031-373 2900.

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population e.g., isiZulu.

Appendix 2b -Letter of Consent -English

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Mrs Reshna Naicker bout the nature, conduct, benefits and risks of this study - Research Ethics Clearance
  Number: _____,
- I have also received, read and understood the above written information (Participant Letter of
  Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix 3a- Letter of info in isiZulu

Isengezo 3a: Incwadi yolwazi kwabazo bamba iqhaza kucwaningo

Ngiyabonga ngokuba uvume ukubamba iqhaza kulesisifundo, nokuthi uvume ukubandakanyeka kulolucwaningo.

Isihloko salolucwaningo: Ukufinyelela Kanye nokusetshenziswa kwemisebenzi yezempilo yentsha enobungane Ekurhuleni South District, Gauteng Province (Access and utilization of adolescent youth friendly health services in the Ekurhuleni South District, Gauteng Province)

Umcwaningi: Mrs Reshna Naicker, umfundi weziqu eziphakeme kwezobuhlengikazi.

Abaholi bocwaningo: Dr V. Naidoo (Umholi), uneziqu zobudokotela. Mrs M Moonsamy no Mrs A Mavundla (osekela).

Isithulo yalolucwaningo kanye nenhloso yalo: inhloso yalolucwaningo ukuthola ulwazi ngabantu abase basha naba hlengikazi maqondana nezindlela zokusebenzisa imitholampilo yolusha (ama-AYFS) eEkurhuleni South District, Gauteng Province.

Uhlelo lokuzokwenzeka: Uyacelwa ukuba ingxenye yalolucwaningo. Imibuzo izobe imaqondana nezindlela kanye nokusetshenziswa kwama-AYFS, ngakho-ke ngizodinga sihlale phansi sixoxisane ngalokhu imizuzu engaba phakathi kwamashumi amabili kuya kwimizuzu engamashumi amathathu. Ngicela nemvume yokuqopha inhlolokhona**.**

Ukuphepha kulabo abazodlala indima kulolucwaningo: Sinesiqiniseko sokuthi lolucwaningo ngeke lukuhlukumeze emoyeni Kanye nasenyameni.

Usizo lwalolucwaningo: Ucwaningo oluhlongozwayo luhlose ukwenza isincomo sokuthuthukisa ukufinyelela nokusetshenziswa kwensiza enempilo yentsha no kuhlangabezanaa nezindingo zempilo emphakathini. Inhloso futhi ukuthuthukisa umzimba esizindeni sezempilo somphakathi ukwenza ngcono ukulethwa kwezinisiza kwentsha okunempilo ukuze kusizakale abasebenzisi, abenzi beziqumo, abenzi bezinqubomgomo nalabo abasebenzayo.

Izizathu ezingengza kuhoxe labo abalekelelayo kulolucwaningo: Ukubamba iqhaza kulolucwaningo akuphoqelekile futhi ungahoxisa noma ingasiphi isikhathi. Loko ngeke kube nemithelela emibi kuwe futhi awuphoqelekanga ukuthi udalule izizathu ezikwenza uhoxe.

Umhlomulo: Angeke uhlomule ngokubamba iqhaza kulolucwaningo.

Izindleko zocwaningo; Akukho zindleko ozobhekana nazo ngokubamba iqhaza kulolucwaningo.

Ukudalulwa kwakho: Ulwazi nemininingwane ebhekene nalolu cwaningo ngeke ixhumaniswe neningi futhi izohlala ingaziwa umthombo wayo. Lolucwaningo ngeke lubalule imininingwane yakho. Ikhodi izosetshenziswa.

Izingozi ezibhekene nocwaningo: Azikho izingqinamba nemibuzo nokunga thuliseki ezobhekana nawe ngenxa yalolucwaningo

Ongaxhumana nabo uma unemibuzo yilaba: Sicela ukuba uxhumane

nomcwaningi Reshna Naicker inombolo yocingo 084 4007639, nalabo abamuholayo o Dr V Naidoo inombolo yakhe yocingo 031 373 2748, Mrs M Moonsamy inombolo yocingo 033 845 8000, no Mrs A Mavundla inombolo yocingo 033 845 9017. Uma ungagculisekile ungaxhumana nalemini niningwane engenhla Institutional Research Ethics Administrator on 031-373 2375

Appendix 3b- Letter of Consent in Isizulu

Isengezo 3b- Ulwazi lesivumelwano

Isivumelwano sokuba yingxenye yocwaningo

Mina…… (amagama aphelele), inimbolo yamazisi…… Ngiyafakaza ukuthi ngichazeleke kahle ngocwaningo lwa Mrs Reshna Naicker. Unginike incwadi yolwazi ngayifunda ngokuqonda. nginalo nolwazi lokuthi imiphumela yalocwaningo uzoyibhala ebhukwini kodwa imininingwane yami izoba imfihlo. Ngingahoxa noma kunini kulolucwaningo angeke kubekhona inkinga ngoba angiphoqiwe. Ngaphezu kwakho konke lokhu ukuba yingxenye yalocwaningo angeke kube nomthelela ongangivimbela ukusebenzisa umtholampilo ngokukhululeka esikhathini esizayo, ngakho ke ngiyavuma ukuba yingxenye yaloncwaningo.

Igama longenela uncwaningo (Ngokuhlukanisa)

……

Isishicilelo Songenela. Ucwaningo

……

Usuku

…… ……

Igama lomcwaningi

(Ngokuhlukanisa)……
….

Isishicilelo Somcwaningi……
usuku……

Igama (ngokuhlanganisa)
likafakazi……

Isishicilelo
sikafakazi……usuku……

Appendix 4a- Interview guide for youth in English

Participant Code:

Date of interview: …….

SECTION A: DEMOGRAPHIC DATA

1. Age: …….

2. Gender: …….

3. Marital Status: …….

4. Level of education: …….

5. Occupation …….

SECTION B: INTERVIEW QUESTIONS

Grand tour question

- What are your experiences when accessing and utilizing AYFHS at your local clinic?

Probing question

- Briefly explain the information that you have been provided with regarding AYFHS?
- Describe the challenges that you have encountered when accessing and utilizing AYFHS?
- Do you have suggestions to improve AYFHS to meet the healthcare needs of the youth in the community?

Appendix 4b- Interview guide for youth in Isizulu

Imibuzo Ngolimu LwesiZulu (IsiZulu)

Ikhodi Yomuntu Obambe qhaza: ☐

Usuku Lomncwaningo: ……..

ISIGABA A: Ucwaningo Lomuntu

1. Iminyaka (onayo manje): ……..

2. Ubulili: ……

3. Ushadile: ……

4. Ibanga lemfundo: ……

5. Umsebenzi ……. **ISIGABA B: IMIBUZO NGOCWANINGO**

Umbuzo omkhulu

- Yini okuhlangabezana nayenwe nakho kwakho lapho ufinyelela futhi usebenzisa izinsizakalo zezempilo zentsha ye Adolescent emtholapilo wangakini?

Umbuzo wokuhlola

- Ingaba uthole ulwazi olwanele maqondona ne AYFS?
- Yiziphi izinkinga ohlangabezane nazo ekusebenziseni izinsizakalo ezinobungane zentsha?
- Iziphi izeluleko ezingathuthukisa ama-AYFS ukuze ihlangabezane nezidingo zempilo yentsha emphakathini?

Appendix 5a-Transcript sample 1 of Interview

Interviewer	Hello. Good afternoon. How are you?
Participant	Good afternoon. I am great and, how are you?
Interviewer	I am well thanks. Is it a convenient time to speak?
Participant	Yes, it is a good time to speak
Interviewer	Thank you for agreeing to participate in the research study. I have received the signed consent form via wats app
Participant	That's fine not a problem
Interviewer	Just to get a verbal consent this afternoon that you agree to participate in the interview. As I discussed with you earlier the information provided is confidential and would only be used for the purpose of the study
Participant	Yes, I do agree and understand
Interviewer	The letter of information that I provided to you earlier, gives a brief explanation of the research study being conducted
Participant	Yes, I have read the information letter
Interviewer	Before we continue with the interview, please note that I would be recording the interview. This is so that I would be able to analyse the information later on. Is it fine with you?
Participant	Yes, it is fine with me
Interviewer	I am going to start with a few questions. How old are you and tell me a little about yourself
Participant	I am 23 years and I live in Palmridge. I live with my partner

Interviewer	Thank you for that information. Furthermore, I would like to discuss the access and utilization of AYFHS at your local health facility. Have you been given any information regarding this service

Participant	Ummm…No information of such a service has been shared to me.
Interviewer	Have you experienced any challenges at your local clinic that you would like to discuss?
Participant	(Participant coughs intermittently) …As I mentioned I work from Monday to Friday and during the weekend the clinic is closed. During the week it is difficult for me to take time of work to go to the clinic. I would prefer to visit the clinic over the weekend. This has been my main challenge and err…. also being afraid of Covid 19
Interviewer	So, you are saying that the clinic is not accessible over the weekend. It is understandable that you may have some fear of the Covid 19 infection
Participant	Yes, and because the clinic is not available, I go to the traditional healer in the community
Interviewer	That's unfortunate that these are the challenges you are facing to access and utilize the clinic services especially over the weekend. With regards to Covid 19, just ensure that you are following the regulation and sanitizing, washing your hands regularly, maintaining social distance, and using a mask
Participant	I am not alone in this there's others in the community who also work and if the clinic could provide a service for us the youth. This would be good for us if the AYFHS

	was available for us to utilize over the weekend during a specific time
Interviewer	I just want to summarize what you mentioned, the challenges of the clinic service not being available over the weekend and after hours, your fear of Covid 19, you have no alternative but to visit the traditional healer because the clinic does not operate after hours and weekends.
Participant	Yes, that's what I mentioned
Interviewer	Are there any other suggestions you would like to make?
Participant	Ummm…My suggestion would be that the clinic would provide a separate building for youth services because we don't want to follow the same queue as our grandmothers and older people from our community
Interview	Thank you for all the suggestions you have made. Do you have any questions thus far?
Participant	No, I don't have any further questions?
Interviewer	If you have any friends or family members who would like to participate in the study, please provide them with my detail. Thank you once more for participating in the interview. Take care
Participant	Thank you. I will do so. Bye!

Appendix 5b-Transcript sample 2 of Interview

Participant	Hello
Interviewer	Hello. How are you?
Participant	I'm fine and you?
Interviewer	Thank you for asking, I am good. Is it a convenient time to talk?
Participant	Yes, it is
Interviewer	Ummm…A few days ago, I called and provided you with some information regarding the research study
Participant	Yes, I did read it
Interviewer	Before we continue, do you verbally agree to the interview today?
Participant	Yes, I do agree
Interviewer	Thank you for participating in the interview. I have also received your signed consent via WhatsApp. A reminder that this interview is confidential and would be used only for the purpose of the study
Participant	No problem
Interviewer	The letter of information I provided to you, gives you a brief description about the research study
Participant	I understand
Interviewer	I'm going to start of asking you a few questions. Answer to the best of your ability and don't be anxious
Participant	That's fine I am ready

Interviewer	Can you tell me how old you are and little about yourself?

Participant	I am 18 years old and in grade 12. I live in Palmridge with my grandmother, who is a pensioner
Interviewer	Do you live alone with your grandmother and are you dependent on her?
Participant	Yes, I live alone with her and I am dependent on her
Interviewer	Thank you for that information. With regards to the healthcare facility in your area, have you been given any information about adolescent/youth friendly health services
Participant	No, (*dragging the word no in her tone*) it's the first time I'm hearing of this
Interviewer	When you attend the clinic do you experience any challenges?
Participant	Yo…. a lot…we have to be at the clinic very early before 6 am and the clinic only opens at 8 am, and they only start working around 910am. We wait at the clinic the whole day, but we don't get the treatment we need. The sisters at the clinic tell us they are short of treatment and to come back to collect
Participant	Do you return to collect the treatment?
Interviewer	I don't have time to come back and spend the whole day at the clinic, I have to be at school

Interviewer	To summarize what you are verbalizing is that the queues and waiting times are too long, the nurses start late to attend to clients and medication shortages are a problem
Participant	Yes, that is what we experience at the clinic and also the nurses are rude
Interviewer	Can you tell me more about that?
Participant	Uhmm…They shout at us because we complain that we have waited there for a long time. They say that there is nothing they can
	do, if we want to be helped, we have to wait for them to finish what they are doing
Interviewer	That is sad to here that you experience this at your local clinic. Do you travel a long distance to go to the clinic
Participant	Yes, I wake up at 4am, take a bath and leave to the clinic to be there by 6 am to follow the queue
Interviewer	Do you have any suggestions that you would like to make, so that the clinic could meet your health needs as a youth?
Participant	Err…We want the youth to be put aside, not mixed with adults because they see us and judge us. There's no privacy, we want our own place as youth and to be differentiated and not mixed with everyone
Interviewer	Yes, that is understandable that you would want privacy. Do you think that if the youth had a separated service this would decrease your waiting time

Participant	Yes, I think that the waiting time would not be long and also the information provided by the staff would appropriate for our age group
Interviewer	Do you have any questions for me thus far?
Participant	No, nothing at the moment
Interviewer	Thank you for participating in the interview and I would like to wish you well for your matric year
Participant	Thank you. Bye
Interviewer	Bye. Take care

Appendix 6: Certificate from the professional editor

AH

EDITING CERTIFICATE

AUTHOR: RESHNA NAICKER: STUDENT NUMBER 20512637

CONTACT

Dr Anita Hiralaal
BA, HDE, B ED HONS, B COMM HONS, M ED, PH D
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0825352777

21 July 2021

Master's Thesis

ACCESS AND UTULISATION OF ADOLESCENT YOUTH FRIENDLY HEALTHCARE SERVICES IN EKURHULENI SOUTH DISTRICT, GAUTENG

has been edited to ensure technically accurate and contextually appropriate use of language, grammar, logical coherency and presentation.

Dr Anita Hiralaal

A

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Appendix 7: Turnitin Report

ACCESS AND UTULIZATION OF ADOLESCENT YOUTH FRIENDLY HEALTHCARE SERVICES IN EKURHULENI SOUTH DISTRICT, GAUTENG

RESHNA NAICKER

(20512637)

Dissertation submitted in fulfilment of the requirements for the Degree of Master of Health Sciences in Nursing in the Faculty of Health Sciences at the Durban University of Technology

Supervisor : Dr Vasanthrie Naidoo