UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN RURAL SOUTH AFRICA: KNOWLEDGE, PERCEPTIONS, AND EXPERIENCES OF YOUTH IN MUTALE VILLAGE, LIMPOPO PROVINCE

By

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DECLARATION

I, **Mulaudzi Vhugala**, declare that: “Utilisation of Sexual and Reproductive Health Services in Rural South Africa: Knowledge, Perceptions and Experiences of youth in Mutale Village, Limpopo Province” is my own work and that all sources that I have consulted or quoted have been clearly indicated and acknowledged by means of references.

Electronic Signature *Date*

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ABSTRACT

Sexual and reproductive health is an essential form of human health. Consequently, it is a fundamental right for every South African. However, young people in South Africa have limited access and exposure to reproductive and sexual health services. Thus, this study aimed to analyse young people's knowledge, perceptions and experiences with sexual and reproductive health services in Mutale village, Thulamela Municipality. A mixed method approach was used in this study, following a descriptive survey design. Both purposive and snow-ball sampling were used to select a total of 126 participants. Data were collected using one-on-one semi-structured interviews and questionnaires. The qualitative data were analysed using thematic analysis, while the quantitative data were analysed using descriptive analysis by SPSS version 19.0 to establish descriptive values, as well as the standard means, deviations, and frequencies from the collected data. The study findings established that young people face many challenges in accessing sexual and reproductive healthcare. Similarly, there is a minimal awareness on SRH services offered in health facilities, which affected their use of those services. Young people's use of SRH services was also affected by religion and attendant social norms, values and beliefs that regard SHR as improper for young people, misconceptions regarding side effects of the use of pill and injection-based contraceptives, which are misconceived as a cause of infertility. It also emerged that the attitude of local healthcare workers in local health facilities also discouraged young people's usage of SRH.

Keywords: Access, Awareness, Health facility, Mutale, Sexual and reproductive health, Youth.

LIST OF ACRONYMS

AIDS:	Acquired Immune-deficiency Syndrome
ASRH:	Adolescent Sexual and Reproductive Health
CTOP:	Choice on Termination of Pregnancy
EBIs:	Evidence- Based Intervention’s
PHC:	Public Health Care
SEM:	Socio-Ecological Model
SRH:	Sexual and Reproductive Health
STI:	Sexually Transmitted Infection
SRHR:	Sexual Reproductive Health and Rights
UNAIDS:	United Nations Programme on HIV/AIDS
VMMC:	Voluntary Medical Male Circumcision
WHO:	World Health Organization
YFHS:	Youth-Friendly Health Services

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 *INTRODUCTION*

In addition to being a matter of human rights and public health, achieving the Sustainable Development Goals (SDGs) depends on sexual and reproductive health (Starrs, Ezeh, Barker, Basu, Bertrand, Blum & Ashford, 2018). Globally, there are striking inequalities in sexual and reproductive health between developed and developing nations (Thapa, 2020). In addition, while sexual and reproductive health issues affect both men and women, they disproportionately affect women and girls, especially in developing nations. Additionally, more young people live in Sub-Saharan African countries than in any other part of the world (McCauley, Dick, Tancredi, Goldstein, Blackburn, Silverman, Monasterio, James & Miller, 2014). Youth made up 18.5% of South Africa's overall population in 2019, and the province with the most youth is Limpopo with 32% of the total population.

In the province of Limpopo, the Thulamela Municipality is part of the Vhembe District. In the Thulamela Municipality, there are 41 wards. Water and sanitation, power, and medical care are among the essential services it provides (IDP review 2020/21-2022/23 of Thulamela). According to Statistics South Africa (2019), Thulamela has a population of 618 462 people, with an estimated 262 769 of those being between the ages of 15 and 24. Mutale is a remote village in Thulamela Municipality. According to the Limpopo District profile (2018), Mutale village has a total population of 2500 people, including 700 youth between the ages of 15 and 24.

Like many other municipalities in South Africa, Thulamela offers clinics offering sexual and reproductive health services (Denno, Hoopes, & Chandra-Mouli, 2015). These services are also accessible to young people, and they include voluntary HIV counseling and testing, contraception, and hospital referrals for male circumcision and pregnancy termination (Ngomi, 2018). As a result, even though the lack of public health care services in rural South Africa has received a lot of attention, it is undeniable that the municipality has several facilities in the Thulamela region (Ngomi, 2018). Tshaulu Health Centre, Tiyani Health Centre, Shayandima Health Centre, Phiphidi

Clinic, Sibasa Clinic, Thohoyandou Health Centre, Univen Health Clinic, Tshilidzini Hospital, and Mutale Health Centre are just a few of the Thulamela's existing healthcare facilities. (Massyn, English, McCracken, Ndlovu, Gerritsen, Bradshaw & Groenewald, 2015). The generally gives us the impression that Thulamela's youth may readily get sexual and reproductive health services at the hospitals closest to them. An estimated 200 individuals, including youth, visit the Mutale health centre each month for consultations on their health and reproductive requirements (Thulamela Community Health Centre, 2012).

While it is undeniable that Limpopo has a variety of medical services and facilities, a study by Peltzer's (2001) in the province discovered that most young people in the region begin sexual activity at the age of 15. Moreover, despite the government's initiative to give youth access to free sexual health care services like contraception, their awareness, and use of contraceptives is lacking in the province (Ritcher & Mlambo, 2005). The province of Limpopo continues to experience an increase in the incidence of teenage pregnancies, which is perceived to be a result of this lack. (Ramathuba, Khoza & Netshikweta, 2012). Additionally, unintended teenage pregnancies and HIV diagnoses among South African youth are both on the rise (UNAIDS, 2019). The authors of Kabiru, Izugbara, and Beguy (2013) argue that the prevention of STIs, AIDS, and unwanted pregnancies is more likely to be successful among young people.

Subsequently, several factors put South African youth at increased risk, including ignorance, false information, limited access to, and non-use of, existing sexual and reproductive health services. According to Ramathuba (2013), lack of confidentiality between youth patients and healthcare professionals and general misinformation about sexual and reproductive health are common amongst South African youth, putting them at extended SRH related risk. Considering the foregoing, this research analysed youths' knowledge, perceptions, and experiences of using sexual and reproductive health services in rural South Africa, using Mutale village in the Thulamela Municipality of the province of Limpopo as the case study area.

1.2 *PROBLEM STATEMENT AND JUSTIFICATION*

The second half of the twentieth century saw a massive development of technologies and services that provided people with sexual and reproductive health care (Godia, Olenja, van den Broek & Hofman, 2014). This expansion, however, has been disjointed and unfocused on meeting all person's health needs. Consequently, there is a disconnection between existence of sexual and reproductive health services and use by youth. Godia et al. (2014) noted that significant proportions of youth in South Africa is sexually active and have several partners in unprotected sex. Additionally, young girls in most parts of South Africa experience unplanned pregnancies due to a lack of access to contraceptives (Ram, Andajani & Mohammadnezhad, 2020). Although, there are a plethora of studies done in rural areas about youth's reproductive health issues

Technology and services for people's sexual and reproductive health care underwent a huge development in the second half of the 20th century (Godia, Olenja, van den Broek & Hofman, 2014). However, this expansion has been unplanned and unfocused on addressing the health requirements of every person. As a result, there is no correlation between the availability of sexual and reproductive health services and youth use. Significant percentages of South African youth engage in sexual activity and have multiple partners in unprotected sex, according to Godia et al. (2014). In addition, the majority of South Africa's young females have unwanted pregnancies because they lack access to contraceptives (Ram, Andajani & Mohammadnezhad, 2020). Even though several studies on young people's reproductive health have been conducted in rural locations by Matlala & Mpolokeng (2010); Ramathuba (2013) and Rasesemola (2017). Studies already conducted concentrate on specific topics; Ramathuba's study, for instance, examined the attitudes and behaviors of high school students concerning contraception. Instead of the school environment, this study concentrated on households and the community.

According to statistics from the regional hospital in Thulamela Municipality, 345 (31%) pregnancies were terminated in 2018/2019, while 1896 young people under the age of 18 gave birth, making up 26% of all deliveries in the district (Tshilidzini hospital maternity and Choice on Termination of Pregnancy (CTOP) register 2018/2019). These figures might indicate that young people underuse reproductive health services to some extent. Strode and Essack (2017) hypothesized that the underutilization of

reproductive health care may result from the failure of existing programs to involve youth in the creation of youth-friendly services.

According to earlier research, sex may have an impact on young people's attitudes about the use of reproductive and sexual health services. For instance, Glinski, Sexton, and Petroni (2014) demonstrate that the stigma that most girls encounter when seeking reproductive and sexual health services at health centers causes them to feel fear, humiliation, and embarrassment. In other studies, male coworkers expressed dissatisfaction with how women-centric reproductive and sexual health services were (Muanda, Ndongo, Bertrand & Taub, 2016; Obong & Zani, 2014). These problems highlight the need to examine whether there is a real divergence between the availability of services for sexual and reproductive health and the perceived underutilization of those facilities by young people from a gendered perspective. An analysis of young people's knowledge, perceptions, and experiences can shed light on these crucial topics, particularly when it comes to how best to use medical services to enhance the sexual and reproductive health of young people in rural South Africa. Such a study could also aid in identifying potential intervention areas to improve the usability and accessibility of the current sexual and reproductive health services.

1.3 AIM OF THE STUDY

The aim of this study is to analyse knowledge, perceptions, and experiences of youth on their utilisation of sexual and reproductive health services in Mutale village, Thulamela Municipality, Limpopo province

The specific objectives are to:

- Analyse youths’ utilisation of existing sexual and reproductive health services in Mutale village
- Determine the factors influencing the utilisation of sexual and reproductive health services by youth in Mutale village
- Examine the youth friendliness of existing sexual and reproductive health services in Mutale village

1.4 RESEARCH QUESTION

The main question that the proposed study will answer is what are the existing knowledge, perceptions, and experiences of youth’s utilisation of existing sexual and reproductive health services in Mutale village in Thulamela Municipality, Thohoyandou? The sub-research specific questions are the following:

- What is the nature of youths’ utilisation of existing sexual reproductive health services in Mutale village?
- What are the factors influencing youths' utilisation of available sexual and reproductive health service in Mutale village?
- How youth friendly are the sexual reproductive health services in Mutale village?

1.5 THEORETICAL FRAMEWORK

The socio-ecological model (SEM), developed by Uriel Bronfenbrenner in the late 1970s as a theoretical framework for comprehending human development, was used in this study. In the 1980s, Bronfenbrenner formalized the model as a theory (Bronfenbrenner, 1992).

The social-ecological model is an effective conceptual framework for analyzing factors that affect young people's health outcomes because it considers how internal and external factors interact to shape individual behavior (Rizvi, Williams, Maheen & Hoban, 2020). The model considers people's interactions at the individual, interpersonal, organizational, and community levels as well as the physical and psychosocial surroundings. The social-ecological model also considers perceptions, beliefs, and attitudes influencing these interactions. For the case at hand, SEM looks at the perceptions, beliefs, and attitudes on the utilisation of sexual and reproduction health, whose specifics are discussed in detail in the literature review from 2.2. onwards.

More academics are utilizing the social-ecological paradigm to comprehend the societal, interpersonal, and systemic aspects of health (Gombachika, Fjeld, Chirwa, Sundby & Maluwa, 2012). As a result, SEM is a technique used by evidence-based youth health programs to increase impact and enhance adolescent health outcomes (examples include Manisha, 2015; Apanga & Adam, 2015). Shelton (2018) indicates

four relational systems of the Bronfenbrenner’s ecological theory, namely microsystem, mesosystem, exosystem as well as macrosystem, which are collectively known as the ecological framework for human development.

According to O'Toole, Hayes & Halpenny (2019), the Microsystem refers to institutions of primary learning about the world, which impact the youth’s development directly and immediately, such as family, school, religious institutions, neighbourhood, and peers. Mesosystem consists of the integrated nature of microsystems such as between family and school teachers or between the youth’s family and friends. As such, what happens in a particular microsystem, such as home affects what transpires in another (Perron, 2017). Soyer (2019) defines Exosystem as the system of associations between social settings that do not involve the youth such as parent's experiences at work influencing their youthful experience at home. The last, most wide Macrosystem is defined as “the set of overarching beliefs, values, and norms, as reflected in the cultural, religious, and socioeconomic organization of society” (Boulanger, 2019). Although it has an unclear framework, Macrosystem is made up of larger systems such as cultural beliefs, social values, political trends, and ‘‘community happenings’’ which are powerful energy sources in individual’s lives as they influence what, how, when and where individuals’ relationships befall (Boulanger, 2019).

Thus, SRH related conceptions existing in different contexts where the youth of Mutale district find themselves supposedly affects their lives broadly, now and later in adulthood. Thus, the socialisations of the Micro, Meso, Exo and Macro ecological systems of youth in Mutale village, evidently impact on their SRH service seeking behaviour, as well as their response to SRH related conceptions. The socio-ecological model was therefore used to analyse how individual factors existing around the Micro, Meso, Exo and Macro ecological systems of youth in Mutale village, such as sexual activities, religious affiliation, educational attainment, sexual orientation, ethnicity, relationships, community status, and socio-cultural factors interact to affect youth's knowledge, perceptions, and experiences in using sexual and reproductive health services in Mutale village.

1.6 ORGANISATION OF THE STUDY

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

This chapter provides an overview of the study, the background, the problem statement, the significance of the study, justification of the study, aim of the study, the research questions, and theoretical framework.

CHAPTER 2: LITERATURE REVIEW

The chapter provides academic view and theory used for sexual and reproductive health service.

CHAPTER 3: RESEARCH METHODOLOGY

The chapter provides the research methodology and design used in the study.

CHAPTER 4: PRESENTATION OF DATA AND ANALYSIS OF FINDINGS

The chapter provides collected data followed by analysis and interpretation of findings by the researcher.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

The chapter outlines the study conclusion on the findings, recommendations, and a summary of the findings.

CHAPTER 2: LITERATURE REVIEW

The literature review highlights several topics involving sexual and reproductive health services that are pertinent to young people and places the current study within the context of the body of existing information. The literature review for this study is structured as follows: perspectives, beliefs, and attitudes towards sexual reproduction and health utilisation are discussed before discussing teenage sexual and reproductive health as a global concern.

2.1 YOUTH SEXUAL AND REPRODUCTIVE HEALTH AS A GLOBAL CONCERN

The sexual and reproductive health of young people is a serious global issue. For instance, in Africa, the prevalence of HIV among people between the ages of 10 and 24 is still alarmingly high (WHO, 2019). Based on data from Statista (2019) and a 19 percent infection rate, Van Wyngaard and Whiteside (2021) ranked South Africa fourth in terms of HIV infection. According to UNAIDS (2015), 37% of new HIV infections among adults in Sub-Saharan Africa occurred in adolescents and young people aged 15 to 24 in 2015. (Dahourou, GautierLafaye, Teasdale, Renner, Yotebieng, Desmonde, Ayaya, Davies & Leroy, 2017). Adolescents make up a substantial portion of the population. Compared to adults, they are more likely to get sick or pass away from problems with their reproductive system such STIs, early pregnancies, abortions, and HIV/AIDS. (2015) Manisha, Sanjeev, Seema, Dilip, and Rashmi Young people are particularly vulnerable because of a confluence of biological and behavioural variables. Physical and hormonal changes on their bodies known as physiological factors might result in risky sexual behaviors, necessitating the utilization of sexual and reproductive health care (Luvuno, Ncama & Mchunu, 2019). Behavioural factors on the other hand, refer to both individual and environmental factors, including perceptions, knowledge and attitudes as envisaged in the socio-ecological model. Specifically, the socio-ecological model recognises that health behaviours are influenced by multiple personal, inter-personal, and environmental factors.

2.2 PERCEPTIONS, BELIEFS, AND ATTITUDES REGARDING SEXUAL REPRODUCTION AND HEALTH UTILISATION

According to Danzereau, Schaefer, Hernández, Nelson, Palmisano, Ros-Zertuche, and Bcheraoui (2017), people's attitudes and beliefs about using sexual reproduction and health services fall into the following categories: fear of side effects, religious beliefs, cultural norms, and societal values. They are described below:

2.2.1 Fear of side effects

Family planning, according to Dansereau et al. (2017), improves people's rights to decide how many and space out their children, prevents newborn and maternal fatalities, particularly in underdeveloped countries, and offers dual protection against pregnancy and STIs. Despite these advantages, people's choice of whether to utilize family planning has been linked to their concern over potential risks.

According to Orach, Aporomon, Komakech, Otim, Amone, Okello, and Odongkara's (2015) study on perceptions and use of family planning services in Northern Uganda, the low use of sexual reproduction and health services in the area is due to both the belief that natural methods of contraception are more effective than modern ones and the worry that such services could lead to health complications like irregular menstrual cycles and excessive bleeding.

Similar findings were found in a study conducted in Chiapas, Mexico, by Dansereau et al. (2017). Although participants had a better understanding of sexual reproduction and health services and expressed a willingness to use them, they also harboured misconceptions and concerns about the long-term fertility risks associated with some hormonal methods of family planning, such as birth control pills and injections. In the Chiapas study, many of the persons interviewed thought that using birth control pills could result in lifelong sterility.

Another study by Apanga and Adam (2015) in the Talensi District of Ghana revealed that people mistakenly think that family planning services may harm their wombs and that these services are only for married people. Ndwamato (2009) conducted a study

on the attitudes and routines of Tshivenda-speaking multiparous women towards the use of contraceptives at Tshilidzini Hospital in Limpopo, here in South Africa. Ndwamato discovered that many survey participants believed that contraception is the primary source of diseases, and some individuals said that contraceptives have an impact on how the body works by causing leg pain and a burning sensation around the waist. Additionally, traditional healers who took part in the study shared the view that modern contraception is to blame for the poor delivery outcomes for both mothers and children. The key inquiry here is if comparable misunderstandings may play a role in Mutale Village's youth's reported underutilization of health services.

2.2.2 Religious beliefs

Effective sexual reproduction and the use of healthcare facilities have been found to be hindered by religious beliefs, particularly Catholicism and Islam. Following such a faith, using contraception, having an abortion, and engaging in sexual activity are all viewed as sinful (Orach et al., 2015). For instance, Osuafor, Maputle, and Ayiga (2018) discovered that among inhabitants of Mafikeng's poorest neighborhoods in South Africa, religious concerns hinder sexual reproduction, health education, and variables influencing married or cohabiting women's decisions to use contemporary contraception. For example, the Christian religion exhorts followers to "be prolific and multiply; fill the land and subdue it. Rule over all living things, including the fish in the sea, the birds in the sky, and every living creature that moves on the ground" (Genesis 1:28). Similarly, Vahed (2007) found that Islam views abortion as being evil and haram (forbidden) in his study on the opportunities and obstacles facing Islam in the public realm in South Africa after Apartheid (forbidden). Such religious doctrines and convictions affect how people, especially young people, view and respond to sex education and family planning services, which may result in a lack of use of reproductive health care. Thus, it is important to comprehend how youth in Mutale village use or underuse health services in relation to religious teachings and beliefs.

2.2.3 Cultural norms and social values

Many societies frown upon premarital sex, public discussion of sexual matters, and the detrimental effects of sex education (Roudsari, Javadnoori, Hasanpour, Hazavehei

& Taghipour, 2013). It is thought that sex education encourages young individuals to be promiscuous. Because of this, many people experience stigma and humiliation when using services or getting information about sexual health (Browes, 2015). In Iran, teenagers' use of sexual health education and services is significantly influenced by taboos around sexuality, according to Roudsari et al. (2013). Adabla also cited UNFPA (2011) to support her claim that traditional values, norms, and beliefs, such as ideas of femininity, sex taboos, the value placed on female virginity, the fear of losing "face," and a belief in fate and karma, are some socio-cultural factors adversely affecting the sexual health of female migrants in the country.

According to Tamang, Raynes-Greenow, McGeehan, and Black (2017), cultural changes in many African nations, including South Africa, have left young people and women caught between traditional customs and modern society's demands for conservative sexual behavior and early marriage. Despite government initiatives to widen access and acknowledge the significance of sexual and reproductive health to overall health, married couples continue primarily use sexual and reproductive health services in South Africa (Tamang et al., 2017).

Ndwambi (2019) employed five focus groups in a study conducted in the Vhavenda culture of northern South Africa to elicit opinions from traditional church groups and traditional healers regarding knowledge and use of contraceptives. Although their techniques varied, all groups utilized some form of contraception, according to the study's findings. It was also claimed that the majority of traditional healers were said to not believe in contemporary contraceptives and still believe in "traditional" family planning that has been carried out or practiced by their ancestors; for this reason, in most cases, they employ herbs to avoid pregnancy. Additionally, the study featured traditional churches, the majority of which emphasize the use of candles and water for healing and prevention (Ndwamato, 2009).

Numerous research conducted around the world have found that cultural barriers to sex education and service use exist (Roudsari et al., 2013; Browes, 2015). All these studies contend that cultural beliefs have an impact on young people's perceptions of and desire to seek sexual health services, particularly in rural areas where cultural traditions are still prevalent. What effect do sociocultural values have on young

people's use of sexual health and reproduction services in rural South Africa, then, is a crucial question. This study provides a chance to explore this issue.

2.2.4 Belief that infections are inevitable

The way that young people view sexual and reproductive health services varies. Madlala (2010) demonstrated that HIV infection is on the rise, particularly among young individuals under the age of 25, using data from study conducted among young people in Kwa-Zulu Natal, South Africa. Youth in Zulu townships have formed a cultural tendency in which they no longer get tested for diseases, even if they suspect they are sick, since HIV infection has become regarded as a new and unavoidable aspect of growing up in townships due to persistent political violence and high crime. However, they make the decision to infect others without their knowledge. Additionally, young people under 25 thought that infections were unavoidable and that it was pointless to put the lessons learned from sex education into reality (Madlala, 2010). As a result, the rate of HIV infection in rural South Africa continues to rise.

The following myths were uncovered by Bogart, Skinner, Weinhardt, Glasman, Sitzler, Toefy, and Kalichman in their 2011 investigation into HIV/AIDS myths in South Africa: Black South Africans believe that HIV/AIDS was created by white people to lower the population of black Africans and that it was caused by supernatural powers or witchcraft in the community. Additionally, they think that HIV education will encourage young people to engage in risky sexual conduct at a young age.

As a result, among those who hold these false beliefs, the use of sexual health treatments is extremely low. In fact, if these misunderstandings are accurate, obtaining a STI is unavoidable, and efforts to dispel them would be ineffective. However, the crisis and misunderstandings spurred researchers and healthcare specialists to develop strategies for altering public attitudes and behaviours (Bogart, 2011). Using this as a foundation, the analyses employed in this study may help debunk any preconceived notions people may have regarding STDs.

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

While youth generally have decent health compared to other age groups, they do confront certain health concerns that could have long-term effects beyond their current situation. According to estimates and data, youth illness and mortality account for a significant share of the disease's overall impact, necessitating special attention (Chandra-Mouli, Svanemyr, Amin, Fogstad, Say, Girard & Temmerman 2015a: S2).

The shortage of youth-friendly services and health products, as well as youths' inadequate, inaccurate, or complete lack of knowledge and information about safe sex and contraceptive usage, make the youth, who are primarily likely to be vulnerable to poor SRH, even more at risk (Chandra-Mouli et al 2015a: S3). In addition to dealing with the challenges that young people experience as they mature, they also must deal with issues like teenage pregnancy, gender-based violence, and HIV/AIDS. The difficulty in accessing ASRH information and services makes these problems worse (Dlamini et al., 2017b:2). The difficulties and impediments that limited access to ASRH services creates, as discovered by studies carried out globally and in the sub-Saharan region, are listed below.

2.3.1 Lack of information

Lack of comprehensive and accurate SRH information may cause young people to be uninformed of their own need for SRH services, unsure of the effectiveness and safety of SRH services, and unwilling to utilise contraceptive methods. Lack of information when it comes to some SRH services and lack of knowledge with regards to where those services might be sought act as a barrier for the youth to utilise SRH services. Youth said they never went to health facilities to get SRH information, according to a Ugandan study on the SRH requirements of adolescents. Some mentioned a lack of knowledge regarding the existence of those services, while others expressed concern of receiving care in the same facilities as senior citizens and healthcare professionals of different sex (Atuyambe, Kibira, Bukenya, Muhumuza, Apolot & Mulogo 2015:6) linked this to what has been gathered from the youth who participated in this study, the same barriers seem to exist in the Mutale village where young people are still being limited to seek SRH services from their fear of being budged by older people who they are expected to consult for the services together and in the same facilities. On the same note, lack of sex education was seen as a gap among the youth.

According to Morris and Rushwan (2015:S41) a number of group of people have a huge influence on youth utilising SRH services that in most cases are close to them, the youth can be influenced by their peers, parents, family members, teachers, and health care workers. This is demonstrated by a Swaziland study on analysis of socio-cultural factors influencing use of sexual reproductive health services by young people, which found that peer and family norms significantly increased the likelihood that young people would use SRH services, with the family having 39% influence and peer influence at 28% (Dlamini et al., 2017a:5)

Godia (2012) found that among the factors preventing young people from seeking health services were a lack of knowledge about the services that were available, the cost of those services, the distance to the facility, fear, and being overly busy. The conclusion gained from this study is that it is possible to strengthen existing services, even in the most distant places, to meet the SRH concerns of young people. Young people are better able to make healthy decisions now and, in the future when they have access and can utilise services freely, accurate and relevant information, decision-making, communication, and critical thinking skills, as well as self-efficacy. As a result, they can prevent unintended pregnancies and unsafe abortions, as well as to protect themselves from other illnesses such as STDs and HIV/AIDS.

2.3.2 Lack of integration

When services that could address counselling and family planning omit HIV/STI care, there is a lack of integration. However, the SRH program run by the South African Ministry of Health offers all children, adolescents, and young people integrated SRH services, comprehensive sexuality education, and information at all levels of the health care delivery system and other relevant settings in accordance with their age and needs (Ministry of Health, 2013b:18). Young people value convenience, according to literature, and providing many services at once which saves customers time and effort. Additionally, integrating SRH services with routine medical care, gives young people some degree of privacy when requesting contraception, post-abortion care, or HIV services. Young clients could just as readily be looking for a general health service as a contraceptive technique at integrated service delivery locations. According to a 2013 study done in Uganda, integrating SRH services appeared to be more crucial for

encouraging young people to use contemporary family planning methods. The problem, though, is that customers must wait a long time.

2.3.3 Accessibility barriers

This includes the location of the SRH service provider, the level of privacy offered by the facility, and the age and gender of the clinic's employees. The cost of SRH services may discourage young people from using them since they may not be able to afford them and may not feel comfortable asking friends or family for financial assistance. In addition, the distance that SRH facilities are from where young people reside, work, or attend school, as well as their restricted access to transportation, may make it difficult for them to reach SRH service providers (Leah, 2015:14).

From the study free health care services seem to be available for many and a majority of the youth used the public facilities which do not require them to pay any amount, a small population of the youth who were part of the study used private facilities which required them to pay. Therefore, at Mutale it is safe to say the availability of free health care facility is available for all. Furthermore, there seem to be clinics that are in most cases a walking distance from most of the youth participants.

Young people in Uganda stated that when faced with issues relating to reproductive health, they seek medical assistance if the issues persist. According to the study some of the factors that were like in this study were privacy concerns, and long lines were some of them contribute to the poor health-seeking behaviour. Some male teenagers reported "nosy" medical staff who constantly interrogated them, making them feel uneasy (Atuyambe et al., 2015:7). Young people in research done in Nepal in 2012 expressed similar thoughts, stating that access to healthcare is limited by a lack of pharmaceuticals, travel time to the facility, a staffing deficit, and a lack of funding (Khanal, 2016:60)

The hours of operation in medical facilities are another issue with accessibility. Male adolescents cited the clinic's few operating hours, which coincided with school and job hours, and its unwelcoming environment in a study on voluntary medical male circumcision (VMMC) (Kaufman, Smelyanskaya, Van Lith, Mallalieu, Waxman &

Hatzold 2016:5). In the same study, a South African study was referenced in which male SRH clients reported feeling uneasy while in line alongside women and young children. The hours of operation were noted in this study of Mutale, where in the local clinics are only open for certain hours which is between 4-8 weekdays, these days, however, do not accommodate the youth who are at school to visit the facilities for any type of consultations since they are usually at schools during the opening hours.

Male youth complained that it was difficult for them to obtain condoms and other medications from general health facilities, where all adults, including parents and relatives, receive medical care, according to Atuyambe et al. (2015:5), which details complaints from young people about infrastructure that is not suited for them. Condoms are part of contraceptives that seem to be used by many of the participants who were part of the study. Furthermore, more youths expressed their concerns about finding it hard to take the contraceptives in a room full of adults at the health facility which is why most youth in Mutale resorted to taking the condoms that are places at the gate.

2.3.4 Provider and service delivery barriers

The utilisation and access of sexual and reproductive health care services by the youth is mainly influenced by the level of how their services are administered to the youth upon consultation and the friendliness of the services towards them. The same as the results that were revealed in the study at Mutale village Mbeba, Mkuye, Magembe, Yotham, Mellah and Mkuwa (2012:4), noted that negative attitude that health care providers have acts as a barrier that mostly affect young people from consulting or being comfortable with using the services. During the research it was noted that “health care workers seem to have an issue with the youth using the services since according to them they believe that as youth they are supposed to be sexually active” (Mbeba et al., 2012:4). They also took note that health care providers act as barriers in the study due to the fact that they are not comfortable giving the youth contraceptives due to the side effects that they carry.

The same study found that when delivering SRH services to young people, service workers act and feel like parents, leading to clinical evaluations of their parental

instinct. This has been shown to be the biggest access barrier for young people. Similar findings were reported in a Kenyan study on the experiences of health service professionals with the delivery of SRH services to young people (Godia, Olenja, Joyce, Lavussa, Deborah Quinney, Hofman & Broek 2013:7). This study discovered that when young people are diagnosed with an SRH issue, such as a STI, or when they need contraceptives or condoms, health professionals tend to be judgmental and easily condemn them by being harsh and giving them lectures. In addressing these barriers, Godia et al. (2013:11) suggest “the training of service providers and the upgrading of facilities are crucial initiatives to increase the uptake of SRH services by young people.”

2.4 YOUTH FRIENDLY HEALTH FACILITIES

The study by Geary, Gómez-Olive, Kahn, and Tollman (2014) on the accessibility of health care services in rural South Africa recognized department of health initiatives that are accessible and provided at both schools and medical facilities. The soul friends’ program, which encourages safe sex, and the love life program are two examples of such programs. According to Geary et al. (2014), most youth-friendly medical facilities are open seven days a week and operate around-the-clock, and all seven of the facilities under study were found to offer most reproductive and sexual health treatments needed by most young people. However, obstacles preventing kids from entering health facilities included a lack of staff, a failure to administer services, as well as a limitation of space for adolescents to access services.

According to a study by Strode and Essack (2017), health centers and clinics are the best locations to provide adolescents with information and services on sexual and reproductive health. With the help of effective programming, traditional healthcare facilities have been made more appealing to teenagers and young adults by adjusting including extending service hours, lowering fees, and modifying physical layouts to encourage privacy and secrecy. To identifying clinics or services that are "adolescent friendly," certain health care organizations have developed assessment tools. Even though youth health services are frequently provided outside of facilities, such as in schools, youth centers, public areas, and pharmacies, Strode and Essack (2017) argued that programs should always include young people in the design of youth-

friendly facilities as this helps to promote healthy sexual behaviour and health utilization. The proposed study will investigate whether and how sexual and reproductive health services now offered in Mutale village, Thulamela Municipality, Thohoyandou, have included youth in their planning and delivery in an effort to make them more accessible to young people.

2.5 SEXUAL AND REPRODUCTIVE SERVICE FOR YOUTH ARE EXPENSIVE OR INADEQUATE?

Eighty percent of the 385 women participants in a study by Lince-Deroche, Berry, Hendrickson, Sineke, Kgowedi, and Mulongo (2019:4) on the costs of obtaining comprehensive health services reported having at least one need for sexual or reproductive health in the year before the survey. According to Lince-Deroche, Berry, Hendrickson, Sineke, Kgowedi, and Mulongo (2019:5), "women spent an average of $28.34 (R384,36) on needs related to their sexual and reproductive health in the preceding year. In comparison to patients who were HIV-negative, HIV-positive women spent on sexual and reproductive health care more annually. At least one unmet need for sexual and reproductive health was mentioned by 60% of women. Only two women experienced catastrophic infertility management costs.

A national policy on sexual and reproductive health and rights was issued by the South African Department of Health in 2019; it made notice of the rising expense of healthcare, particularly in the private sector. Approximately 43% of women living in rural South African communities, teenagers, the underprivileged, and the key population were facing these costs and difficulties (Simbayi, Zuma, Zungu, Moyo & Marinda, 2019).

The Essential Package of Healthcare Services (EPHS) does not always cover important sexual reproduction and health services, such as safe abortion services and the currently limited number of reproductive facilities. Inequitable access to sexual and reproductive health care and excessive levels of out-of-pocket spending are caused by inadequate foreign and domestic public support. 2020 (Ravindran). Restrictive gender norms, gender-based inequities, and policy and legal obstacles all make it difficult to provide excellent care and access to sexual and reproductive health

services, which may result in juvenile underutilization. For instance, because it is viewed as the boy's responsibility to purchase or look for condoms, rigid sexual norms make it difficult for girls to request condoms from clinics (Ramathuba, 2013). Girls are reluctant to ask the clinic for condoms as a result. Treatments for sexual and reproductive health are therefore underutilized in clinics. In this context, the study sought to understand the variables influencing youth in Mutale village, Thulamela Municipality, Thohoyandou's utilization of sexual and reproductive health services.

2.6 KNOWLEDGE AND COGNITIVE BARRIERS

According to Thongmixay, Essink, Greeuw, Vongxay, Sychareun, and Broerse (2019), the biggest barriers preventing young people from accessing sexual and reproductive health treatments are cognitive and psychological accessibilities. Uncertainty about sexuality and a lack of resource understanding are two cognitive accessibility hurdles. A perceived barrier to psychosocial accessibility is the worry that parents will learn about visits to public sexual and reproductive health services due to a lack of confidentiality in the services and among health providers, as well as feelings of shyness and shame brought on by unfavourable cultural attitudes toward premarital sex. Inaccessibility due to geography, a lack of youth-friendly medical facilities, a lack of knowledge, and a lack of prescriptions are some additional barriers to the younger generation's utilization of reproductive and sexual health services (Lince-Deroche, Hargey, Holt & Shochet, 2015).

Although students in secondary schools in the Limpopo province of South Africa were aware of a variety of contraceptive methods for preventing conception, many did not know about emergency contraception, according to a study by Ramathuba (2013). The pressure from male partners, worry about how parents would react to contraceptive use, reluctance to use contraceptives, and inadequate contraceptive instruction and counselling were found to be the main causes of ineffective contraceptive use and non-use. Furthermore, Ramathuba, Ngambi, Khoza, and Ramakuela (2016) found that young people lacked knowledge of cervical cancer and its prevention. However, children displayed favourable attitudes regarding using the services when they were made available or when health professionals appropriately educated them about their availability. This suggests that the social environment has

an impact on how and when young people seek medical care. Given this, the goal of this study was to determine whether healthcare providers provide youth with the necessary information about available sexual and reproductive health services in an efficient and youth-friendly manner, as doing so may increase the use of these services in Mutale village, Thulamela Municipality. Participants' awareness of the available services and opinions of them being youth-friendly were evaluated using a Likert scale. Nonetheless, when services were made available or when health practitioners sufficiently informed them about the services' availability, youngsters showed positive attitudes toward using them. This points to social surroundings influencing the youth on how and when they should seek health care needs. Given this, this study sought to understand whether healthcare care professionals avail the relevant information on available sexual and reproductive health services to youth in an effective and youth-friendly way, as this has the potential to improve the utilisation of available sexual and reproductive health service at Mutale village in Thulamela Municipality. A Likert scale was used in gauging participants' knowledge of the existing services, as well as perceptions of their youth friendliness. The aim here was to determine whether lack of knowledge about existing services could also be a factor in the under-utilisation by youth in Mutale village.

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

In 1994, the Cairo-based International Conference on Population and Development (ICPD) published a strong, straightforward, and thorough definition of reproductive health. Nations were urged to provide the services and information that young people needed to deal with their sexuality healthily and responsibly (Chandra-Mouli et al., 2015a).

Projects formulation Ipas Nepal launched a project in Nepal between 2012 and 2014 to improve young women's capacity to avoid unintended pregnancies and access safe abortion services. Peer educators collaborated with healthcare institutions, and the outcomes demonstrated that young people may contribute significantly to enhancing the standard of SRH services for adolescents by collaborating with medical professionals and other adults. Additionally, the findings demonstrated that young

people can effectively educate and counsel their peers about SRH and rights, including abortion if given the necessary training and assistance (Ipas, 2015).

In Kenya, a multi-pronged approach was adopted, and the same strategy was applied. Evidence-Based Interventions (EBIs) used a variety of strategies at the same time to the same target group to address the comprehensive SRH needs of kids and have the greatest impact (Kenya Ministry of Health, 2013:7). The Ministry of Public Health in Thailand has created 350 hospitals dedicated to promoting health and improving the usability of healthcare services (Rushwan, 2015). In retail centres and neighbourhood living areas after school and college hours, a Friend Corner was established. Teen peer counsellors are the initial point of contact. Health professionals offered counselling, and basic primary care, or directed teenagers to specialty therapies. On the Friend Corner website, one may get information on music, fashion, and health. It has received recognition for providing information access in a pleasing manner (Rushwan, 2015).

The Department of Health in South Africa has also tried to introduce the soul buddies' campaign that gives the youth glimpse of what SRH education is at their schools. The campaign gives them a glimpse because its focus is on HIV/AIDS education, and according to the department data the campaign has since not been active at schools. Therefore, the South African Department of Health together with the Department of Education need to work on coming up with projects that educate the youth about SRH at a place where they are most comfortable and are most likely to be at schools.

2.7.1 Community involvement

Another strategy is community engagement, which tries to alter social norms and enhance the physical environment where young people reside. By doing this, environments that are supportive of teenagers' SRH and where they feel safe and respected are created (Plourde, Fischer, Cunningham, Brady & McCarraher, 2016:2). A program to enhance birth spacing and delay first births among married teens was established in India, and community people were involved in conversations about the health advantages of such practices. The program caused married teens to use contraceptives at significantly higher rates than before (Plourde et al., 2016).

2.7.2 Family involvement

This has been seen as a successful tactic to increase access to ASRH services. Adolescents have the chance to build meaningful relationships and contribute to better SRH outcomes through programs that improve family ties, boost association with supportive peer groups, and create safe spaces for youth to interact with peers (Plourde et al., 2016). To safeguard and advance adolescent health, parents and other domestic influences play a crucial role. As youngsters enter their teenage years, a secure family where difficult topics are openly discussed serves as a springboard for self-respect, esteem, and confident decision-making (Chalk, 2015:18). An intervention to promote parent-adolescent communication on SRH was found to have a positive impact on young people's understanding of condoms and their self-efficacy to use them in a randomised control study (Plourde et al., 2016).

2.7.3 Access to economic and academic opportunities

The outcomes of SRH were significantly influenced by good access to educational and economic opportunities. Building teenagers' financial capital can result in decreased sexual risk-taking behaviour, increased health knowledge, and enhanced service-seeking behaviour when coupled with other forms of social support and life skills (Plourde et al., 2016:2). They also indicated that lower teen pregnancy rates, fewer pregnancies, and delayed sexual debut are all related to greater rates of educational engagement.

In 2006, the WHO created the "Do not go, Steady, Ready, Go" categorisation for a number of systematic reviews on teenage HIV/AIDS, including the review on the utilisation of health services. The classification is helpful because it converts the evidence basis for various interventions into policy recommendations, according to the results. Based on the weight of the evidence, the "Do not go, Steady, Ready, Go" categorisation in the 2006 evaluation was made. It was evaluated in relation to established evidence thresholds for each type of intervention. Feasibility, risk-averse outcomes, and possible effect magnitude with widespread adoption were among the factors considered (Deno, Hoopes & Mouli, 2011).

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 RESEARCH DESIGN

To better understand the phenomenon than would be possible using simply qualitative or quantitative methods, the study used a sequenced mixed methods research design (Creswell, 2014). Although the use of a quantitative approach made it possible to collect data from a larger group of people, increasing the likelihood that the results could be generalized to a larger group of people, qualitative data helped to bring the in-depth and precise nuances required to a fuller understanding of the perceptions and knowledge from participants. As a result, it is possible to thoroughly respond to the research questions in both depth and breadth due to the strength of a mixed technique. To obtain the depth of knowledge required for qualitative research as well as more generalizable quantitative data, a mixed method design allowed for the triangulation of data types and sources (Tashakkori & Teddlie, 2010). This was accomplished by having participants provide a thorough reflection of their experiences and points of view, while the quantitative component was helpful in gathering data from a larger sample and making it possible to generalize to the research population.

To acquire information for the current study, which examined youth knowledge, perceptions, and experiences regarding their use of sexual and reproductive health services in Mutale village, Thulamela Municipality, explanatory and descriptive cross-sectional surveys were used. For a sociological study on health, a cross sectional survey is preferable since it can reduce the bias based on the researchers' attitudes, convictions, and personal impressions while producing adequate amounts of high-quality data quickly (Grove & Burns, 2012).

After the survey portion of the study was finished, semi-structured interviews were utilized to learn more about the knowledge, perceptions, and experiences of young people in Mutale village, Thulamela Municipality, regarding their use of sexual and reproductive services. The researcher had the freedom to delve deeper during semi-structured interviews to learn more about the participant's ideas and experiences

(Adams, 2005). The study sub-questions to be addressed are listed in Table 3.1 below along with the corresponding data sources and methodology.

3.2 STUDY AREA

The village of Mutale, which falls under the purview of the Thulamela Municipality, is the case area of this study. The Kruger National Park connects the Category B municipality of Thulamela with Mozambique in the south-east and Zimbabwe, Botswana, and Zimbabwe in the north-west. It is made up of the local municipalities of Collins Chabane, Musina, Thulamela, and Makhado (Limpopo District Profile, 2017). There are 497 237 people living in Thulamela Municipality overall, with 192 769 of them being young people (Community Survey, 2016). According to Statistics South Africa (2015), Tshivenda speakers make up 96,8% of the village's dominant culture. There are 2500 people living in Mutale overall, of whom 700 are youth between the ages of 15 and 24 (Limpopo District Profile, 2018).

Both Mutale village and Thulamela Municipality have several amenities that provide services to the local youth and other residents. The community health centre and Tshilidzini public hospital are the two primary public health facilities that directly serve Mutale village. According to Strasser (2003), 75% of South Africa's poor and disadvantaged people live in rural areas, where there is a high concentration of poverty, a poor standard of living, and a high burden of diseases like AIDS. Although this community has clinics and other health facilities that offer services to its residents, there are not enough studies that concentrate on how sexual and reproductive health is used, perceived, and understood in remote villages. The study's optimal setting was Mutale Village, which provides a chance to expand academic knowledge of these problems in this area.

3.3 TARGETED POPULATION AND SAMPLING

Youth between the ages of 18 and 24 (both male and female) who knew about and had used sexual and reproductive health services at Mutale community health centers were the study's target group. Because they are still too young to commit to serious

partnerships or marriage, young people between the ages of 18 and 24 are picked because this is the beginning of their sexual activity.

An equal number of youngsters from Mutale village were given self-administered questionnaires (online and in person), with the expectation that at least 100 of them would successfully complete the survey. An online sample size calculator called Raosoft was used to calculate the sample size. The estimated sample size of 700 young people living in Mutale is used to calculate the sample size of young participants, with the response rate estimated to be around 28% of the total population (Fatoki, 2010). The estimated sample size is calculated with a 5% margin of error and a 90% confidence level.

The study used non-probability sampling technique to choose appropriate individuals for both the quantitative and the qualitative components of data collection (both youth and healthcare workers). Because of this non-probability sampling, not every member of the community had an equal chance of being chosen for the sample or being included in the sample. Both snowball sampling and purposive sampling were used. To ensure that the sample is made up of elements that include the majority of features, representatives, or typical attributes of the population, purposive sampling is said to be entirely dependent on the researcher's judgment, according to Blanche, Blanche, Durrheim, and Painter (2006). As a result, the features that the study was seeking for in the adolescent participants were present. The study used non-probability sampling technique to choose appropriate individuals for both the quantitative and the qualitative components of data collection (both youth and healthcare workers). Because of this non-probability sampling, not every member of the community had an equal chance of being chosen for the sample or being included in the sample. Both snowball sampling and purposive sampling were used. To ensure that the sample is made up of elements that include most features, representatives, or typical attributes of the population, purposive sampling is said to be entirely dependent on the researcher's judgment, according to Blanche, Blanche, Durrheim, and Painter (2006). As a result, the features that the study was seeking for in the adolescent participants were present. The specific characteristics were informed by the socio-ecological theoretical framework employed in the study and included the following:

- Age (18–24-years)

- Sex (both male and female)
- Ethnic/cultural diversity
- Religious diversity
- Sexual orientation
- Level of education

In addition, snowballing sampling was used wherein participants who were sampled and agreed to participate helped to identify other potential qualifying participants.

In order to find volunteers for the study, the researcher went door-to-door and asked for young people who fit the criteria listed above (i.e., they were between the ages of 18 and 24 and had used any health care facility in the Thulamela area). The researcher next informed the household's eligible member of the study's purpose and requested their voluntarily participate. The qualified participants were given a questionnaire to complete once they had consented to participate. To provide participants time to respond as truthfully and privately as feasible, the researcher gathered it the following day for some individuals and after two days for others. A question to help recruit young people to take part in the qualitative interview was included in the questionnaire's final section. This question specifically asks if the young participants would be interested in additional interviews about the study's topic. The researcher then chose participants for a semi-structured interview based on their response to that question, using the demographic characteristics mentioned above as guidance.

An additional strategy to reaching participants that was used was google docs. An online google document youth questionnaire was created and distributed on social media platforms that a lot of youth in the village tend to access such as WhatsApp, WhatsApp groups and Facebook. In cases where the researcher had email addresses, some questionnaires were distributed through personal emails address to access as many participants as possible within a short space of time to collect the required data.

For qualitative component of data collection, eight 24-28 years old youth (purposefully sampled based on sex) were interviewed in this study. As previously mentioned, participants were enlisted during the administration of the survey by being asked if they would be interested in additional interviews. To gain a thorough understanding of

their knowledge and experiences on how youth use their services, at least four healthcare professionals who have been providing sexual and reproductive health services in these facilities for at least a year two of each sex were interviewed. Male and female youth were included in the study. The precise number of participants needed to gather qualitative data was determined by the researcher's perception of data saturation. This meant that there was no need to interview more participants for the research

As already indicated, purposive sampling was also used in identifying the four health care workers to be interviewed in this study. Four healthcare professionals who have been working in Mutale for at least a year and are actively involved in the technical and professional delivery of sexual and reproductive health services were particularly sampled by the researcher. This was to ensure that they can offer their insights based on some level of accumulated experiences. The health care professionals were accessed at specific clinics and hospitals; however, they were interviewed at the comfort of their homes since the researcher knew them. They were from the same community which made it easy to collect data faster compared to going through the health care administrators which was the initial plan. Data were only collected from health care workers only with their full consent and at times it was most convenient for that specific health care worker because most of them the time was during their off days or after their shifts.

3.4 DATA COLLECTION INSTRUMENTS

The socio-ecological approach, which acknowledges a variety of factors impacting health behaviours, was used in the study. This indicates that a variety of factors, including those related to an individual, an interpersonal relationship, a community, a public policy, and an organization, can affect a person's health results. A self-administered questionnaire and semi-structured interviews were the specific data gathering tools.

3.4.1 Self-Administered Questionnaires

The instruments utilized to collect data on individual, interpersonal, communal, and socio-cultural aspects were a self-administered questionnaire and semi-structured interviews (see appendices 3, 4 and 5). Both open-ended and closed-ended items were included in the self-administered surveys. Self-administered questionnaires were favoured since they made it possible for quick data collection from a variety of people and saved the researcher both time and money (Bausewein, Jolley, Reilly, Lobo, Kelly, Bellas, Madan, Panell, Brink, De Biase, & Gao, 2012). Due to the sensitivity of the topic and the fact that not everyone is comfortable discussing their sexual and reproductive health with others, a self-administered questionnaire was ideal.

An acceptable time to collect the completed questionnaire from the participants was decided upon when the individual received the self-administered questionnaire. Participants could complete the questionnaire at their own convenience thanks to this manner. This questionnaire's recruitment of possible participants for the youth qualitative interviews was another function. In this regard, the final questionnaire question asked young respondents if they would be open to more project-related interviews. Data collection from the participants took place over the course of 5–6 weeks (immediately upon receipt of the university's ethical approval).

3.4.2 Semi-structured interviews

Semi-structured interviews with both health professionals and young people were used for the qualitative portion of data gathering. The inclusion criteria for the medical professionals were those who were actively involved in meeting patients' requirements for sexual and reproductive health care at the medical institutions daily. They should ideally be medical experts who had been employed at the facilities for a longer period since they had access to superior historical data and knowledge about the delivery of health services and how they believed young people behaved.

to identify the young people who agreed to take part in the semi-structured interview that was made just for them. A chance to identify those individuals was provided by the self-administered questionnaire at the conclusion, which allowed participants to offer their names and contact information to get in touch with them (see appendices

3). After determining which candidates were available for the interview, a convenient time and location were chosen.

For this, a set of interview questions, namely questions two and three from the interview guide, were used to address the study's research topics. To guarantee the accuracy of the data collection, interviews were audio recorded with the participants' permission. The researcher made sure to take field notes and record any significant information given by the participants while conducting the interviews. This made it easier to verify the data that had been recorded on audio.

3.4.3 Research questions

Table 3.1: Research questions matched with data collection instruments

Research questions	Data collection instruments
1. What are the youths' knowledge, perceptions, and experiences in their utilisation of existing sexual reproductive health services at Mutale village in Thulamela Municipality?	Questionnaires targeted at the youth Semi-structured interview with the youth and health care professionals
2. What are the factors influencing youths' utilisation of available sexual and reproductive health service in Thulamela Municipality?	Questionnaires targeted at the youth Semi-structured interviews with health professionals and the youth.
3. How youth friendly are the sexual reproductive health services in Mutale village, Thulamela Municipality?	Questionnaires targeted at the youth Semi-structured interviews with health professionals and the youth.

Questionnaire with both open-ended and close-ended questions was used to collect data from the youth. While semi-structured interviews were used to collect qualitative data from five selected health care professionals who are responsible for the provision

of youth services at health centres. The researcher interviewed further eight youth. The qualitative interviews relied on the point at which the researcher felt that data reached saturation.

3.5 DATA ANALYSIS

Through a procedure that involved information synthesis, reducing, organizing, and analysis, quantitative data were statistically analyzed (Bausewein, 2012). Data analysis involved making assessments about it, presenting information in tables, figures, and illustrations, and drawing clear conclusions. The data analysis was done using SPSS version 19.0, which stands for Statistical Package for Social Sciences. To analyze data trends, descriptive analysis of frequency, mean, and average was utilized. In this analysis, particular focus was placed on demographic factors (gender, ethnicity, educational attainment, religious affiliation, and sexual orientation) to ascertain whether they had an impact on knowledge, experiences, and views. To demonstrate patterns and the significance of differences in knowledge, perceptions, and experiences of youth regarding their use of sexual and reproductive health services in Mutale Village, data were then displayed in tables, graphs, and pie charts.

Thematic content analysis was used to conduct a qualitative study of the interview data. Qualitative data analysis looks at people's perceptions, attitudes, understanding, knowledge, beliefs, feelings, and experiences to determine how they interpret an event. Maree (2012). (2012). The researcher carefully listened to and typed out the transcripts of the recorded interview talks after consulting Henning, van Rensburg, and Smit (2004:187). Then, the researcher's field notes from the interview conversations were matched to the transcripted data. The themes needed to be created next. This was accomplished by carefully analyzing the transcripts to identify patterns in the participants' opinions, which the researcher then organized into themes and sub-themes. The researcher was able to derive conclusions and study findings from the identified themes and subthemes from the data that had been gathered.

3.6 VALIDITY AND RELIABILITY

3.6.1 Validity

The degree to which an instrument measures what it purports to measure is known as validity, according to Creswell (2014). Validity was assessed in this study using both content validity and face validity. The phrase "facial validity" refers to whether the exam seems to measure what it claims to be taken at face value (Babbie & Mouton, 2010). To ensure that the questionnaire measures what it is intended to measure namely, youths' knowledge, perceptions, and experiences using sexual and reproductive health services in Mutale Village the researcher made sure that the questionnaire's questions asked what they were intended to measure.

Content validity is the degree to which the test items accurately reflect the entire domain that the test is intended to assess (Babbie and Mouton, 2010). To ensure that the instrument accurately assesses all the information that it is intended to measure, the researcher evaluated content validity. The researcher examined the instrument's components to the research goals and theoretical framework to guarantee congruence. Furthermore, the researcher ensured content validity by piloting and pretesting the study methods and analyses. This helped assess the questions' applicability and validity.

3.6.2 Reliability

According to Polit and Hungler (2008), the three key elements that affect an instrument's reliability are internal coherence, equivalence, and stability. The consistency with which the same results are delivered over time by an instrument is referred to as its dependability. Because it is appropriate for measuring the reliability, or internal consistency, of a group of scale or test items, especially those in a Likert scale, such as those in my research questionnaire, Cronbach's alpha was used to determine reliability in this study (Babbie & Mouton, 2010). This was accomplished by analyzing the variance of the final score as well as the average covariance between item pairings (Babbie & Mouton, 2010). To determine whether the questions in this questionnaire accurately measure the same hidden variable (youth knowledge, perceptions, and experiences), a Cronbach's alpha was run on a sample size of 20 youth. This was done because some questions on the questionnaire have a 5-point

Likert item ranging from "strongly disagree" to "strongly agree." As a result, on a certain set of the questions, internal consistency was attained, and reliability ensued.

3.7 ETHICAL CONSIDERATIONS

Any researcher conducting a study should follow ethical guidelines (Leedy & Ormrod, 2005). When it comes to ethics, it's frequently a matter of whether everyone in a group of people agrees to follow the code of conduct for a certain profession or group (Babbie & Mouton, 2010). In performing this study, the researcher abided by the following ethical principles: informed permission, privacy, secrecy, beneficence, non-malfeasance, respect, fairness, and reflexivity. These are explained in detail below:

3.7.1 Beneficence and non-malfeasance

Gostin (2014) argues that beneficence (do good) and non-maleficence (do no harm) are complementary ethical principles that impose positive obligations on researchers to maximize any benefits for subjects while minimizing any risks. Therefore, researchers need to do more than just respect people's decisions. The researcher took care to avoid putting participants in danger by watching out for any potential risks they might face because of taking part in the study. The researcher achieved this by withholding the names of the participants. By respecting those who might not feel comfortable participating in the study and respecting and protecting the wishes of those who would, the researcher also made sure that socio-cultural factors such as religious practices and beliefs, reputations, and ethnic values that affect thoughts, feelings, and behaviours of individuals are taken into consideration.

Although not stated directly, individuals may obtain knowledge about sexual and reproductive health care by taking part in the study. Additionally, the results may contribute to understanding about how Mutale village residents use sexual and reproductive health services as well as recommendations to enhance them for the benefit of youth. Debriefing was crucial in letting participants know about the advantages of being properly informed about sexual and reproductive health services. This was carried out either at the end of the interviews or when the researcher collected the field surveys.

3.7.2 Respect to participants and informed consent

The researcher requested informed permission by fully disclosing the study's aim, the procedures involved in gathering data, and the potential outcomes to participants to assure their respect (Blanche et al., 2006). The individual was given the option to decline participation without repercussions from the researcher. The researcher also let the participants know that they had the freedom to withdraw at any moment and the right to refuse to answer any question that would make them feel uncomfortable. Without interfering, the researcher respected the participant's decisions and choices. The researcher also avoided making snap judgments about individuals based on what they told me while data was being collected.

3.7.3 Privacy, anonymity and confidentiality

Data collection and analysis were done using codes (pseudo names), not real names, to protect people's privacy, identity, and confidentiality. Based on Wiles, Bengry-Howell, Crow, and Nind's (2013) investigation, the researcher did not record participant identities in any way. Participants' names were kept secret from outsiders thanks to anonymity. The original data were secured with a password. After five years have passed after the study's conclusion, the original data will be destroyed. The right to decide when, how much, and in general which conditions personal information may be disclosed to others was defined as privacy and secrecy (Burns & Grove, 2010). It was ensured by keeping to myself any information that should not be shared with third parties, as well as the use of pseudonyms.

3.8 DATA MANAGEMENT

The filled questionnaires were collected from participants using an envelope as a way of maintaining confidentiality and protecting participants to not feel like their identities are being exposed to the researcher. As already indicated above, data were captured in an anonymised manner in password protected data files. The physical data questionnaires are now stored in a safe place under the lock and key by the researcher and would be destroyed after ensuring correct capture and analysis.

The data collected from participants using google docs is now saved under an encrypted file by the researcher as a way of insuring that the data do not get lost or exposed to other people thus infringing the participant's confidentiality.

3.8.1 Reflexivity and positionality

The researcher resides in Mutale where this study was conducted. The researcher acknowledges that beliefs, experiences, assumptions, and my relationship with participants can may somehow have influenced the study, especially the interpretation of the results (Renz, Carrington & Badger, 2018). However, the researcher was reflexive of these circumstances to guide my conduct and analysis to ensure some level of objectivity in my study. The researcher tried as much as possible to rely on the literature and theoretical framework in the formulation of my study problem, objectives, questions, and the study instruments. Based on the need to maintain a distance from participants, the researcher used a mixed method, with the hope that the self-administered questionnaire would further give some room for participants to answer the questions the best way they understand them. Furthermore, since the study is of sensitive nature, collecting data through google docs allowed participants to be more open and truthful since the researcher was there and therefore did not influence the participant's response in any way. Sharing the questionnaire online was advantageous in savings such us cutting down on printing copies of the questionnaires for participants.

Going forward, the researcher asked questions, especially in the semi-structured interviews without allowing her own beliefs and experiences of what is wrong or right clouding this exercise. This means that the researcher did not try to interject on any participant even when an opinion they offered was factually incorrect problematic. To further avoid refrain from bias, the researcher jotted notes about participants' comments and researcher's thoughts during the interview for proper reflection into subjectivity issues at a later stage, followed by memoing the identified concepts. The researcher also developed and continually edited the subjectivity statement to reduce as much bias as possible. At the analysis level, the researcher was guided by what the data entail. The data was therefore collected and interpreted as it was. The

researcher did also debrief participants at the end of data collection to ensure that the project can also contribute to knowledge development for participants.

3.9 COVID-19 CONTINGENCY PLAN

The Covid-19 pandemic specific safety protocols were observed during the data collection process. For example, to administer the questionnaire to the participants, the researcher followed COVID-19 rules protocols such as hand sanitising self and participants. Wearing of masks and social distancing was always observed when the questionnaire was being administered. This was done to protect the participants and the researcher as well as to prevent infection or the spread of COVID-19.

In cases where physical contract was not possible during data collection, the researcher enquired that participant's cell phone numbers, and schedule telephonic interviews or if possible, distribute some questionnaire through emails, Facebook, and a WhatsApp. Specifically, as a way of reducing the spread of the virus, Google docs was used with the hope that most of the youth may opt to use it from the convenience of their home. This meant that the researcher would not visit 196 households for the data, thus reducing the number of people to be interacting and reduced the chances of spreading the corona virus. Since Mutale village is a developing area, most of the youth have access to the internet then documents were sent out on WhatsApp group, individuals, Facebook as well as through emails.

3.10 DELIMITATIONS OF THE STUDY

Due to the short study duration, only 196 people were included in the sample for this study, which was carried out under the auspices of the Thulamela Municipality. The participants did not accurately represent the young in Mutale community. The results of this study were therefore extrapolated to the youth population of Mutale village. Although the findings might not apply to other regions, they nonetheless provide pertinent information about the sexual and reproductive health treatments provided to young people in a rural setting. For the participants to be honest while providing information, the study was only conducted with youths that the researcher did not know. Language barrier seemed to be an issue for some participants since the

questionnaire was presented in English and most people who reside there are Tshivenda and Xitsonga speakers. In such cases the researcher translated where participants were seemed not to understand.

CHAPTER 4: PRESENTATION AND ANALYSIS OF FINDINGS

4.1 INTRODUCTION

This chapter presents the empirical findings of the study conducted with youth in Mutale. As discussed in the previous chapter, the primary data was collected through questionnaires as well as semi-structured interviews. The results are presented thematically focusing on the research objectives and themes from the data. The themes used are based on the ways in which they resonated with the objectives of the study. Themes thus focus on young people's knowledge, perceptions, and experiences with SRH services in relation to the ways in which they utilise the SRH services in Mutale. Therefore, the findings will be discussed in this chapter under the following subheadings:

- Youths' knowledge and perceptions on sexual and reproductive health care at Mutale village.
- The experiences of youth with SRH Institutions and services at Mutale village.
- Factors that hinder young people's utilisation of SRH services at Mutale village.
- Strategies used by young people to access SRH services at Mutale village.

The themes developed were meant to present information that captures the everyday realities regarding young people's knowledge, perceptions, and experience in the utilisation of sexual and reproductive health services at Mutale village. These themes directly address the key objectives of the study.

The following section describes the demographic characteristics of all the participants, and this is done through summarised tables and figures. This is important to capture the nature of the participants and how demographics tend to influence young people's access to and utilisation of SRH in Mutale.

4.2 DEMOGRAPHIC DATA

Data were collected through a questionnaire which was administered to a targeted number of youth as well as through semi-structured interviews with the youth and

health care professionals in Mutale village. Data were transcribed and coded, after being captured on an Excel spreadsheet, and analysed, using SPSS version 25.0 software. This section of the chapter starts with a detailed description of the study sample's demographics.

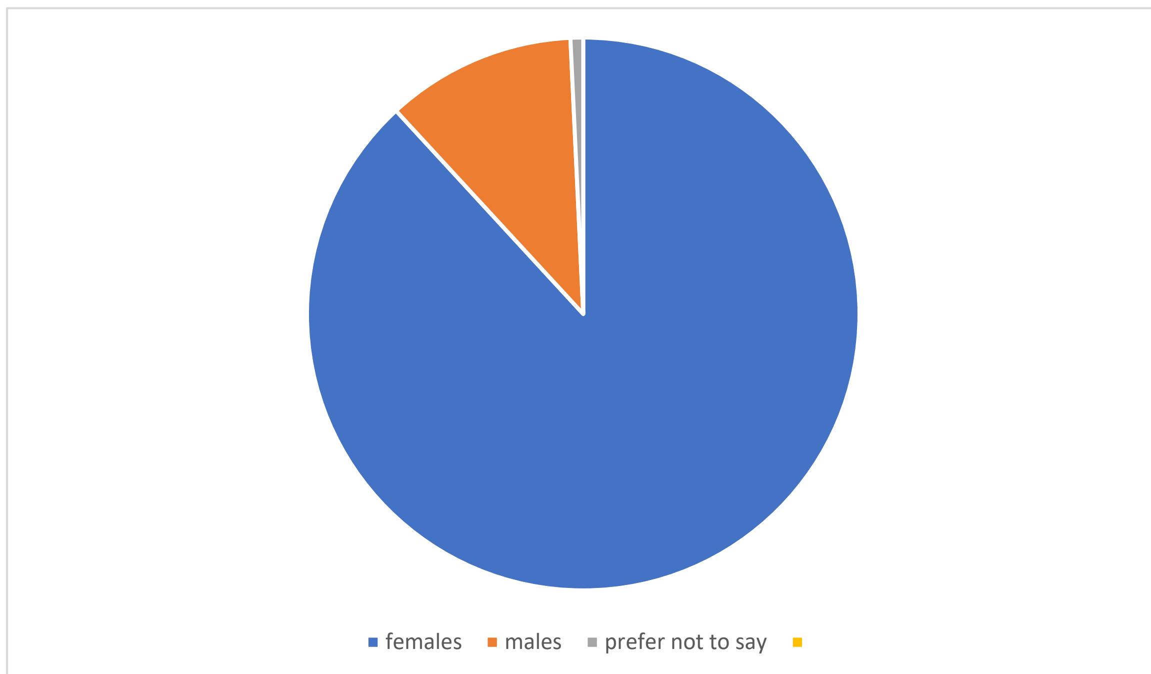
The total sample according to the Limpopo District profile (2018), the Mutale remote village is estimated to have seven hundred (700) youth aged 15 to 24 years. The self-administered questionnaire was intended to reach at least 100 youths from across the village. From the Google questionnaire document that was shared, there were 126 responses and out of those 126 (13 male and 113 females), one person preferred not to disclose their gender. Out of that population, 19 people stated that they never accessed sexual and reproductive health care services which automatically disqualified them from taking part in the study. Therefore, after analysing the responses only 105 questionnaire responses were usable from the 126 that were submitted. A few male participants (13) were comfortable in participating in this study as compared to a relatively huge number of female participants (113). This might be due to the gender of the researcher or the sensitive nature of the topic of this study.

Apart from the completed online questionnaire, another form of collecting primary data that was going door to door and hand delivering questionnaires to suitable participants. The researcher managed to distribute 30 questionnaires around the village to people who are within the selection criteria. Of those that the researcher distributed, 9 were returned and were all usable of which 7 of those were females and 2 were from male participants.

4.2.1 Gender composition of respondents

The figure below shows a graphical representation of the gender of participants who participated in the study. The study shows that many female respondents took part in the questionnaires compared to males. The total number of responses gathered from both the google docs and door-to-door questionnaires was 126. There were 15 male participants in the study which constituted 11% of the total population. Females dominated with 119 responses (88%).

Although there was a high response rate, the researcher only analysed 100 responses to highlight and describe young people's access to and use of reproductive health services. This means that since there were only 15 male responses and one of them was not usable since the individual has never accessed the services, all the 14 remaining male participants were considered and analysed for the study. When it comes to females the first 86 responses were considered (80 from google Docs and 6 returned face-to-face questionnaires) to make 100 participants as the total demographic that was analysed for the study.

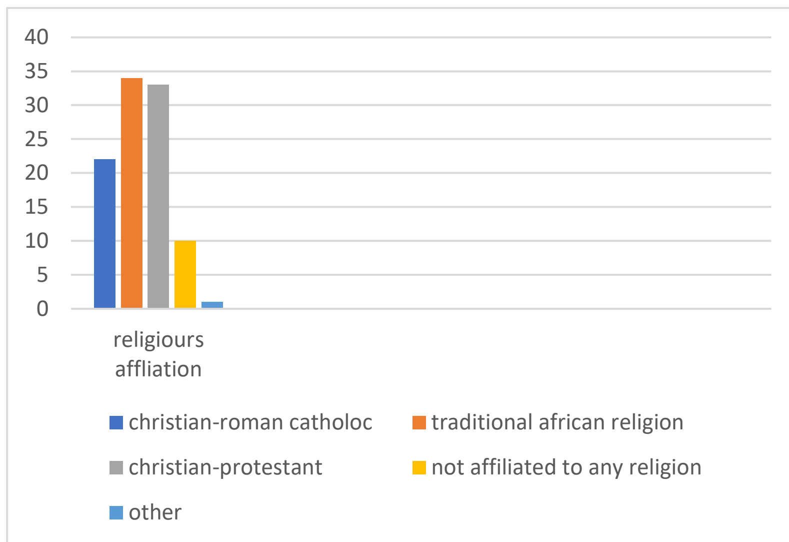


Gender composition of respondents

4.2.2 Religious affiliation

Participants' religious affiliation was significant to the study as there is clear evidence to show that that one's religious beliefs play an important role when it comes to young people's perceptions on and access to as well as utilisation of sexual and reproductive health care services at Mutale village. Although there were youth participants who did not want to be associated with any religion (10%), most youth respondents were of traditional African beliefs, at 34%. Other religious affiliations that participants belonged to include the Christian Roman-Catholic (22%), Christian Protestant (33%) and those that identified themselves as 'Other' at 1%. Those whose religions were not included

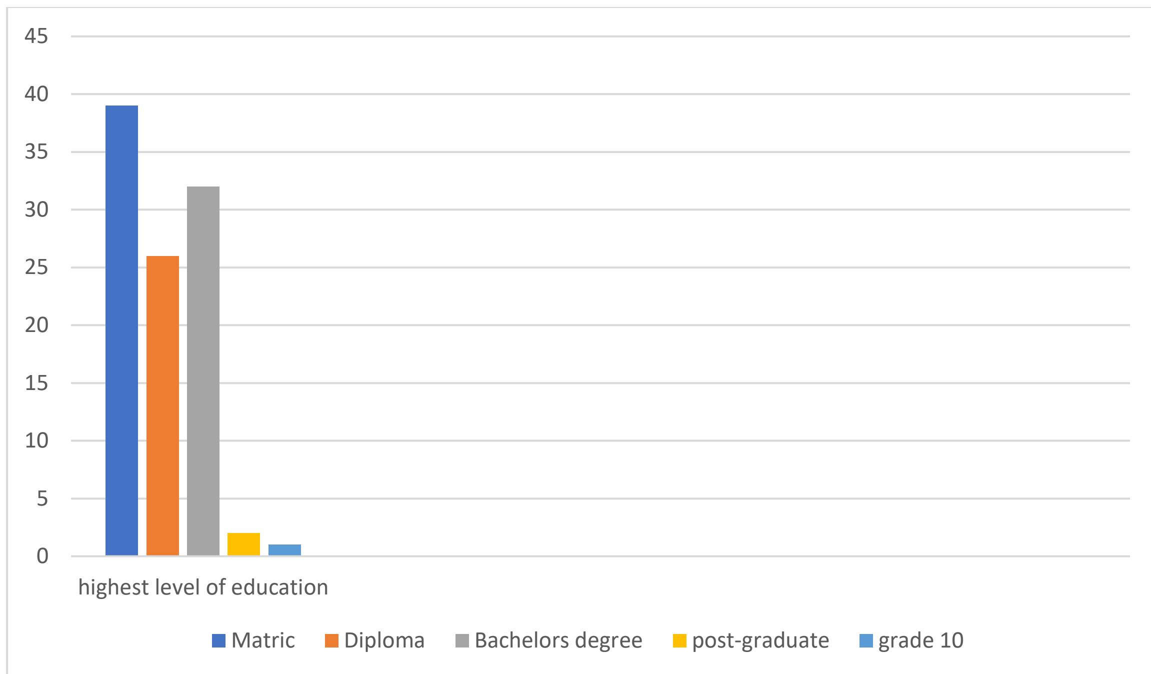
in the questionnaire indicated filled out that they identify as Christians, who are herein counted amongst Christian protestants.



Religious affiliation

4.2.3 Education levels of participants

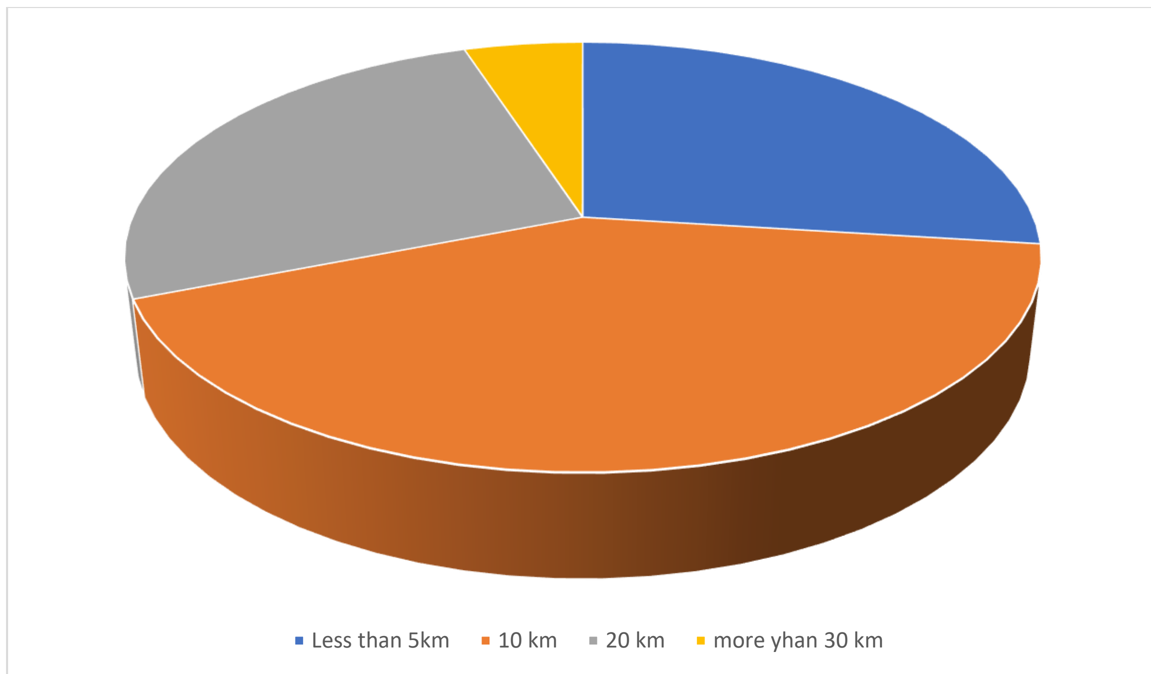
The level of education in the study was meant to give an idea of the type of academic background that most of the youth possess and how it may influence their perceptions on and utilisation of reproductive health services. Which in some cases might have an impact on the level of understanding when it comes to the knowledge of sexual and reproductive services. From what was collected from the youth, 39% of the participant's highest level of education was matric level followed by those with bachelor's degrees who at 32% and then those with diploma at 26%. Lastly, 2% of the participants possessed postgraduate qualifications. The lowest, at 1% of the population, indicated to have grade 10 as the highest education level. The researcher did not come across any participant without any education at all. As such, it can be assumed that the population was somewhat highly participates in education. Furthermore, it can be deduced from this finding that the higher the education level, the higher the chance of using SHRH services, and less chance if otherwise.



Higher Education level

4.2.4 Distance to the nearest healthcare centre

The researcher was interested in finding out the distance to the nearest health care facility which can impact youth accessing the reproductive healthcare services. The empirical data drawn from the participants revealed that many people walked long distances to the nearest healthcare centre. About 42% of the youth walked a 10km distance from their home to the nearest clinic/hospital, 26% with a 20km distance, and 5% with a 30km distance. Only 27% of them indicated that they have less than 5km of distance when traveling to the facilities for SRH services. Consequently, it is important to highlight that this had an impact on young people's access to SRH in Mutale. Many of them highlighted that they could not afford to walk long distances neither did they have the money for public transport. Therefore, some noted that they only go to seek medication when they have a critical illness.



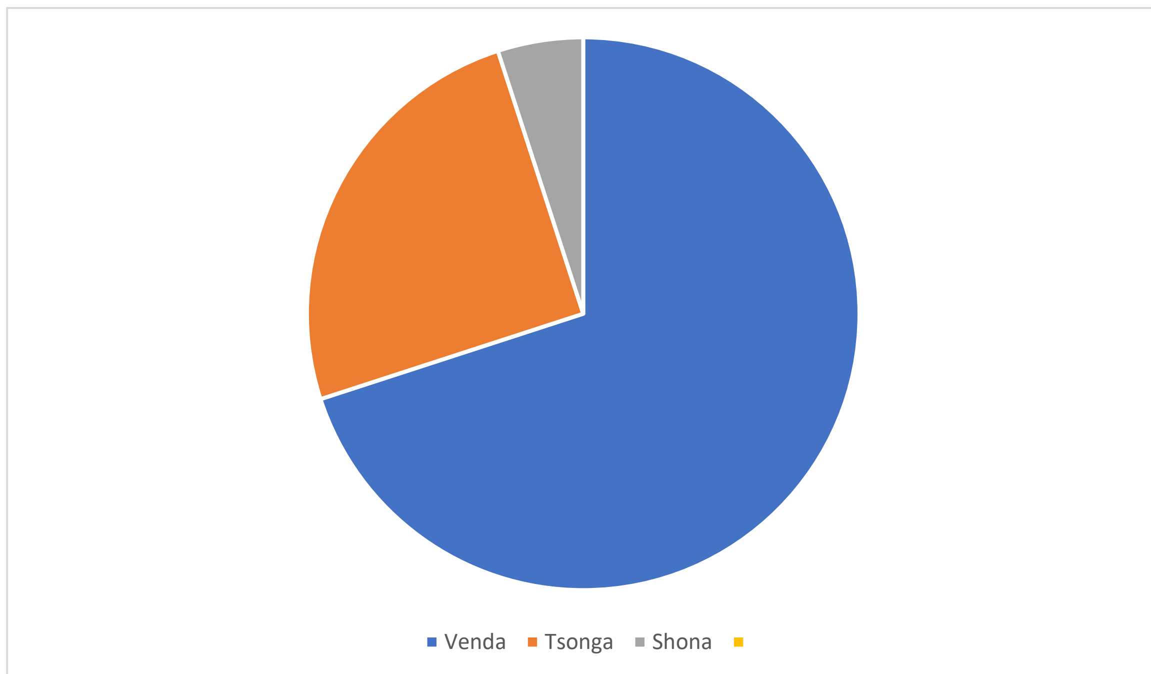
Distance to the nearest healthcare centre

4.2.5 Ethnic group

There are different ethnic groups that live within the village of Mutale. As such, this ethnic diversity needed to be captured as different cultural norms and beliefs exist within them and some of them have a bearing on people's perceptions on SHR and by extension the usage of such services. Tamang, Raynes-Greenow, McGeehan, and Black (2017) indicated that cultural shifts that exist within different cultural groups leave young people feeling trapped between the modern generation cultural ideology and what has been practiced traditionally in the olden days by the indigenous people of that culture. This seemed to be the case with many participants in Mutale village.

Looking at the area where data were collected, it was expected that the dominating ethnic group would be the Vhavenda people since they are the dominant ethnic group from that area. However, they ended up making up 70% of the population followed by the Tsongas who were 25% of the total population and the smaller population were Shonas who made up 5% of the study population. Although Shona is not a South African language, Shona speaking youth participated as they formed part of the existing population and have access to SRH and other health services. Generally, the

above ethnic sample composition is representative of the geopolitical nature of the Limpopo province.



4.3 YOUTHS' KNOWLEDGE AND PERCEPTION OF SEXUAL AND REPRODUCTIVE HEALTH CARE

4.3.1 *Knowledge of SRH*

Knowledge is said to be an essential (though not in itself sufficient) component for young people to be able to take action to protect their sexual health and in this case accessing and making use of SRH services. The educational system plays a major role in creating that knowledge about sexual and reproductive health (Langille 2000:18). In Mutale, knowledge about SRH is acquired from a variety of sources including family, peers, schools, churches and Non-Governmental Organisations among other institutions.

Adequate and accurate knowledge is important for the youth when it comes to sexual and reproductive health care services because of its significant impact on sexual decision-making, and sexual behaviour. It emerged in the study that most of the youth acquired SRH knowledge through sex education in school, friends, parents, extended family, local organisations (including healthcare clinics), and the mass media.

During the interviews 4 (one male and 3 females) participants mentioned that they acquired their knowledge concerning SRH through the “Soul buddies” awareness campaign, which “work with children and adults to create a platform that gives voice to and promotes real action for children’s health and wellbeing” (Soul City Institute for Social Justice, 2019: online). The campaign exists at high schools, wherein they were taught about safe sex and different contraceptives methods that they can use. One participant noted the “soul buddy’’ group taught about young people’s health and mainly preventing the spread of HIV/AIDS.

According to the data that was collected by means of interviews, young people showed that they do have extensive knowledge of what SRH services are and their importance. In addition, they also demonstrated understanding of where these services can be accessed. With regards to knowledge on SRH, four of the participants defined SRH service in the same way and according to them SRH services are:

P1: *“Services provided in a hospital, clinic relating to reproduction.”*

P3: *“Being helped with anything that has to do with reproduction such as when seeking contraceptives.”*

P6: *“Those services relating to the reproductive health offered in hospitals.”*

P8: *“Any service relating to reproductive that is offered by health practitioners.”*

During the data collection process, it was observed that most of the participants who were aware of what SRH is had an educational background and were taught about SRH from a very young age through their high school educational activities such as dramas and awareness group campaigns. Some of the participants had more knowledge on contraceptives use. For instance, two participants talked about the morning-after pill and the condoms to which they have access through health facilities and sometimes local schools. Some participants noted that condoms are placed in school toilets for people to access them easily and confidentially. For some of the participants this has helped to reduce teenage and unplanned pregnancies as well as other sexually transmitted diseases.

4.3.2 Youth perceptions of sexual and reproductive services

This section of the dissertation presents young people's perceptions on sexual and reproductive health. These perceptions often mediate young people's usage of reproductive services. In this case, some participants expressed that the use of contraceptive pills is harmful for women's reproduction, as they have long-term side effects such as infertility. A scoping review of fear of infertility in Africa in 2020 discovered 15 qualitative studies that claimed contraception causes infertility (Boivin, Carrier, Zulu, et al., 2020). According to research, both men and women believed that contraception remained in the body and blocked blood flow, and that it could cause structural damage to a woman's reproductive organs (Sedlander, Bingenheimer & Lahiri, 2021). This belief is not only present but also deeply ingrained in the minds of some young people. According to Williamson's et al. (2012), systematic review on barriers to contraceptive use among young people in low-to-middle income countries, the belief that contraceptive use would cause infertility was the most cited reason for non-use of contraceptives.

The same sentiments were also noted during interviews with some of the participants having reservations on contraceptives. Three of the youth (girls) also believed that the use of contraceptives can cause infertility, the participants expressed their views as follows:

P7: *"Contraceptives have a long-term negative effect because one can end up not being able to give birth in the future."*

P5: *"Contraceptives harm your womb."*

P1: *"For injections, if you inject the family planning drug, it will flow inside your body and go to block your womb so you cannot be impregnated by a man."*

Young people's perceptions tended to be influenced by the environment and people around them. This means that society, culture, tradition as well as people's indigenous knowledge are some of the things that could influence participants' 's perception of certain reproductive health services. During the interview, on female participant, believed that contraceptives have a long-term effect that might cause her to be infertile

and ill. Although she had not experienced that before, some of her friends from school told her that some contraceptives have serious aftereffects**.**

This shows that when people around the community are misinformed about SRH services and what they entail, different perceptions might be formed which in some cases might affect young people's use of contraceptives. Indeed, such beliefs and stories left many young people less interested in some SRH services such as contraceptives. Furthermore, some participants were interested in gaining proper knowledge from the service providers because of a number of factors such religious beliefs.

According to one male participant:

> P5: *"The use of condoms reduces total pleasure for both parties and injections cause menstrual problems.''*

Besides contraceptives being viewed as a method that can cause infertility in the youth, the youth expressed that they had some problems during menstruation period such as skipping their dates. According to some of them such problems might be caused by the contraceptives that they are given at health care facilities. From the quantitative data collected, 36% of the youth who participated indicated that they had experienced menstrual problems after taking contraception. Almost all of these participants believe that these could be caused by contraceptives. A female participant indicated that:

> P3: *"Those contraceptives that we are offered at the clinic usually make me go two months without seeing my periods, which is scary because I usually think I am pregnant in most cases''.*

In a study on missing menstrual periods, Marcin (2016) noted that the pill works by introducing different hormones into a person's system, which can affect the menstrual cycle. Marcin (2016) further highlighted that some women may have lighter bleeding, and others may skip their periods entirely. An abnormal lapse in monthly menstruation is called amenorrhea. There are several other reasons why a woman might miss their

period while on birth control pills. Some of these reasons might be stress, dietary change, too much exercise, and continuous birth control pills.

Although this perception might play a huge role in explaining why the youth discontinue using contraceptives, perhaps lack of knowledge on how to use the contraceptives and when they should use them is lacking on their side. Because of lack of education and awareness of how to properly use sexual and reproductive services. Consequently, some of the youth end up viewing contraceptives and other reproductive health services as hazardous to their health and well-being. Regarding health awareness amongst young people, a systematic review study by Fatusi and Hindin (2010) highlighted common issues such as poor knowledge about sexual and reproductive health issues, myths about contraceptive methods and fear about possible side effect, poor attitude to condom and poor access.

4.4 YOUTH'S EXPERIENCES WITH SRH INSTITUTIONS AT MUTALE

4.4.1 Public institutions versus private institutions

Mutale village provides both public as well as private health care institutions. The private health centres include the Mutale healthcare centre and the Tshilamba health centre, with small buildings that are only available for consultations during the day and do not accommodate nor can admit a large number of patients, the private institutions provide sexual and reproductive health which is not free. However, the facilities are far from the residential area where most community members are found which means that for one to access them, one has to use transport to get there. There are also several different doctors that have their private facilities and surgeries. The community is also provided with public health care by facilities that offer free healthcare services to the people. These facilities are available and open to the public. For instance, local clinics as well as the main hospital (Tshilidzini hospital) tend to offer healthcare services free of charge to citizens.

Throughout conversing with the youth about sexual and reproductive health care facilities, the researcher noted that most of the youth use public health care facilities for their SRH services. This is largely because they offered healthcare services free

of charge and they are also accommodating many people from all walks of life. Although most participants relied on public healthcare, there were few who noted that they used private healthcare. For instance, there were 2 participants (male and female) who mentioned that they consult their family doctors. Although this might be an issue of preference, it is important to note that the Mutale village in Limpopo is a largely impoverished and most of the people are underprivileged and can hardly afford fees for private healthcare. Interestingly, the Mutale village is still having issues such as service delivery challenges and poverty which also hinders access to healthcare in the community especially the youths. This means that affording private health care services is a hug challenge. For some, reproductive health is not viewed as a priority unless under critical circumstances. For the youth in Mutale, public clinics and hospitals that do not require them to pay any fee are the only option. A female participant who has access to a private health care institution shared the following about her experience:

> P7: *"I usually do not encounter any problems when consulting with my doctor about the availability of medication because he always has the medications with him, however, the only issue is that it is expensive."*

Unlike the above participant who is seemingly from an affluent background as she can afford a private doctor, most young people in Mutale expressed problems with consulting at the public health institutions, such as rude healthcare workers, long waiting periods as well as poor or lack of other healthcare services. Although the World Health Organization (WHO) recommends having a healthcare facility within a 5km radius of reach, yet patients still travel long distances to primary healthcare facilities to access services (Rampamba et al., 2018:662). Bakeera, et al. (2009:9) establishes that in some healthcare facilities where the distance standard is met, there are other challenges such as shortage of medicines, operational hours of the healthcare facilities and bad roads that deter people from accessing healthcare facilities. However, "such barriers could be experienced due to the number of people who seek help at the facility which in most cases is always full and the staff is usually short" (Rampamba et al., 2017:645).

4.4.2 STI services

STIs can create major health problems if they are not detected and treated promptly. If not treated early, some STIs can reduce the likelihood of having children in the future. Some of the interviewed youths were aware that STI services are provided at the local clinic and 78% of them agreed that they have been assisted with STI services at the local public hospital.

From the quantitative data, 49% of the participants agreed that they were rendered services even when they did not bring their partners along for STI treatment, while 27% of the participants expressed that health care workers require them to come along with their partners as a prerequisite to get treated for STI. This was the norm to bring a partner for treatment after being diagnosed of STIs. As a justification, this practice allows contact tracing of potential STI patients. According to Gavin's (2019) article on Teens Health, "If you have an STD, like herpes or HIV, treatments can lower the chance of passing the infection to your partner. If you or your partner have multiple sex partners, it's important they all get tested and treated". On the same note, the Ministry of Health in Malawi (2007), on Policies On HIV/AIDS/STIs, stated that "Partner referral and treatment should be encouraged during STI management." Thus, contact tracing and health-seeking behaviour of patients was at the top of the priority list of healthcare workers in Mutale and the Limpopo region at large.

4.4.3 Availability of sexual and reproductive health counselling services for youth

During interview, young people were asked about the availability of sexual and reproductive health counselling services at the local clinics and hospitals. From the data that was collected, almost half of the youth interviewed which constitutes about 42% of the population, agreed that the facilities closest to them did not have counselling available to them. However, 32% of them agreed that some of them do have counselling facilities. Others noted that they do not know about the availability of such services at their local healthcare centres because they have never sought for them. 26% of the sample indicated being unsure about the availability of such services. The quantitative data were collected as follows:

Table 4.1: Counselling and SRH information

Variables	Frequency	Percentage
Disagree	32	32%
Not sure	26	26%
Agree	42	42%
Total	100	100%

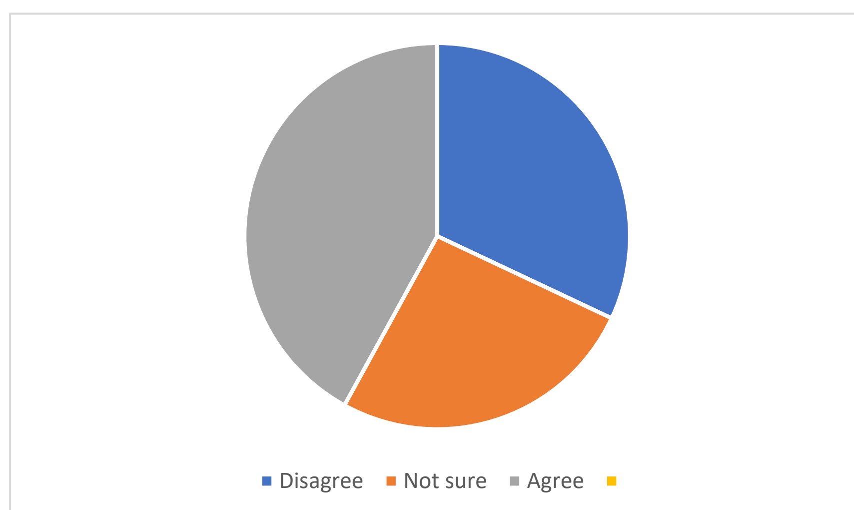


Figure 4.4: Counselling and SRH information

During the interviews, one of the participants, a health professional, indicated that the healthcare facility offers services such as prevention, diagnosis, and treatment for health conditions such HIV/AIDS, STIs, as well as other diseases that affect reproduction. Furthermore, the participant indicated that counselling is also offered in relation to these conditions. When health care providers were asked about the services available, a male nurse who works at Tshilidzini hospital indicated that:

> P2: *"We mostly provide prevention on diseases such as HIV/AIDS as well as STIs, we diagnose different diseases that affect reproduction we do counselling, as well as treatment of different diseases, and the hours of*

operating for the services, are mostly during the day since it is not an emergency and, in most cases, they are always available''.

The participant further indicated that these services are always available especially during the day. Exceptional instances, as per the participants, are when there are emergencies.

4.4.4 Pregnancy prevention services

Health care professionals explained about the services that are available for pregnancy prevention at the different facilities were the following:

- Condoms
- Injections
- Loops

From the study empirical data, it emerged that many young people were aware of some of the services and even upon consultation they are usually referred by their peers who were using them. The healthcare providers indicated contraceptive injection as one of the methods used by young people in the area to prevent pregnancy and the spread of diseases. The health care providers indicated that condoms are accessible and the most used form of pregnancy prevention among the youth, as it is possible for them to just pick a pack of them from the retainers available at the facility and leave without being noticed. One female nurse explained that:

P1: *"Because most of these services are usually used by young people without their parents knowing they don't usually prefer anything being injected into their body like the 6 months injection and I think it's because they fear the complications/side effects that could come with that injection and their parents noticing that they are sexually active''.*

The same sentiments are shared by a health care practitioner who indicated that:

P2: *"Mostly, the youth want something which they do not constantly have to return to the hospital to collect, due to the fear of their parents knowing they are having sex, which is why they might take packets of condoms and go".*

This type of data show that the youth are aware of the type of precautions that they need to take when it comes to preventing themselves from unwanted pregnancies. Many of them noted that they know the importance of using a condom, which not only prevents pregnancies but also prevents them from diseases such as HIV and AIDS, STIs, and many others. However, these services are being hindered by the lack of support or SRH related support from parents/guardians, as well as the community of Mutale. According to the HIV/AIDS Network (2014), society's attitudes play a vital role in an individual's treatment seeking behaviour, whereby the degree to which society evaluates behaviour favourably or unfavourably imposes guilt on the acting individual.

This can also be traced down to the type of beliefs that exist within a community. The Mutale village is mostly dominated by the Vhavenda ethnic group. The Vhavenda culture is very strict on issues of sexual and reproductive health, and it is taboo for the young and unmarried youth to have sex and to talk about sexual issues. In the Vhavenda culture, young girls can only get to hear discussions about sex from their elders when they are about to get married, as sex discussions with young people is considered bad influence on them. A study by Phetla, Busza, Hargreaves, et al (2008) established that "Communication between parents and young people about sex has been identified as a positive influence on young people's sexual behaviour". This eventually prevents low utilisation of SRH by people at Mutale.

4.4.5 Stigma, discrimination and name-calling

During the interviews, one of the participants indicated history of witnessing maltreatment of a care-seeking youth by a healthcare provider at one of the local health facilities around Mutale, whereby a nurse publicly humiliated the young person about her pregnancy and age, saying that she is too young for pregnancy.

P7: *"I once accompanied a friend to the clinic, and upon arrival, there was a girl who came before us and was pregnant, the nurse who was assisting the*

patients came to call the next person who was in line who was her, but she did not address her by name but was rather making fun of how she is pregnant again to all the people who were sitting in line, she furthermore went on to make fun of how many kids she will have if she has two kids at the age of 19"

Young people may experience stigma and discrimination in multiple ways, and a range of settings and circumstances. Examples of specific attributes or practices that may be stigmatised in young people about their sexual and reproductive health include being HIV-positive or having an STI, practicing pre-marital sex, falling pregnant outside of marriage, and engaging in same-sex activity. HIV+ and STIs infected individuals are secluded based on an idea that they are defiled and capable of infecting other, while young people who are sexually active as well as pregnant are regarded as unruly children (Phetla, et al., 2008) and homosexual individuals are marginalised based society's attitude towards homosexuality, that homosexuals are sexually unruly and wicked (Kennedy et al., 2013).

These different kinds of stigma may interact with each other. Thus, a person who is both pregnant and has an STI is likely to be doubly stigmatised. Different kinds of stigma are often exacerbated by existing forms of inequalities and power relations in specific settings, those related to gender, ethnicity, culture, and socio-economic status.

4.5 FACTORS THAT HINDER THE UTILISATION OF SRH SERVICES FOR YOUNG PEOPLE IN MUTALE VILLAGE

Participants viewed SRH services when inaccessible due t to the following obstacles:

4.5.1 Lack of privacy and confidentiality

One of the biggest obstacles that the youth are facing when accessing SRH services is the lack of privacy and confidentiality. Many participants revealed that some health care workers are not respecting their privacy when providing services to the youth Mutale village is a small area that is mostly occupied by families and extended families that have been living there for a long period and in most cases, those families know

each other and interact intimately. Furthermore, health care workers who are providing services are the very same people who are part of the community, and some end up divulging personal information to other community members about patient's confidential information, which eventuates in the private lives of the concerned individuals being violated, and them losing their dignity to society.

The concept of a child belonging to a community is still very much respected and something that is still being practiced and valued in the village. This will mean that elderly health care providers do view it wrong to inform parents about what services their child was seeking at the facilities.

From the semi-structured interviews 8 youths who were asked if other youths in the area use sexual and reproductive services at the clinic, five (5) indicated that the youth prefer not to use the SRH services. Some of them had the notion that youth from the area prefer not to visit the local health care system, because of lack of confidentiality between the health care officials and the patient as well as the fear of being seen by other community people. The main concerns expressed by the participants were that the consulting nurses in these facilities are fellow community members, which risks the secrecy and confidentiality of their SRH consultation information. Thus, leading to the young people bypassing nearby facilities to consult the ones far away. Participant 3, 5, and 6 responded as follows:

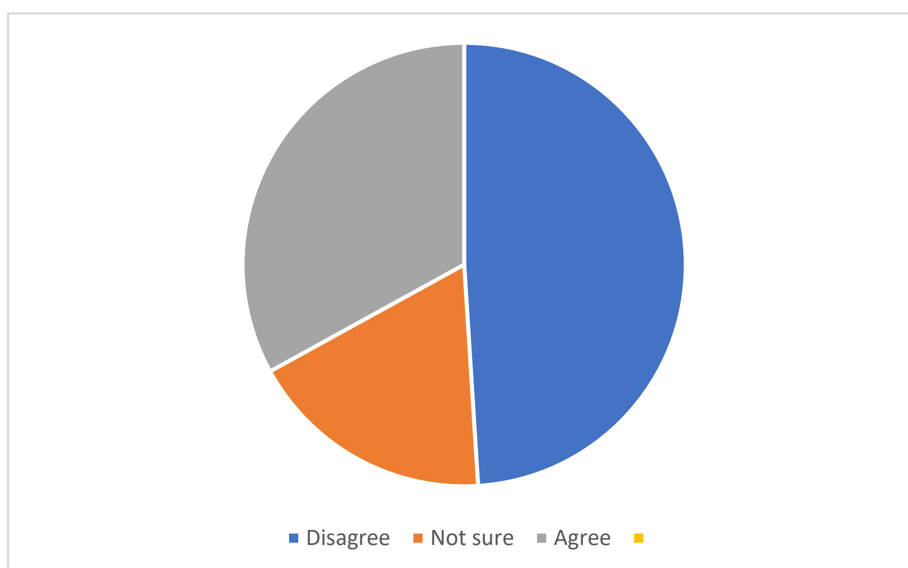
P3: *"No, most youth go to other communities to find a clinic because they fear nurses who in most cases are our neighbours and know our parents"*

P5: *"No, a lot of young people fear being talked about if they access such services by the nurses"*

P6: *"No, a lot of my neighbours/friends go for SRH at other hospitals/clinics far from home*

Lack of respect assurance for the confidentiality policy was also viewed as something that is not adhered to by data collected through the 100 youth participants almost half of the study participants who took part in the study indicated that they are not assured of their confidentiality at health care facilities, and 33% of the participants acknowledged that they were assured of their confidentiality upon consultation.

Variables	Frequency	Percentage
Disagree	33	49%
Not sure	18	18%
Agree	49	33%
Total	100	100%



Lack of privacy and confidentiality

The lack of confidentiality and privacy by the service providers ended up forcing young people to utilise other facilities that are not close to where they live due to fear of their community or family knowing that they might be sexually active or suffering from sexually related illnesses from the health care workers who are assisting them at local hospitals and clinics.

4.5.2 Health workers' negative attitude

Participants complained of health care workers' attitude. For them this negative attitude from healthcare officers affects the way young people access healthcare services. The attitude might include, not giving patients enough time to discuss their

issues but they would rather conclude for the patient without allowing them to speak, and not informing or advising the youth to adhere to some of their follow-ups at the facilities which might assist you in identifying misunderstandings, answering queries, or conducting more assessments and making therapy adjustments.

Youth participants did share some of their experience concerning the attitude of health care workers during their visits, two participants' responses were as follows:

P6: *Nurses are just rude most of the time, and I think it's not only towards us the youth, but to most people who go to the clinic seeking their services, once when I went to visit a nurse did not even want to answer some of my questions because according to her, I was "asking too much and wasting her time."*

P7: *People who work at the clinic as well as the hospital never speak to patients nicely and they always answer anyhow in a rude way, some can even go as far as threatening to not assist you if you are in the wrong line, and such mistakes do happen of being in the wrong que, since patients are divided upon consultation at the health facilities."*

According to the data from questionnaires, health care providers encourage consultation follow-ups SRH treatment. About 54% of youth agreed that follow-ups are encouraged by healthcare officers. As described in Lee, Ko, Lee, et al (2022) evaluation study of the follow-up health consultation program. Follow-up consultation is any proceeding consultation aimed at identifying the physical symptoms that remained after the first treatment, addressing any other problems associated with the condition in question, as well as offering information regarding the condition in question (Kim, Lee, Lee, et al., 2021). This demonstrates a positive attitude toward health care service providers, as motivation for further consultation is a sign of care. However, about 22% of the youth were not sure if the attitude of health workers in the facilities was negative. In addition, 24% of the youth disagreed that health care providers encouraged the youth to make follow up appointments.

4.5.3 Inaccessibility of services

Inaccessibility is the degree to which a service or environment is not available to as many people as possible. Inaccessibility can be viewed as the "inability to access" and benefit from some system or entity. Inaccessibility is not to be confused with usability, which is the extent to which a service can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use.

During the semi-structured interview, participants were asked if they believed it is vital for a young person to have access to reproductive health services. The responses showed that all respondents seem to believe that access to SRH is of significance to them. For participants 1,2,4 and 6 access for all to the service allows them to gain knowledge from health care providers on things that they were not aware of or in some cases not educated about. Responses from participants about the vitality of SRH services were collected as follows:

P1: *yes, it is an important way of promoting a healthy living*

P2: *Yes, it helps young people gain knowledge and prevent things like unwanted pregnancy/infections*

P3: *It is very much important as one can be knowledgeable this will mean that you can tackle different challenges that might arise*

P4: *Yes, it creates a safe and open environment for young people that allows them to be educated as well as wise*

P5: *Yes, it is, if I know all about SRH then I will be able to protect myself from diseases as well as unplanned babies*

P6: *Yes, it is important as it can help me do away with some of the misconceptions that society has and has instilled in young people*

P7: *Yes, for us to gain knowledge and be aware of things we didn’t know*

P8: *Yes, this allows us an equal chance to also be successful and not be limited by issues such as* having *children while we are still at school.*

All youth participants were aware of the importance of using SRH services and for most of them gaining knowledge about SRH through access to those services is what

matters most to them. The interviews established that benefits of SRH knowledge includes preventing unplanned pregnancies, self-protection from diseases, as well as unlearning SRH related misconception. According to Kim, Lee, Lee, et al (2021), health education is vital for the patient's insight of their condition.

Based on the interviews, access to health care services at Mutale village is also affected by distance, whereby patients walk long distances to the health facilities, which reduces the consultation frequency for SRH amongst young people. According to Leah (2015:14), distance between SRH facilities and where young people reside, work, or attend school, as well as their restricted access to transportation, may make it difficult for them to reach these facilities.

4.5.4 Fear of family backlash and peer ridicule

The fear of being judged by parents is the biggest factor that has been discussed and that has somehow limited the youth from accessing their nearby SRH service. Similarly, peers also play a part in whether a youth is interested in using the service. With regards to the role of peers in issues of sexual and reproductive health, 72% of the youth noted that their partners do not discourage them from accessing the services but rather they are the ones who promote the use of the services if it is available.

Peers seem to share the same sentiments with sexual partners and 58% of the surveyed participants said that as peers, they do encourage each other to use the services. When it comes to fear of peers and sexual partners, some participants mentioned that they are the ones who provide them with health-related social support compared to the elders. This simply implies that people are comfortable when they are around each other and they are aware of the importance of them accessing these services.

From the semi-structured interviews, discussions about partners influence and how it is linked to people's access or lack of access to reproductive and sexual health services), one young participant responded as follows:

P6: *“My partner is the one who encourages me to access such services since we both are still in school and are not ready for any responsibilities”*

Another participant further supported this by saying that:

P7: *“I have learned not to be influenced by anyone into doing certain things, which is why I try to make decisions on my own so that will protect me in the long run.’’*

The above information demonstrates how the youth are aware of what is right and seem to not have any fear of whether their peers or partners know if they are accessing SRH services. In this manner, social support is seen amongst young people from their peers. According to Plourde, et al., 2016:2), safe environments are created when young people receive support for SRH, as the affected feel safe, trusting and respected by significant others.

4.5.5 Young people’s lack of exposure and ignorance

Young people’s ignorance towards the necessity of SRH services can further be associated with one of the barriers that limit young people from accessing the SRH services. Ignorance was demonstrated by the unwillingness of the youth to go to health care facilities when they are sick, while they are afraid of being tested for illnesses. Instead, they would resort to self-diagnosing themselves and after they try to find an unprofessional solution to their health problems such as the use of non-prescribed traditional medicines instead of prescribed services such as SRH.

One male participant responded as follows:

P6: *“As young people who were raised by traditional parents, we do not always go to the hospital when we are sick. Some do but we are not the same, some believe in traditional medicines so they will tell you that for a certain illness you mix certain herbs to be treated.”*

This means that some youth simply ignore seeking health services due to their traditional beliefs which are mostly fuelled by societal beliefs surrounding SRH

consultation and sexual issues. As already highlighted in the geographic demonstration people who participated in the study are from the local village and many of them are those who believe in traditional and conservative practices such as self-cure.

Although the participants knew about SRH services, they viewed these services as meant for adults, and not for young people.

One participant expressed her views as follows:

> P1: "*I think the stigma that the community has attached to these services, is that the services are thought to be for adults only, thus we young people are afraid of being judged for seeking this service."*

Similar findings were presented in Vanuatu where adolescents perceived SRH services to be meant for married people only, not adolescents (Kennedy et al., 2013:7). Thus, young people distance themselves from SRH related services with an idea that it does not concern them.

One male youth participant from this study shared the same sentiments and his views were as follows:

> P2 *"The youth in Mutale somehow live in their world; we feel that illness is for old people, not us because we are young, we also think like adults are the ones who are supposed to receive contraceptives and not us because we are still at school."*

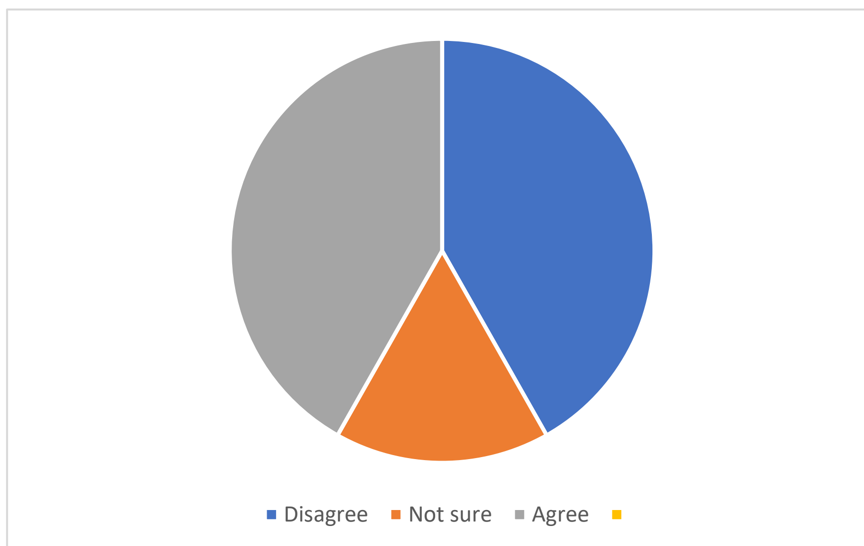
Ignorance was also associated with the lack of awareness about the various services provided at the nearest facilities. Two participants (male and female) shared the same sentiments on what they think should be done to improve the reproductive health services offered in local health care services and the participants noted awareness level as a factor that needs to not be ignored but rather promoted by both the community and health department as a way of encouraging the use of the services by the youth.

The participants said the following:

P6: *"Educating the public about such topics and creating awareness around them in rural areas could improve the use of SRH by the youth''*

P3*: "Creating awareness about it by letting health care workers work with the youth for the implementation''*

Variables	Frequency	Percentage
Disagree	29	29%
Not sure	20	20%
Agree	51	51%
Total	100	100%



Lack of awareness programmes was also highlighted by some of the young people who participated in this study. Of the 100 youth who participated in the study, about 51% them noted that the Mutale village lacks youth clubs that could encourage the use of SRH services among the youth. Furthermore, it should also be noted that community members, as well as the youth, felt that creating awareness of the SRH

service was not only the responsibility of the health department or health care providers but also the community. They believed that the community should also take a stand in educating the youth about such service rather than waiting for health providers who might take their own time.

However, these results corroborate findings reported in Zimbabwe, where adolescents reported that they had limited knowledge about ASRH services available in their community. In the same study, participants highlighted that they knew that SRH services were being provided to the nearest clinic, but they had not been to the clinic for such services (Kurebwa 2017).

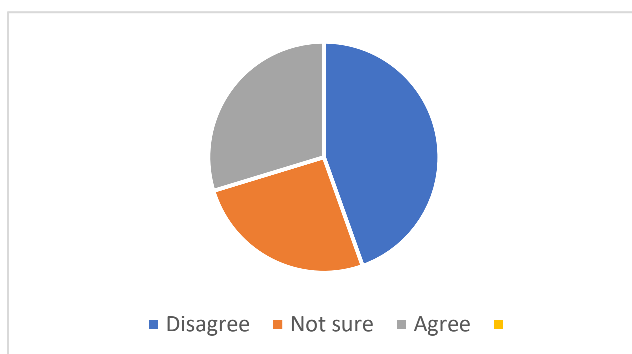
4.5.6 Religion and religious norms

In Mutale, religion plays an important role on how people interact with sexual and reproductive issues. For some, it is also one of the barriers that exist in accessing SRH. Some religions are much "stricter" than others and other religions can blend in with the modern world and adjust perfectly. Traditional African beliefs showed 34% of identification by the youth of Mutale, which implies more influence on youth attitude towards SRH services. Based on the findings, Christian Protestant showed second predominance, at 33% of the population. Independently and in integration, the two predominant religions are conservative on sexual and reproductive issues and teach and instil the tradition of a female keeping their virginity until they are married. A study by Tamang et al. (2017) discovered that sexual and reproductive health services are still predominantly used by married couples in South Africa, showing the subsequence of the religion's impositions.

When asked if the specific religious faith encourages them to use sexual and reproductive health services, 45% of the youth disagreed with the fact that they are encouraged by their religious faith, with 30% agreeing that their faith encourages the use of sexual and reproductive health services. The youth's data were recorded as follows:

Variables	Frequency	Percentage

Disagree	45	45%
Not sure	26	26%
Agree	30	30%
Total	100	100%



During interviews, one of the participants responded as follows:

> P4: *“Yes. Religious faith at one point has made me view people who do abortion, those who prevent at a young age, and sometimes those who go to clinics just to take condoms as ‘’loose’’ people when in fact they are doing the right thing”*

On “subjective norms”, the Theory of Planned Behaviour states that people approve or disapprove behaviour based on their structured beliefs that dictate whether they should engage in the conduct (The HIV/AIDS Network, 2014). These beliefs stem from religious or societal standards for behaviour, forming individual perspective. Although one of the male participants stated that he does not share the same sentiments because he believes he is now more aware of what SRH services are, he went on to explain how his Christian religion misinformed him about what SRH truly is and prevented him from gaining the same SRH knowledge that he has now and could have possibly had at a younger age.

According to a study that was conducted in Nigeria, “adolescents were subjected to religious norms that tended to view the use of contraceptives as sinful” (Nmadu 2017:42). The same results were also reported in Kenya where religious beliefs reflected 61 strict religious teachings and practices on reproductive health issues, especially family planning methods (Mutai, 2016).

The same sentiments were shared by another female participant:

> P1: *“Yes. Our religious faith is one of the reasons why a lot of my peers, including me, do not usually access SRH services freely at the local clinic, for the fear of being judged and being called names for doing things that our elders do not feel like we should be participating in if not married. However, I do go to another clinic far from home so that they don’t see me.”*

Although most of the participant’s religious faith did not always allow them to access SRH service without making them feel like judged, few participants (about 2) agreed that their religion encourages them positively by allowing the use of SHR services.

A female participant said that:

> P5: *“yes. I feel like mine does as it encourages me to take care of my body and I believe by accessing those services (SRH) is exactly what I am doing, so in another way my religion encourages me in a positive way*

Another female said who is a Christian Roman Catholic said that:

> P3: “*yes. My faith has positively influenced me to be educated about certain topics in society and to take care of my health and I would like to believe that SRH is a way of taking care of one’s body.*

According to the study findings, most of the African traditional believers, as well as Christians, viewed the youth accessing SRH service as an appropriate act, while on the contrary, studies that was conducted in Nigeria as well as the one conducted in Kenya about youth religions affecting youth SRH access stated otherwise, indicating

that “seeking SRH health services was regarded a sinful act” (Nmadu, 2017:42; Mutai 2016:48).

From the interview with young people in Mutale, it emerged that that are not necessarily afraid of their church members but rather, they live in fear of accessing those services because they did not want to be judged by the religious and spiritual community in the village they lived in and belong to.

4.6 FACTORS THAT PROMOTE ACCESS TO SRH SERVICES FOR YOUNG PEOPLE IN MUTALE VILLAGE

From the data collected during interviews with the youth there were a few factors that emerged to promote access to SRH services were knowledge of the SRH services and information that are accessible, sociocultural support, youth-friendly delivery services, awareness campaigns, school visits, and prolonged exposure to disease are all factors that are encouraging access to SRH services in Mutale village. These will be discussed in detail below.

4.6.1 Knowledge of available SRH services and information

The data collected demonstrated that the knowledge that could be given to the youth about SRH services is somehow limited by the facilities offered to them. For instance, 54% of the population agreed that their health facilities do not provide them with any audio-visual materials that could make the youth understand SRH service better when visiting that health facilities, furthermore the facilities are also not equipped with things such as SRH educational pamphlet.

Participant 5 stated that:

> *“The local clinic always emphasises to the community people about how the government/the department of health do not always provide them with resources that might be useful to the public, from something as simple as a pain killer to those pamphlets that could raise awareness to the youth.”*

Participant 3 responded that:

> "*The community are the ones who makes it impossible for the facilities to provide audio visual material and other instructional materials, through negligence when those services are being provided by health care providers."*

Young people suggested that instructional materials may be distributed through avenues for raising awareness, such as by handing out pamphlets to clients entering the facility. The materials could be put at facilities' exit points and other locations where young people will not be afraid to take them and not seen by most people who are seeking services at the facility. On the importance of publicising SRH knowledge to the public, a study conducted in Ethiopia demonstrated that "the level of knowledge about SRH services is crucial to the success of the SRH service access and usage" (Abajobir & Seme, 2014:9).

4.6.2 Socio-cultural support

Sociocultural support stresses the role that social interaction plays in the psychological development of an individual. It suggests that human learning is largely a social process and that our cognitive functions are formed based on our interactions with those around us who are "more skilled." This could mean that for a young person to gain knowledge about the sexual and reproductive process it is the responsibility of those around her/him to pass on the knowledge that they have.

Failure to offer support to the youth can affect young people's access to the facilities that offer sexual and reproductive health services because it reflects a that community and culture are regarded as being extremely essential. This means that the community's culture greatly influences how it behaves, reacts, and develops both individually and collectively. Cultural factors (beliefs, norms, and values) also play a significant role in determining how people live their lives in society, as many people experience a strong sense of connection because of culture, especially when they share a common language (The HIV/AIDS Network, 2014).

The four healthcare providers' response was as follows:

P1: "*yes, a huge our community people are the ones who make it uncomfortable for young girls and boys to go to the facilities for help based on their remarks.''*

P2: *"yes elderly people do not want to discuss such topics with the youth, and they end up not being aware that the hospital/clinic can provide them with such services.''*

P3: *"the community is where these kids learn most things so, in my view, I feel like they do not encourage them enough to seek SRH help from professionals.''*

P4: *"the community tends to spread false rumours once someone visits a health facility, and they end up being the ones who are influencing youth people to be shy about something as simple as going to the wrong clinic.''*

What is most common about all the health care workers' responses above was the fact they believed that the community of Mutale is responsible for the youth not accessing the services. Most of the health care workers voiced out how the remarks from the society, false rumours (such as of poor service) that are spread around the community about the services are some of the factors that make the youth people to not feel comfortable which usually affects their access to the services.

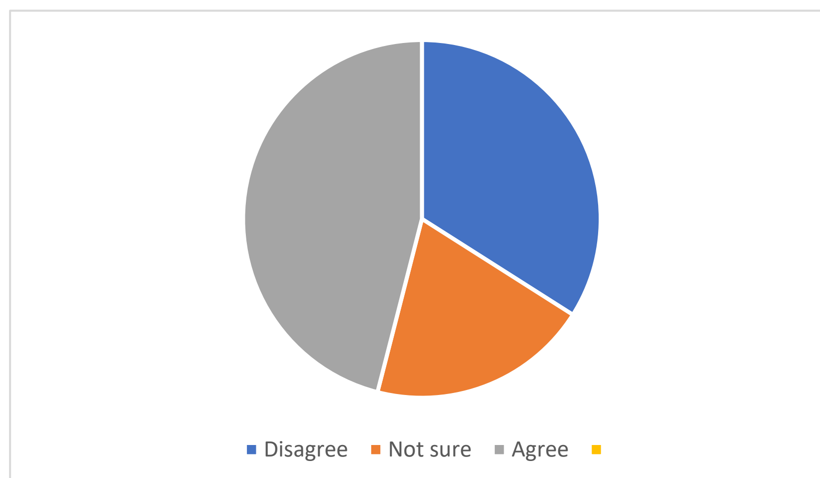
In 2014, the Ethiopian researchers Ayelew, Mengiste, and Semahegn conducted a study on "Adolescent-Parent Communication on SRH Issues Among High School Students." The findings demonstrated that youth understood the value of having SRH conversations with their parents, and most parents reported having these conversations with their adolescents (Ayelew et al., 2014). The same findings from research on "Attitudes of Gatekeepers towards Adolescent Sexual and Reproductive Health (ASRH)" were also published in Ghana. According to the study's findings, "mothers tend to converse with their daughters more than with their sons" (Kumi-Kyereme et al., 2014:147).

However, the data collected in Mutale indicated that the idea of opening about such a topic to parents is not what both male and female participants were keen on doing as it is considered age and morally sensitive. Moreover, some participants appeared uncomfortable discussing the topic with their parent, as seen from their shaking of

heads during the interviews when asked if they discuss it with their parents or guardians.

Culture and health are intertwined and manifest through the values, norms, and beliefs of the people in society. Ignoring the influence of culture on SRH undermines the effective provision of appropriate adolescent SRH services, youth participants' self-administered question on whether they feel like their culture prohibits them from accessing SRH services was presented in the following manner:

Variables	Frequency	Percentage
Disagree	46	46%
Not sure	20	20%
Agree	34	34%
Total	100	100%



Based on the findings, 46% of the youth participants agreed that their culture limits their access to the facilities and those who say that they are not affected by the views of their culture from accessing the services were 34% of the study population. The findings further highlighted the lack of parental encouragement, lack of support, and good communication with parents about SRH issues that would've made it easier for them to access reproductive health services, which is most likely due to the contextual

belief that sex topics cannot be discussed with unmarried individuals, especially children (Kumi-Kyereme et al., 2014:147).

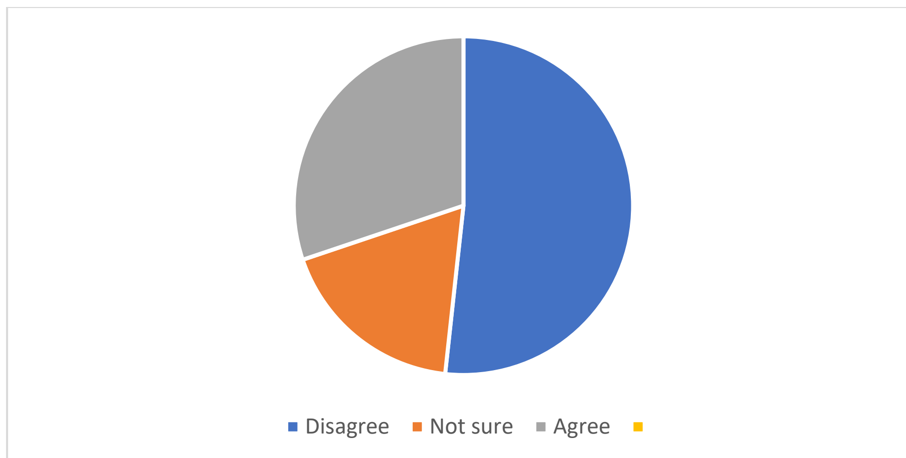
4.6.3 Friendliness of healthcare institutions

Youth-friendly health services (YFHS) are one of the evidence-based interventions recommended by the World Health Organization (WHO) to address health system barriers by providing health-enabling social environments that are more accessible, acceptable, equitable, appropriate, and effective for young people (WHO, 2012).

Youth-friendly health services (YFHS) are normally effective in an environment where service providers are non-judgmental, unbiased, and considerate in their dealings with the youth. Officials should also have competencies needed to deliver youth responsive SRH services, and health facilities are equipped to provide the youth with services they need and commodities that they want in an appealing and friendly manner, and youth are aware of where to obtain the services when they need them.

From the data that were collected, the participants were asked whether they received any form of pamphlets and youth friendly services at their local clinics and the data that was collected were collected as follows:

Variables	Frequency	Percentage
Disagree	44	44%
Not sure	21	21%
Agree	35	35%
Total	100	100%



Out of the 100 participants, 52% of them were of the notion that the SRH service centres are not friendly. Some participants felt that the staff were rather hostile to young people. Similarly, others felt that they do not receive any sort of pamphlets that are informing them about SRH services at the hospital/clinic.

Besides the services being accessible to the youth, many participants felt that it was important to also ensure that the services that are being provided to the youth are friendly towards their needs, regardless of their age, marital status, HIV/ STI status, sexual orientation, gender identity, occupation, geographical location, or ability to pay. Similarly, it was emphasised that these services must be confidential, non-judgmental, and private for better usage. However, some youth felt that the services that are provided to them at their health care facilities do not focus on their pressing needs, but rather works against them, some of their opinions were expresses as follows:

P1: *"I feel as if the services are only designed for certain people who have titles if I can put it that way, (those who are married and older) but not for someone who is 18 years of age like me."*

P7: *"The services I think are not friendly and mostly this is caused by the health care workers."*

P8: *"The services that are offered to us the youth after certain judgemental criticism from health care workers which is why I feel like in terms of the services being friendly for the youth there is still room for improvement."*

Although for SRH service to be considered friendly needs to be non-judgemental and accommodate everyone despite their social standards, many young people expressed

how the services are not friendly and how one's marital status is often key to the way one is treated. Many expressed concerns with judgemental criticism from the health care workers discourage them from accessing the services.

When health care practitioners and youth have a positive relationship, the young feel more at ease and can discuss their sexual and reproductive health issues without feeling judged by the providers. In that way, the youth will feel friendly and access the services without feeling like they are being judged.

4.6.4 Level of education and School attendance

As previously mentioned, six of the youth mentioned that they were educated or gained their knowledge about SRH services at their high school's awareness campaigns. The high schools had what they call the soul buddies campaign. The campaign allowed nurses to visit their schools and come and elaborate more on things such as HIV/AIDS as well as sex. This initiative can be viewed as another promotion of access to health care facilities for the youth. While talking about this awareness campaign one male participant indicated that:

> P2: *"The Soul Buddies campaigns are beneficial and convenient for us because they are being provided at school and with our peers this limits the fear that we might have of visiting the facilities since they are coming to us, to educate us on things we might not have been quite aware of"*

These findings are supported by a study that was done in Zimbabwe by Chibaya (2016) on the effectiveness of SRH and rights service on young people, where he found that young people should be encouraged at school to seek SRH services. In that way, school dropouts due to pregnancies can be reduced as well as young people who are getting sick at a younger age through sexually transmitted infections (Chibaya, 2016:45)

By further looking at the data and listening to the youth, it was evident that young people are comfortable learning about the services in an environment where they did not feel like they are being judged such as at school. The awareness campaigns go a

long way in teaching these young people about SRH services, and according to some participants, they were not sure of what SRH service until they were taught about it at their respective high schools through this initiative.

Two participants shared their view and according to them:

P1: *Learning at school is comfortable for me since I am mostly learning with people of my age*

P7: We are mostly taught about such topics in our life orientations class, and we don’t judge each other when doing so

4.7 INTERVENTIONS TO IMPROVE SRH UTILISATION SERVICES FOR YOUNG PEOPLE IN MUTALE VILLAGE

Youth participants, as well as health care workers, were asked about the different initiatives that they suggest should be implemented to improve the SRH service in the village. Different suggestions were brought forth by all the participants to increase SRH service facilities, allow youth people to have their consultation rooms as well as educating the society about the services to reduce the stigma that the village associate it with were some of the interventions that were proposed by the participants.

In Cairo in 1994, the International Conference on Population and Development (ICPD) outlined a bold, unambiguous, and thorough definition of reproductive health. Countries were urged to provide the services and education that young people needed to deal with their sexuality healthily and responsibly (Chandra-Mouli et al., 2015a: S1). Below is the discussion of some of the recommended strategies:

The intervention of increasing the facilities was suggested by a health care provider who was a female nurse at the clinic and her suggestion was as follows:

P4: *“The department needs to also introduce more facilities to assist the ones that exist because the ones that exist now do not accommodate everyone’’*

The shortage of facilities according to the health providers makes them work under strenuous pressure from the public. Consequently, this compels them to underperform

in their jobs since the clinics are usually packed from morning to evening. Increased accessibility of facilities can also be linked to the working hours where one youth participant even suggested that some of the clinics need to be opened even on weekends and such is not happening at this point since their clinics are only open from Monday to Friday during working hours.

According to a male health care worker:

> *Since I started working for this community, I have noticed that youth people do not access SRH cervices based on the believes of their culture and them not being open when it comes to discussions that have to do with sex, from our part the access can also be limited by the fact that we are under stuffed, and I can also admit that we are constantly not provided with some resources such as medications for our patients.*

Some youth participants suggestions for SRH to accommodate the youth were as follows:

P1: "Allow youth people to have their consultation rooms.''

P7: *"Having a section at hospitals that only deal with SRH for the youth could be helpful and comfortable for young girls and boys.''*

P3: *"Clinics and hospitals need to be youth friendly and accommodate the younger generation.''*

P8: *"The department needs to do more in ensuring that the health care workers create a safe environment for the patients."*

Findings from this study revealed how young people are likely to visit SRH services when the services are friendly, with limited risk of being judged by older people in the community. Participants expressed that they would be more comfortable seeking these services when such freedom has granted them.

According to the youth SRH service for the youth can be improved by:

P3: "Educating the society about the services to reduce the stigma that the village associate ''

P5: *"Educating the public about such topics and creating awareness around them in rural areas could improve the use of SRH by the youth.''*

P7: *"Creating awareness about it by letting health care workers work with the youth for the implementation.''*

4.8 CHAPTER SUMMARY

This chapter presented the analysis, presentation, and interpretation of the data gathered from young people. Two sections were used to present the findings: participant demographics, including age, gender, and education levels as well as their distance to the health facilities from their homes. The research findings were presented in the second section. They encompassed comprehension of SRH services, locations where these services are offered, and attitudes toward access to SRH services. There were subsections in this section that discussed obstacles to SRH services for young people. The main aim was to find out more about the challenges that young people are facing when utilising the services. Findings on the factors that facilitate access to SRH services were reported in a different subsection. The objective was to ascertain what drives young people to use the services. Finally, recommendations for how to make SRH services more accessible were offered. The goal was to offer suggestions on how to improve the reproductive health care provided to young people in Mutale.

Rising from the findings as presented by this chapter, the youth of Mutale are somewhat aware of SRH services offered in health facilities, but they use these services minimally due to perceptions driven by societal and personal religious and cultural values and beliefs such as the inappropriate nature of SRH consultation by young age individuals and being involved at all in sexual and reproductive activities at a young age. Youth's bad experiences at these facilities were found to hinder the youth from consulting for SRH services, such as being judged by health care workers and service seeking adults from their communities. Lack of support from peers and parents/ guardians was highlighted as another hindering factor to youth consultation for these services. Overall, majority of participants indicated the health facilities are less friendly for young people's consultation for SRH services, as mostly caused by judgmental nurses in these facilities.

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

CHAPTER 5: SUMMARY OF FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This last chapter presents a discussion with inferences drawn from the problem statement as presented in Chapter 1 of the proposal. Research conclusions will be based on the literature review deduced from Chapter 1 to Chapter 2. The empirical findings emanating from the survey in Chapter 4 are linked with the objectives of the study, hypothesis, and research questions to determine the study's achievement of its purpose. Furthermore, recommendations are presented to suggest strategies for creating the friendliness of existing sexual and reproductive health services in Mutale village and redress current barriers of the fluent offering of SRH services.

5.2 SUMMARY OF THE STUDY FINDINGS

A summary of key findings based on each of the study's methodological imperatives are herein discussed. A mixed method (both qualitative and quantitative methods) was used this study. Both purposive and snowball sampling was utilised. Both purposive and snowball sampling were utilised in selecting the youth participants who are both males and females and aged between 18 and 24; as well as 4 nurses health care providers who happen to be nurses within and around the Makonde locality. Data was collected using both questionnaires and interviews. Descriptive analysis of frequency, mean, and average was used to analyse data trends for quantitative data using the Statistical Package for Social Sciences (SPSS) version 19.0, as well as thematic analysis to analyse the qualitative data.

5.2.1 Sample demographics

126 responses and out of those 126 (13 male and 113 females), from that population only 105 were usable since 19 did mention that they have never accessed the service and the study was seeking participants who utilized the service to gain their knowledge. From the questionnaires that were distributed face to face only 9 from the 30 were returned, and since the data saturating was reached, the 9 youth participants

together with 91 from the self-administer questionnaire were considered for the findings.

The data interpreted showed that most participants are 10km away from a health care facility and most participants who were interested in taking part in the study were 18-year-olds and 21-year-old youth (both male and female).

5.2.2 Themes and sub-themes

In order to address the objectives of the study so as to analyse youths' awareness, perceptions, and their experiences in utilising existing sexual and reproductive health services; determine the factors influencing the utilisation of sexual and reproductive health services by youth; and examine the youth friendliness of existing sexual and reproductive health services in Mutale village, the main research findings are below presented thematically:

5.2.2.1 Theme 1: Youths' knowledge and perception of sexual and reproductive health care

The findings from the study showed that the youth had a vast amount of knowledge when it comes to what SRH services are and what they entail, though there are different definitions of what SRH is. It became clear that the youth are aware of the different services that are offered at the facilities that they can access. For many, the knowledge that they have about the service was something they learned through a school awareness campaign and the general knowledge among society. The findings showed that most of the participants learned about SRH services through the "Soul buddies" awareness campaign, which is a programme that "work with children and adults to create a platform that gives voice to and promotes real action for children's health and wellbeing" (Soul City Institute for Social Justice, 2019: online). This campaign is run in schools, whereby learners are taught about safe sex and different contraceptives methods that are useful in preventing teenage pregnancy. Additionally, this programme teaches about preventing the spread of HIV/AIDS and other STIs (Soul City Institute for Social Justice, 2019: online).

On the contrary, young people with less awareness about SRH services showed a most common perception that the youth seem to have about the service was that services such as a contraceptive pill can cause them to damage their womb and not give birth in the future. Based on literature, this misconception is common. A systematic review study by Fatusi and Hindin (2010) highlighted common issues such as "poor knowledge about sexual and reproductive health issues, myths about contraceptive methods and fear about possible side effect, poor attitude to condom and poor access" as causes of SRH problems such as teenage pregnancies and spread of diseases. On the same note, a study by Ritcher, et al. (2005) disclosed that apart from the governments' initiative on free sexual health care services such as contraceptives to the youth, youth's knowledge and use of contraceptives is poor in Limpopo province. Thus, leading to the high number of teenage pregnancies in the province (Ramathuba, et al., 2012).

It is thus evident that a good proportion of youth in Mutale are less aware of SRH services offered by health service centres around their area, which is mostly the perpetuating factor to SRH problems such as teenage pregnancies, HIV/AIDS transmission and refrained behaviour towards seeking RSH related services such as contraceptives, regular HIV/ AIDS testing and STIs testing. Moreover, the youth's negative attitude due to negative perceptual knowledge about the use of services including contraceptives, such as that contraceptives cause women to become infertile. This idea therefore shows the impact attitude and perception, as well as knowledge has on the youth's service seeking behaviour in Mutale.

5.2.2.2 Theme 2: Youth experiences with SRH institutions in Mutale

Both public and private facilities were reported as available and used by the youth, however many young people use free public facilities due to financial reasons. From the findings, private facilities such as the doctor's private office are much faster and the practitioners always have all the services that they require at that time, the opposite is the case when it comes to public health facilities which are said to have a longer period of waiting and they usually run short of some services. According to the World Health Organization (2013:7), "health inequality continues to be a reality because as owed unequal socio-economic conditions of different people. While the needy struggle

to meet their health needs the financially capable can" (World Health Organization, 2013:7). According to Honwana, (2012) most young African youth find it hard to afford life's necessary expenses, including payable health expenses. This hardship is a result of the lack of proper employment caused by defective market-oriented policies, poor governance, and political instability. As quoted from Habermas (1992: 1), Vigh (2009) states that young people under these circumstances are "condemned to passivity and temporarily deprived of the possibility of being a subject in full possession of his powers". Vigh (2009) further quotes Lindquist (1996: 58) in that youth deprivation to social becoming is an experiential and social crisis in form of "stagnation, decline, and decay (signifying) the opposite of correct and desirable progress". Due to this kind of crisis, some young people of Mutale village cannot resort to private health services to socio-economic incapacity, leading to further deprivation from necessary health assistance. In the interest to understand how young people respond to this form of crisis, Vigh (2009) refers to the action as social navigation, which an environment changing concept that is used to describe how people act in difficult or uncertain situations, such as disengaging themselves from restricting situations, actively planning their escape, and moving to better positions.

Public facilities on the other hand, are usually full and mostly run short of essential resources such as experienced stuff, medication, and equipment due to the number of people who want to access free services as compared to available service capacity in the facilities. Rampamba et al. (2017:645) articulates that "common issues of concern in most rural health facilities are such as shortage of medicines and medical equipment such as blood pressure and blood sugar levels monitoring machines, long patient waiting times and healthcare practitioners' attitudes."

Although the experience of the youth was valid and understandable, it is important to also take into consideration the different working conditions of the two rather than comparing the two. Private facilities are usually fast in services and always have services available due to the number of people they get, as not many people share the services because they are expensive and especially for rural people from the village of Mutale. Socioeconomic factors are therefore influential in the kind of service one would be able to access, as those who can afford financially can pursue health services that are of a high standard as determined by the sufficiency of resources and

skill set in private, payable health services facilities, while those who are financially disadvantaged continue to rely of free, less quality health services.

Among other experiences discovered in the findings regarding STI services was that these services are available. However, a smaller proportion of the participants highlighted that in some cases, healthcare workers would require consulting youth to bring along their sexual partners as a prerequisite for STI treatment. This credential stems from the recommendation that an STI infected patient should be advised to bring a sexual partner with so that the two may be treated together to prevent further reinfection on either of the partners (Gavin, 2019). Nonetheless, this prerequisite does not imply deprivation of services in any given situation. As documented by Thiagraj Soobramoney versus Minister of Health (Kwazulu-Natal) (1997:53), the Constitution of the Republic of South Africa guarantees the right of access to healthcare for all, and states that no one should be deprived of emergency medical treatment.

While the matters of confidentiality are essential, presenting to health facilities for RSH with a sexual partner is clearly more essential, as it allows for the assessment and treatment for STIs and other SRH related conditions to be thoroughly facilitated as an effective way to curb re-infection and further infection between partners, as the consulting partner will have the opportunity to know the health status of their partner in accompany, and vice versa, while treatment will be given to both partners when need be.

5.2.2.3 Theme 3: Factors that hinder the utilisation of SRH services for young people in Mutale village

The study found privacy and confidentiality as a hindering factor for the youth to access the service close to them, most young people would rather go to a health care facility that is far away from their home due to the fear of being attended to by a health care provider that might leave close to their house or share their private consulting information with their guardian or the community, this fear that the youth have seemed to be one of the biggest factors and is simply caused by the communal life that village people live by wherein they do not respect confidentiality and in most cases, by health care workers telling a youths guardian they feel like they are protecting the youth when

in fact they are hindering the chances of youth from accessing the service. Kumar (2018) defines confidentiality as an act of protecting the personal information of a person under assistance through not sharing such information with a second party. Bender, Cyr, Arbuckle, Ferris, et al. (2017) substantiates the significance of confidentiality as that it helps in handling sensitive information of other people in a safe and secured manner, from risk of publicity.

With regards to different pregnancy prevention methods as a parcel of RSH services, youth of Mutale seem to have less experience due to a lack of knowledge, as well as ignorance as owed to by misconception of some of these contraceptives being capable of causing fertility related side effects, such as infertility. A scoping review study about the fear of infertility in Africa in 2020 found that participants from about 15 qualitative studies claimed that contraception causes infertility (Boivin, Carrier & Zulu, 2020), which owes to less use contraceptives among African societies.

Health workers' negative attitudes and fear of judgment also fall under some of the factors that hinder the youth's utilisation of the service. The findings of this study also discovered that most young people refrain from consulting to local healthcare facilities, especially for SRH services due healthcare workers' negative attitude and fear of judgement for consulting for sexual and reproductive health related services as young agers. Stigmatisation of young people consulting for SRH services was noted amongst the problems faced by young people in Mutale, such that another young person was humiliated by a nurse in public about falling pregnant at a young age. According to Phetla, et al. (2008) and Kennedy et al. (2013), HIV positive and STIs infected individuals are secluded based on an idea that they are defiled and capable of randomly infecting others, while homosexual individuals are marginalised based society's attitude towards homosexuality, that homosexuals are sexually unruly and wicked. As such, these groups are restrained from seeking SRH related services, hence less SRH service seeking amongst young people in Mutale.

Stemming from the overall findings of this objectives,service behaviour and attitude of health workers has a deterministic effect on whether or not youth and other patients in general seek SRH treatment. It therefore remains vital that health workers guard from mistreating youth and all other patients, whether through humiliation, mockery, verbal

disrespect or divulging the patients' confidential information regarding their consultation. Thus, health should keep patients' information safely and privately, while offering those services in a way that leave the patients dignity and human worth still maintained.

5.2.2.4 Theme 4: Factors that promote access to SRH services for young people in Mutale village

Becker (1978) in the Health Belief Model postulates that one of the reasons for behaviour change is the perceived benefits of preventive action. As such, people are therefore more inclined to abiding by medical advice when they think that it will aid in the prevention, detection, or treatment of sickness and thereby lessen the risk to them (Becker 1978). The study discovered that knowledge of SRH services and other health information that is accessible, as well as sociocultural support, youth-friendly health services, health awareness campaigns, health-based school visits are all factors that are expected to encourage access to SRH services in Mutale village. Due to the importance of young people's awareness of SRH and other health services, many organizations globally, including the United Nations, Amnesty International, and CARE, are said to have instigated educational media campaigns to improve public health for children (Mall, et al., 2018).

While counselling is another available service that young people of Mutale are less aware of, it is important for awareness to be brought to these young people to improve access and utilisation of this service for mental health and other related issues in the public health facilities in and nearby Mutale. On this note, South Africa homes young people's trauma oriented services initiatives such as the Phodiso training programme, which was established to reduce the harmful physical and mental health consequences of trauma, depression and posttraumatic stress disorder (PTSD) amongst children and young adults (Wyatt, et al., 2017).

Furthermore, the findings of this study established that social support from parents and peers can help improve youth consultation for SRH services at Mutale and surrounding health facilities, as most young people do not seek these services by the fear of being judged by their parents/guardians and other adults in their community.

Ayelew's, et al. (2014) study "Adolescent-Parent Communication on SRH Issues Among High School Students" in Ethiopia found young people to embrace having SRH related conversations with their parents, which showed a positive impact in influencing SRH services seeking amongst young people in the region.

Lastly, creating a friendly service environment in health facilities was another recommendation by the youth of Mutale, stating that if health workers be friendly and welcoming, it would be easy for the young people to seek services for SRH even in its culturally sensitive nature as a subject and activity. A Ghana study about pregnant women's consultation to Public Health Care (PHC) facilities for reproductive services showed that PHC that do not respect the privacy and dignity of patients to suffer low consultation rate (Hokororo et al., 2019). Thus, treating patients with respect creates a friendly health service environment and has an influence on whether or not patients further consult to such a facility. As such, the young of Mutale are most likely to consult for SRH services if they would be treated with respect by healthcare workers.

A number of factors exist that can reasonably play a role in having young people and wholly community members consulting for SRH services. The exercising of human based factors such as service-friendliness as well as adding work competency and skills by health workers can play a role having young people consulting to these facilities. When service consultants are friendly while offering health services, the more patients will want to consult to such health facility, while adding more competencies will allow for health workers to be more skilled and experienced. Non-human based factors that can be useful in influencing SRH services are such as resources in health centres, which are useful in facilitating patient treatment and assessment. Budget for resources to use in a health services facility are essential to have, as these support in the process of serving patients with health services.

5.3 RECOMMENDATIONS FOR POLICY

5.3.1 Training

Based on the above discussions, the below sentiments stem as recommendation for policy in so far as this study's aim is concerned. Improving access and utilisation of

SRH services amongst the youth of Mutale is imperative, thus, the use of peer educators for SRH to the youth by local health facilities and other relevant stakeholders would serve effectively in ensuring both access, awareness and utilisation of these services by the youth. Awareness campaigns should be hosted by the Department of Health and stakeholder bodies in schools and in the communities on Mutale to teach young people and the community as a whole about SRH services. Part of this could be teaching young people on how to use contraceptives such as condoms and others.

In support of this awareness and training motion, the Department of Health and relevant stakeholders have a responsibility to Improve the services by making essential resources such as contraceptives and SRH treatment in local health facilities available to avoid partial or completely deprived health care would assist in making sure that SRH are usable by young people.

5.3.2 Community and parents' involvement

The involvement of the community, as well as the guardians of the youth, would create a friendly environment where youth will not feel judged. The community, as well as the parents, need to be educated about what SRH is and educated about how they can support the youth in accessing the services instead of judging or even preventing them from accessing the services This will provide the opportunity for the local community members to acquire more culturally appropriate information on SRH issues while the youth will hopefully be open about discussing such topics.

Another aspect that was noted as not existing in the village by the youth was youth groups or they were just not enough, those youth groups should be encouraged or developed if they are not there, and the youth groups should make it a priority that they initiate dialogues between the youth and the community or the parents as a way of educating both of them and also making them open up about such sensitive topics that they might shy from talking about on a day to day.

5.3.3 Open communication and education of young people

This might be accomplished by expanding the youth's reach, for example, by using telephone hotlines staffed by professional counsellors at the clinic location. Additionally, young people ought to be urged to visit the clinic for guidance or information. As an alternative, peer educators and health service professionals can give services in the community. This is to guarantee that they have access to enough information about SRH services to enable them to make wise decisions. It is crucial to raise awareness of SRH using the media and other forms of extensive communication to encourage young people to talk about reproductive health issues.

HSPs and youth peer educators can raise awareness of the SRH services available to young people and community members by performing outreach activities from the health facility into the schools and churches. The South African Department of Health should further make a regular reminder to healthcare workers in local healthcare facilities about the importance of a friendly service for healthcare seekers, especially SRH services, which are surrounded by a lot of stigmas. In this case, the attitudes of service providers toward teenagers, as well as secrecy about youth sexuality, should be covered in health service professionals' training. This may assist young people to proudly seek SRH services without fear of being judged by healthcare workers and society at large.

5.4 RECOMMENDATIONS FOR FURTHER STUDIES

This study has made an effort of contributing information that might be important that can help bridge the gap that exists between reality and the perceptions, knowledge as well as experience of services by the young people of Mutale village. However, it is important to note that this research was mainly focussing on the village of Mutale, therefore more research/studies need to be done to get more insightful information about the different perceptions, experience as well and the knowledge that young people have in other rural areas when it comes to sexual and reproductive health care services. It is important to compare the access and utilisation of reproductive health care among urban and rural adolescents and young people to inform the development

of policies and policy changes. It is also advised to conduct research into how to make community social and cultural norms more accommodating of SRH needs.

5.5 LIMITATIONS OF THE STUDY

Firstly, the study used mixed methods to collect data from participants, and the participants who were involved in the study were those that were available and accessible to the researcher, therefore the findings of the study cannot be generalised to all the young in the village of Mutale. Other youth from other villages may not share the same sentiments as well as those who are from urban areas utilisation in terms of their experience, knowledge, and perceptions of the youth of Mutale village. As such, inference to the entire population did not apply to this study. However, due to the number of participants from which data were collected, it can be concluded that a good proportion of young people of Mutale with similar circumstances as the participants are somewhat represented in the findings.

5.6 CONTRIBUTIONS OF THE STUDY

The study provides ample evidence that youth people know SRH services however they are experiencing different challenges when it comes to utilising the services, as well as the different perceptions that exist in the community that play a barrier in enabling them to utilise the services. In as much as quantitative data helped to get the knowledge of most of the youth, the use of a qualitative approach with the semi-structured interview as a method of data collection was found to be effective. In that way, the researcher was able to interview some of the participants who gave quite diverse views to the questions that were being asked. This study offers significant findings that may be useful in promoting the utilisation of SRH among young individuals.

5.7 CONCLUSION

The purpose of the study was to find out the experience, knowledge, and perception that young people of Mutale village have come across through their utilisation of the Sexual reproductive health care facilities available. Regarding the aim, objectives, and theoretical concept of this study, the following projections were established: According to the study, young people in Mutale village were aware of the sexual health services available in both public and private health institutions. As deduced from the findings, the utilisation of the SRH services is hindered mostly by the society/community through morality related beliefs, misconceptions, and lack of knowledge about the importance of this programme. Interventions including community outreach programs, peer educators for health education, and policy creation could therefore be useful in overcoming obstacles to SRH accessibility, such as ignorance of some young people and the surrounding community towards SRH services that are available in local health facilities. While health care providers also play a role in young people feeling uncomfortable with using SRH services, a regular reminder to these professionals regarding patient treatment would be essential, which would teach them about the respect of information, dignity, human worth and preferences of young people and other SRH service seekers in general. Finally, as per the ecological systems theory, the socialisations of the Micro, Meso, Exo and Macro ecological systems surrounding the youth of Mutale, evidently impact on both their knowledge, as well as motivation to consult to health service facilities for SRH services amongst the youth of Mutale. The findings of this study have highlighted the boundaries and issues of concern for the Sustainable Development Goals (SDGs) depends on sexual and reproductive health, as well as recommended strategies that can be useful to remedy the studied predicaments towards the achievement of the SDGs' objective pertaining to sexual and reproductive health as a human rights accomplishment.

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APPENDIX 1: CONSENT FOR PARTICIPATION

My name is Mulaudzi Vhugala, a Master of Art (sociology) student at Sol Plaatje University. I am conducting titled, "*Utilisation of Sexual and Reproductive Health Services in Rural South Africa: Knowledge, Perceptions and Experiences of youth (in Mutale Village, Limpopo*"***.*** I am requesting for your participation in this study. Any information you will provide will be treated as confidential and thus will not be divulged to any other person. Your participation is voluntary, implying that you are free to decline this invitation to participate, as well as opt out at any time to deem so, it will approximately take 10-15 minutes of your time to fill out the questionnaire provided. Please feel free not to answer any question that may make you feel uncomfortable.

Signature of Researcher ______________________ **Date**__________________

I………………………………. have read and understood the purpose and contents of this invitation to participate in this study/ have been clearly explained the purpose and contents and hereby confirm my consent to voluntarily participate in the research.

Respondent signature ____________________ **Date** __________________

Should you have further any questions about this project, please feel free to contact me, Mulaudzi Vhugala on the following details:

Phone Number: 076 133 0399

Email address: mulaudzi.vhugie@gmail.com

Or my supervisor Dr. SIMBARASHE GUKURUME on the following details

Senior Lecturer: Sociology

Sol Plaatje University

Email: Simbarashe.gukurume@spu.ac.za

APPENDIX 2: PARTICIPANTS CONSENT FOR AUDIO-RECORDING OF THE INTERVIEW

Project Title: Youth Utilisation of Sexual and Reproductive Health Services in Rural South Africa: An Analysis of Knowledge, Perceptions and Experiences of users in Mutale village in Thulamela Municipality

I ____________________________, hereby consent to be interviewed and tape-recorded. I have been informed that the purposes of tape-recording the interview are for accuracy and reliability reasons of this study. I have also been informed that the tape records will be retained and kept securely in the custody of the researchers and the information will remain confidential.

Participant's signature:______________________Date__________

Participants email:________________________________

Researcher's signature:______________________ Date:__________

Place:__________________________

APPENDIX 3: QUESTIONNAIRE

Screening question

Have you ever used sexual and reproductive health services at the clinic/ Hospital?

1. Yes
2. No

Section A: Demographic information

Please provide the following general information about yourself.

Instructions: Please tick the appropriate response

A. How old are you?

[1] 18years [2] 19years [3] 20years [4] 21 years [5] 22years

[6] 23years [7] 24years

B. What is your sex?
[1] Male [2] Female

C. What is your religious affiliation?
[1] Christian Roman Catholic [2] Traditional African religion [3] Christian Protestant [4] Islam

[5] Not affiliated to any religion [6] Other (specify)

D. What is your relationship status?
[1] Single [2] Married [3] Dating [4] Co-habiting/living with a partner [5] Divorced

E. What is your employment status?
[1] Employed [2] Unemployed [3]Other

F. What is your highest level of education?

[1] Grade 10 [2] Matric [3] Diploma [4] Bachelor's Degree [5] post-graduate

G. How far is the nearest health centre for you?

[1] Less than 5 km [2] 10 km [3] 20 km [4] More than 30 km

H. What is your ethnicity

[1] Venda [2] Tsonga [3] Shona

I. What is your sexual orientation (optional)

[1] Heterosexual [2] Homosexual [3] Bisexual [4] Asexual [5] Others (Specify)

Section II

Instructions: Below are a series of questions that I would like you to answer as truthfully as possibly by ticking a number that best describes where you stand. Indicate the extent to which you agree with the following statements, Use the scale below, Mark with an X where appropriate.

Strongly disagree	**Disagree**	**Not sure**	**Agree**	**Strongly agree**
1	2	3	4	5

Section 2.

Instructions: Below are a series of questions that I would like you to answer as truthfully as possible by ticking a number that best describes where you stand. Indicate the extent to which you agree with the following statements. Please use the scale below and ark with an X where appropriate.

Strongly disagree	**Disagree**	**Not sure**	**Agree**	**Strongly agree**
1	2	3	4	5

	Statements on knowledge, perceptions and experiences on utilisation of sexual and reproductive health services	1	2	3	4	5
2.1	Sexual and reproductive health counselling services are available for all youth at the local clinic/hospital					
2.2	Contraceptive methods such as the condom, the pill, and the injection are constantly available at clinics and hospital for youth.					
2.3	Emergency contraceptives are always available at the local clinic/hospital for the youth					
2.4	The clinic/hospital always provides/stocks contraceptive methods that are most popular among youth patients.					
2.5	Treatment for STIs is always available for all youth who need it at the local clinic/hospital.					
2.6	Both male and female adolescents are accepted and served at the local clinic/hospital for the youth					
2.7	There is no discrimination in reproductive health service provision for both married and unmarried youth at the clinic/ hospital.					
2.8	Healthcare professionals involve youth in decisions regarding sexual and reproductive health treatment options at the local clinic/hospital					
2.9	Youth are given their preferred treatment/contraceptives at the local clinic/hospital					
2.10	Sexual and reproductive health referral services are available for youth when necessary at the clinic/hospital					
2.11	Healthcare providers identify and establish plans for youth who require specific assistance, such as a young woman whose boyfriend opposes the use of contraceptives in the clinic/hospital where the youngster is being treated.					
2.12	Youth are assured of the confidentiality policy at the clinic/hospital					
2.13	Youth are provided with pamphlets on sexual and reproductive health and youth-friendly services at the local clinic/hospital for the youth					
2.14	The local clinic/hospital provides all patients information and/or audio-visual materials on reproductive health services.					
2.15	Youth are encouraged to adhere to follow-up care by health providers at clinics/hospitals.					
2.16	Youth who are STI patients receive a friendly welcome from the health care providers at the local clinic/hospital.					
2.17	I am familiar with the different sexual and reproductive health services available at the local clinic/hospital					

2.18	I have been served quickly at the clinic/hospital					
2.19	I have experienced long waits at the clinic/hospital, although they did not have a lot of patients					
2.20	I have been given sufficient time to discuss issues related to sexual and reproductive					
2.21	No parental consent is required for any service					
2.22	Youth with an STI are forced to bring their partners for them to get treated for STI.					
2.23	Health care professionals at the clinic/hospital always inform the youth alternative sources of services in their community.					
2.24	Clinics and hospitals have youth friendly services.					
2.25	Cost and expenses of sexual and reproductive health are a barrier to access sexual and reproductive health care needs for youth					
2.26	Existing policies and strategies for sensitizing youth to utilise sexual and reproductive health services at the clinic/hospital are effective.					
2.27	My sexual partner discourages me from accessing sexual and reproductive health services					
2.28	Peer pressure discourages youth from using sexual reproductive health care services					
2.29	As youth, we encourage each other to use sexual reproductive health care services					
2.30	Parents discourage the youth from using sexual reproductive health care services					
2.31	Cultural beliefs prohibit youth from accessing sexual and reproductive health service					
2.32	Religious beliefs prohibit youth from accessing sexual and reproductive health services					
2.33	My religious faith encourages youth to use sexual and reproductive health services					
2.34	There are youth clubs that encourage youth to use sexual and reproductive health services					
2.35	Healthcare facilities provide/stock contraceptive methods that are most popular to among young patients					
2.36	Safeguards in place to ensure that the service is used indefinitely are in place					
2.37	Healthcare professionals are accommodating and use language that is understandable to you					

2.38	Medical supplies and contraceptives are always in shortage at the facilities					
2.39	Youth are often included in the design and delivery of service.					
2.40	My sexual partner discourages me from seeking sexual and reproductive health services.					
2.41	STIs are inevitable.					
2.42	Use of contraceptives makes one infertile.					
2.43	Use of contraceptives makes girls have problems in their menstruation.					

Would you be willing to be interviewed (by me) in details on these aspects?

Yes NO

If yes, please provide your name and cell number (*only for the purposes of contacting you as these will not be divulged to any third parties*)

Name (only to be used for the purposes of reaching you) ………………………………………………………………………………………….

Cell number…………………………………...

Thank you for your participation.

APPENDIX 4: INTERVIEW GUIDE FOR YOUTH

Please provide general information about yourself.

Section A: Demographic information

Please provide general information about yourself.

Instructions: Please tick the appropriate response

A. How old are you?

[1] 18years [2] 19years [3] 20years [4] 21years [5] 22years [6] 23years[7] 24years

B. What is your sex?

[1] Male [2] Female

C. What is your religious affiliation?

[1] Christian Roman Catholic [2] Traditional African religion [3] Christian Protestant [4] Islam [5] Not affiliated to any religion [6] Other (specify)

D. What is your relationship status?

[1] Single [2] Married [3] Dating [4] Co-habiting/living with a partner [5] Divorced

E. What is your employment status?

[1] Employed [2] Unemployed [3] Other

F. What is your highest level of education?

[1] Grade 10 [2] Matric [3] Diploma [4] Bachelor's Degree [5] Post-graduate

G. How far is the nearest health centre for you?

[1] Less than 5 km [2] 10 km [3] 20 km [4] More than 30 km

H. What is your ethnicity

[1] Venda [2] Tsonga [3] Shona

I. What is your sexual orientation (optional)

[1] Heterosexual [2] Homosexual [3] Bisexual [4] Asexual Others (Specify)

Section B: Knowledge, Perceptions and Experience of Sexual Reproductive Health Services

1. What do you understand by reproductive health?
2. What do you understand by reproductive health services?
3. Can you tell me some of the reproductive health services your aware of?
4. Can you tell me if you have used these services?
   a. If yes, please share your experience.
   b. If no, why have you not?
5. Do you believe it is vital for a young person like you to have access to reproductive health services?
   a. Why do you think so?
6. Do you feel like our society is open enough for youth to freely seek sexual and reproductive health care services? Please explain your answer.
7. Does your religious faith influence your views and experiences with/ or lack of accessing sexual and reproductive health care services? Please explain your answer.
8. Does culture influence your views and experiences with/ or lack of accessing sexual and reproductive health care services? Please explain your answer.

9.If you are in a relation, to what extent does the views of your partners influence your views and experiences with/ or lack of accessing reproductive and sexual health services? Please explain your answer.

10. How youth friendly are the reproductive and sexual health services offered at the local clinics/hospital? Please explain your answer.
11. What are some of the challenges you encounter when you visit a clinic/hospital for reproductive and sexual services. Please explain.
    a. Do you feel they can be addressed? Please explain your answer.
12. Given your experience in using the sexual and reproduction health services from any of the places that you mentioned, would you advise your friend to do the same? Please explain your answer.
13. Do other youth in your area use sexual and reproductive services at the clinic?
14. What are some of the misconceptions that could prevent youth from accessing reproductive and sexual services at the clinic?

15. In your opinion, what discourages the youth like you from making use of reproductive health services?
16. What do you think should be done to improve the reproductive health services offered in local clinic/hospital?

APPENDIX 5: INTERVIEW GUIDE FOR SERVICE PROVIDERS

Demographic information

Please provide general information about yourself.

Instructions: Please tick the appropriate response

A. How old are you?

____

B. What is your sex?

[1] Male [2] Female

C. What is your religious affiliation?

[1] Christian –Roman Catholic [2] Traditional African religion [3] Christian Protestant [4] Islam Not affiliated to any religion [6] Other (specify)

D. What is your relationship status?

[1] Single [2] Married [3] Dating [4] Co-habiting/living with a partner [5] Divorced

E. Length of service in the clinic/hospital

[1] 5 years [2] 10 years [3] more than 10 years [4] Others (specify)

F. what are your duties at the clinic/hospital

[1] Nurse [2] Doctor [3] psychologist [4] Others (Specify)

G. What is your ethnicity

[1] Venda [2] Tsonga [3] Shona

Section B

1.What reproductive health services do you provide to the youth at this health centre/hospital? *[Inquire about the kind of services provided, the hours of operation, and how frequently they are supplied.].*

2. Do you think the youth prefer seeking sexual and reproductive health services at your health facilities?

a. If yes, explain why they prefer this facility
b. If no, what might be the reason why youth don't prefer to consult at the health facility you work at.

3. Do some services appeal to the youth more than others? If so, what makes you believe that?

3. Are there any services that adolescents do not utilize or have used but no longer use? If that's the case, what could be the source of the problem?

4. What is your view towards contraceptive promotion and its provision to the youth?

5. Do you feel like the village/community has an influence on youth seeking sexual and reproductive health from the clinic/hospital?

a. If yes, explain how

b. If not, kindly elaborate further

6. During a consultation with a youth, is there anything that you do as a health care provider to make the patient feel comfortable with you.
If yes, what do you do? and do you feel like it helps youth patients
7. What can be done at the hospital and clinic to make the facility friendlier towards the youth?
8. How do you think youth sexual and reproductive health services at the facility can be improved?
9. What are your thoughts on the use of sexual and reproductive health services by the youth?
Probe Is it good or wrong?
Are there any of the services that should not be provided to the youth?
If so, why?
10. What is your view towards contraceptive promotion and provision for the youth?
11. Are there any preference for some services over others? If so, what makes you believe that?

12. Are there any services that the youth do not utilize or have used but no longer use? If so, what's the reasoning behind it?

DR SHUMANI ERIC MADIMA
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29 October 2022

TO WHOM IT MAY CONCERN

This serves to confirm that I, Dr SE Madima, edited and formatted the research dissertation titled "Utilisation of sexual and reproductive health services in rural South Africa: Knowledge, perceptions, and experiences of youth in Mutale village, Limpopo Province" by Mulaudzi Vhugala (Student No.: 202120250).

With Regards

………………………………………………
Dr SE Madima (PhD)
Senior Lecturer (University of Venda)
Department of English, Media Studies and Linguistics

TSHIVHALE ROYAL COUNCIL

P.O BOX 4891

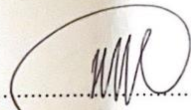
LWAMONDO

0985

Dear Madam,

RE: PERMISSION TO CONDUCT RESEARCH

With reference to your letter dated 2022/03/08 on the above subject matter, I am directed to issue you permission to conduct research in the Mutale village, this will include interviewing young females around the community as well as having interviews at our local health care facility. I wish you all the best.



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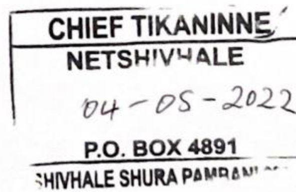
CHIEF TIKANINNE NETSHIVHALE: 081 773 7008

04/05/2022



OFFICE OF THE VICE-CHANCELLOR AND PRINCIPAL
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23 March 2022

Feedback on a research proposal submitted:

UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN RURAL SOUTH AFRICA: KNOWLEDGE, PERCEPTIONS AND EXPERIENCES OF YOUTH (18–24-YEAR-OLDS) IN MUTALE VILLAGE, LIMPOPO – M Vhughala

Dear M Vhughala

The letter serves to inform you of the outcome of your research project which was resubmitted to the Senate Research Ethics Committee (SREC) for ethics clearance.

Outcome: Approved. Ethics clearance was granted.

Kindly note the following comments:

a) To interact with members of Mutale village, a permission letter should be obtained from the Chief of the village.

Prof A M Crouch
Acting Chairperson: Senate Research Ethics Committee (SREC)