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***EXPLORING THE ROLE OF ADOLESCENT YOUTH-FRIENDLY SERVICES
(AYFS) IN PRIMARY HEALTH CARE CLINICS THAT OFFER HIV AND SEXUAL
REPRODUCTIVE HEALTH (SRH) SERVICES FOR ADOLESCENT GIRLS AND
YOUNG WOMEN IN VULINDLELA, KWAZULU-NATAL, SOUTH AFRICA.***

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A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

Centre for Communication, Media and Society (CCMS)

University of KwaZulu-Natal

January 2020

Research Protocol: HSS/0212/017D

Supervisor: Prof Eliza Govender

Acknowledgements

I would like to thank the Centre for Communication, Media and Society (CCMS) at the University of KwaZulu-Natal for growing my capacity and passion for academia. I began my journey in 2013, when I registered for an Honours degree at CCMS under the leadership of Prof Keyan Tomaselli. CCMS has given me many opportunities to learn and to grow my academic trajectory. I thank my supervisor Dr Eliza Govender for her valuable supervision and support! You are a wonderful person and supervisor, thank you.

I thank the National Research Foundation (NRF) that funded this study and covered all the costs that were needed to complete this study. In 2017, I also received a travel grant from NRF to present my work at the International Association for Media and Communication Research (IAMCR), an international conference in Colombia – it would not have been possible without the support of this funding.

I would like to thank my fiancé, Ntuthuko Mbonambi (Qhawe) - “*My Strength and Dignity*.” Thank you for your support and friendship. You arrived in my third year of this Ph.D. journey. But when you came, suddenly I knew that you were the missing piece I needed to give me more strength to finish well. Thank you for all your prayers.

To my mother Xoliswa Vukapi and my boota (brother) Lwandile Vukapi, thank you for everything that you do for me. I love you.

I would also like to thank Phiwe Nota. Thank you for your support and for your availability during this process. You have been there since the beginning of this journey. To my great friends Dr Funsho, Dr Sarah, Lebo, Siphokazi, Bongo and so many others, thank you for your support and love.

Thank you to all the young women in Vulindlela, who made this study possible. I saw great futures in you, some of the circumstances some of you come from and are raised caused me pain. But I have faith that you will grow strong and build your futures. You are the future of our country. Thank you to the nurses who added so much value to this study.

Declaration – Plagiarism

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Acronyms and Abbreviations

AGYW	- Adolescent Girls and Young Women
WHO	- World Health Organization
AYFS	- Youth Friendly Services
AIDS	- Acquired Immunodeficiency Syndrome
SRH	- Sexual Reproductive Health
HIV	- Human Immunodeficiency Virus
STI	- Sexually Transmitted Infection
NDOH	- National Department of Health
UNAIDS	- United Nations Programme for HIV/AIDS
DoH	- Department of Health
KZN	- KwaZulu-Natal
CC	- Cultural Competence
CCA	- Culture-Centred Approach
PW	- PhotoVoice Workshop
PAR	- Participatory Action Research
PVM	- Participatory Visual Methods
IDI	- In-depth interviews
FG	- Focus Groups

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Abstract

In sub-Saharan Africa, adolescent girls and young women (AGYW) bear a disproportionate burden of sexual and reproductive health (SRH) risks, where HIV infection and adolescent fertility are a major concern. Specifically, in South Africa, it is estimated that nearly 2 000 AGYW between the ages of 15 to 24 years are infected with HIV every week. Furthermore, it is estimated that by 2019, 15,6% of females between the ages of 15 and 19 years in South Africa had begun childbearing. Consequently, systemizing and expanding the reach of quality AGYW health service provision is part of the South African National Adolescent and Youth Health Policy. To promote accessibility, efficiency, quality, and sustainability of adolescent youth-friendly health services (AYFS) in primary health care clinics, national response to the HIV and SRH needs of AGYW need to be prioritized. It is for this reason that AGYW is a key focus in this study.

This study was conducted in Vulindlela, in the uMgungundlovu district in KwaZulu-Natal. This area reports high levels of HIV infection, with notable high fertility rates among AGYW. The study was conducted in 3 primary health care clinics that have initiated the AYFS programme, providing HIV and SRH care to AGYW. This study has three aims: (1) to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW (2) to assess the current strategies employed in primary health care clinics to make HIV and SRH services adolescent youth-friendly and (3) to explore the potential of adolescent youth-friendly services in influencing HIV and SRH care among AGYW.

This study is framed by the culture-centered approach (CCA) in understanding AGYW's experiences when accessing HIV and SRH services in primary health care clinics. CCA is founded on the principles of listening to the voices of the margins that have hitherto been unheard in policy and programming circles. Purnell's cultural competency model (CC) of health care nurses is also crucial for AYFS to be effective among AGYW. This model encourages health care nurses to understand the heritage and culture in which their patients come from in order to provide acceptable and suitable HIV and SRH services. A participatory action research design was adopted, where data collection was threefold: a PhotoVoice workshop, focus group discussion and individual interviews.

Key findings from this study highlighted that lack of congruent care, administration, time management, shortage of infrastructure and health care nurses negative attitudes were identified as the main deficits to AGYW SRH care clinic. However, AYFS in primary health care clinics could encourage HIV and SRH care among AGYW. Having younger health care nurses at the clinic was one strategy that AGYW alluded to in this study. AGYW also mentioned that having a separate building for AYFS would improve their adherence to HIV and SRH services like HIV testing, family planning and antenatal care.

This study highlighted the need for greater understanding of the socio-cultural perceptions of health care workers' perceptions of adolescent sexual and reproductive health, and the provision of HIV and SRH services. This study found that HIV and SRH services are currently not youth-friendly for AGYW across all three clinics in which the study was conducted. AGYW described that the clinic structure does not have enough space to, and therefore hinders their privacy at the clinic. Health care nurses attitudes and the lack of communication between AGYW and nurses at the clinic were some of the key findings in this study. On the contrary, health care nurses find it challenging to focus one patient at the clinic because of shortage of clinical staff and administrative staff.

Key words: Adolescent Youth Friendly Services; Adolescent Girls and Young Women; Sexual Reproductive Health.

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Chapter One: Background to the study

Introduction

This introductory chapter provides a context for the thesis, which is an exploration of the role of user-driven adolescent youth-friendly services (AAYFS) in primary health care clinics and its influence in HIV prevention and sexual and reproductive health (SRH) care among adolescent girls and young women (AGYW). By exploring the perceptions of AGYW as the users of PHC clinics, greater understanding of AAYFS will be gained through their experiences and knowledge of SRH services. This study is situated in light of the escalating unplanned teenage pregnancies and increasing HIV rates among AGYW in South Africa. The study comes at a time when several global and local initiatives that set out to address some of these public health issues, the development of the World Health Organisation (WHO) global 90-90-90 goals of ending the AIDS epidemic by 2020 and the South African (2017) National Adolescent and Youth Health Policy designed to promote accessibility, efficiency, quality, and sustainability of AAYFS. This chapter outlines the foundation of the study, signifying the landscape of SRH among AGYW in South Africa. The research background and the research problem are clearly outlined, and then the chapter proceeds to provide the research questions and the objectives of this study. It gives an overview of the assumptions and theory upon which the study is based. The chapter goes on to briefly discuss the research approach and methodology used for the study, introducing the totality of the work.

HIV and AIDS in South Africa

In 2017 an estimated 36.9 million people were living with HIV (including 1.8 million children) with a global HIV prevalence of 0.8% among adults (UNAIDS 2018). Since the start of the epidemic, an estimated 77.3 million people have become infected with HIV and 35.4 million people have died of AIDS-related illnesses (AVERT, 2019). The vast majority of communities living with HIV are located in low- and middle- income countries, with an estimated 66% living in East and Southern Africa See table (1.1) (AVAC, 2019). Despite the significant progress in the HIV and AIDS epidemic, Sub-Saharan Africa still bears the brunt of this public health challenge. Moreover, the

healthcare systems in high burden contexts in Sub-Saharan Africa have been greatly affected as demand for prevention and treatment continue to increase (Naidoo, Adeagbo *et al.* 2019). In 2017 there were 1.8 million new infections globally, and Sub-Saharan Africa accounted for two thirds of these estimates, and young people in Sub-Saharan Africa accounted for one third of these estimates (Mojola and Wamoyi 2019, Skovdal 2019). Sub-Saharan Africa is a hyper-epidemic setting with persistently high HIV incidents rates despite numerous interventions, and AGYW are disproportionately affected, with 7000 weekly new infections estimated (Mojola and Wamoyi 2019, Skovdal 2019). An projected 12.2% of the population, approximately 6,8 million South Africans, are currently believed to be living with HIV and AIDS (UNAIDS, 2014; Statistics South Africa, 2015a).

In South Africa, KwaZulu Natal has been termed the HIV and AIDS hub with HIV prevalence is highest among AGYW. Research from the sub-district of uMgungundlovu, where Vulindlela is located, shows that although HIV prevalence has stabilized, incidence rates remain unacceptably in women below 30 years of age (Dellar, Dlamini *et al.* 2015, Kharsany, Frohlich *et al.* 2015, Karim, Baxter *et al.* 2017). For example, in Vulindlela, by age 16, one in every ten women who go to the clinic for antenatal services are already infected with HIV and this increases to one in three by age 20 and one in two by age 24 (Karim, Baxter *et al.* 2017).

It is evident that HIV and AIDS has escalated from being a public health challenge to multi-faceted issues that permeates all levels of Southern African society requiring a multi-disciplinary response. Sub-Saharan¹ regions indicate that AGYW between the ages of 15 to 24 are at higher risk of HIV infection and experience vulnerability to other SRH issues compared to their male counterparts (UNAIDS, 2016, WHO 2016; (Karim, Churchyard *et al.* 2009, Shisana, Rehle *et al.* 2014). HIV incidence rates among AGYW have remained high in South Africa; UNAIDS (2016) estimates that AGYW make up 70% of new infections among young people in sub-Saharan Africa suggesting that the already existing prevention interventions have not been effective in curbing the epidemic in this population group (Aral and Peterman 1998, MacPhail

¹ Defined here as including eight countries: Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

and Campbell 2001, Airhihenbuwa, Ford *et al.* 2014, Hall, Fottrell *et al.* 2014, Dellar, Dlamini *et al.* 2015).

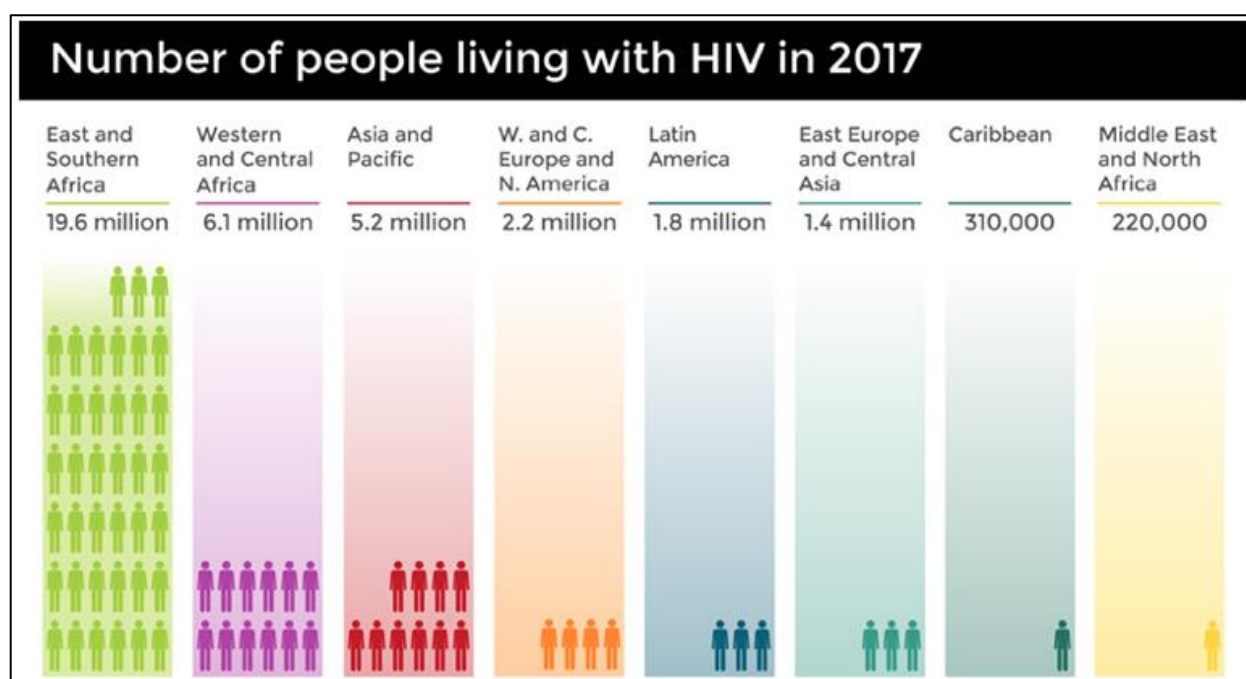
In order for HIV prevention methods to be effective among AGYW, support structures such as health care services² need to be accessible and youth friendly for AGYW given the disproportionate rates of HIV infection. Moreover, AGYW have been cited to have high unplanned pregnancy rates, various sexually transmitted diseases, and other sexual and reproductive health challenges in South Africa (Karim, Kharsany *et al.* 2014). However, this population group usually experiences limited access to SRH services, including stigma, lack of youth-friendly services and parental consent policies, making this a key group in the global 90-90-90 goals (Kranzer, Meghji *et al.* 2014, UNAIDS 2014, Davies and Pinto 2015).

Condom use among AGYW aged 15 to 24 years has been reported to dropped significantly from 66.5% in 2008 to 49.8% in 2017, this means that more and more AGYW are engaging in risky sexual activity, making them more vulnerable to HIV infection, and unplanned pregnancies (Naidoo, Adeagbo *et al.* 2019).

The points highlighted above suggest that AGYW sexual and reproductive health needs require urgent attention in South Africa. HIV prevention and SRH services that are adolescent youth-friendly, contextually relevant and culturally sensitive are important in South Africa. However, AGYW seeking HIV prevention and SRH services continue to face barriers in accessing these services, cited barriers include, discrimination, ill treatment from healthcare professionals, lack of confidentiality and privacy, inconvenient operation hours, fear of parents finding out about accessing SRH services, and other social challenges that hinder them accessing SRH services (Braeken and Rondinelli 2012, Mulaudzi, Dlamini *et al.* 2018, Naidoo, Adeagbo *et al.* 2019).

² Health care services, mean a service provided by a health workers to a patient aimed at preventing a health problem, or detecting and treating one. It often includes the provision of information, advice and counselling.

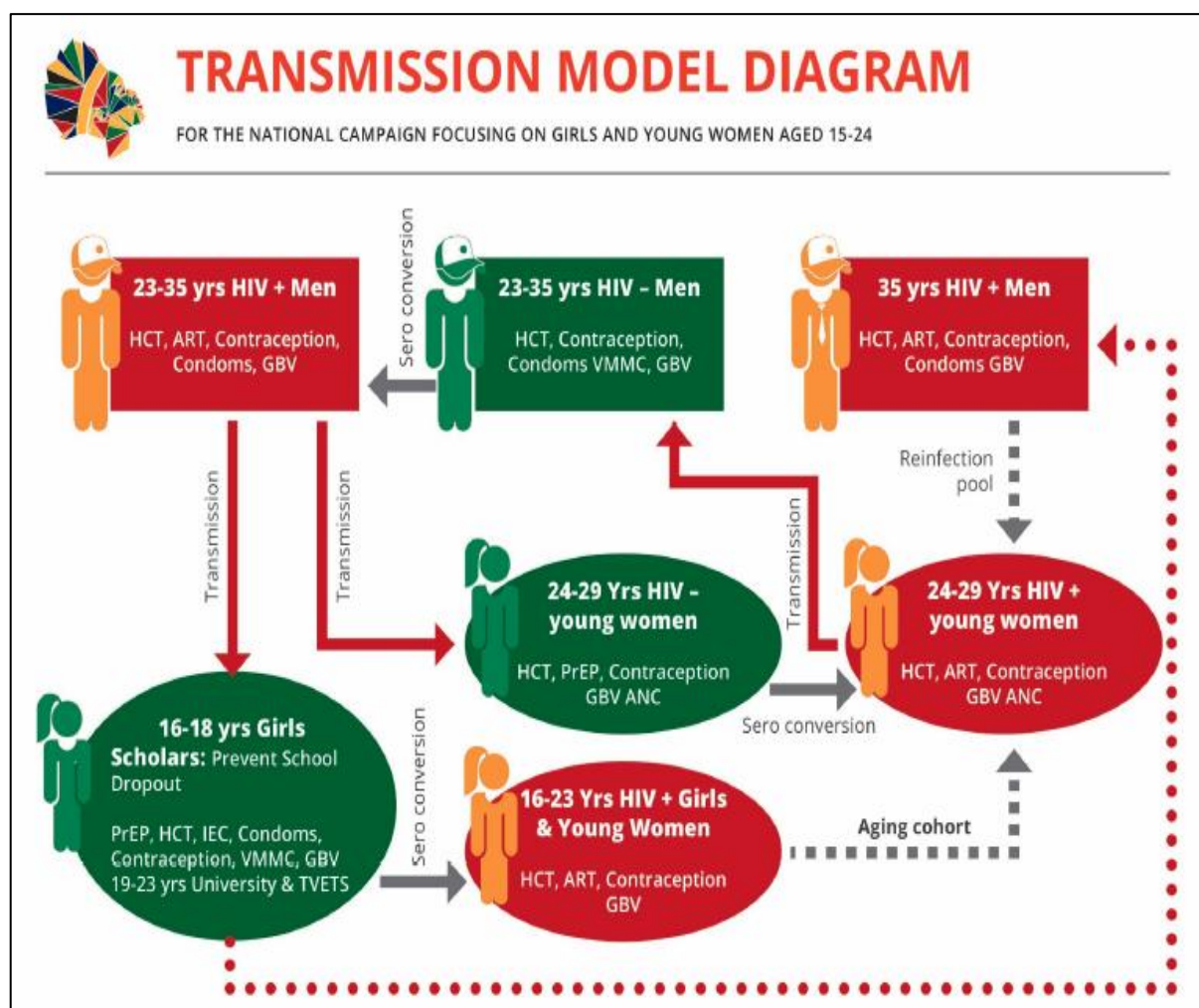
Table 1.1 Diagram representing the global statistics of HIV infection



Source: UNAIDS, (2018)

The diagram below depicts the transmission pattern among AGYW that highlights some of the social issues that subject AGYW to disproportionate HIV rates. These social issues include, early sexual debut and sexual relationships with significantly older male partners. These social issues are influenced by several factors that can often be traced to economic, cultural and contextual issues placing AGYW at high risk of HIV infection (Leclerc-Madlala 2003, Pettifor, Measham *et al.* 2004, Dellar, Dlamini *et al.* 2015). This underscores the crucial need to provide accessible adolescent-friendly services that offer HIV prevention interventions that are sensitive to their needs.

Figure 1.2 Diagram representing the transmission network of HIV-positive and men and adolescent girls and young women (AGYW)



Source: (De Oliveira, Kharsany *et al.* 2017)

Literature highlights that HIV prevention in combination with SRH services need to be prioritized in order to alleviate the HIV and AIDS epidemic among AGYW, and part of this process is understanding the geographical patterns in which the epidemic is spreading and identifying those that are most at risk (Penazzato, Lee *et al.* 2015). Informed by the need to alleviate HIV infection among AGYW, Tulio de Oliveira *et al* (2016) highlights the underlying dynamics of HIV, greater explanation of the sources and consequences of high rates of HIV infection among AGYW in South Africa.

Acknowledging the high prevalence rates of HIV among AGYW is crucial, however, the crux of this study is the inclusion of AGYW's voices in the design of adolescent youth-friendly services (AYFS) within primary health care clinics. Investigating youth-friendly services from the perspective of AGYW is imperative. As a key vulnerable population to HIV, exploring the role of AYFS in primary health care clinics and its role in influencing AGYW for HIV prevention and SRH care services is essential. This study seeks to understand user perceptions and user perspectives that are culturally relevant, localised and context specific from AGYW who are ultimately the users of HIV prevention tools and SRH care in primary health care clinics. This study aims to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW.

Adolescent and youth-friendly services (AYFS) for AGYW

Currently, SRH methods including HIV prevention and contraceptive methods available at the clinic like family planning, are part of the endorsed core packages that AGYW should have access to when they visit the clinic (Conner, 2015). However, these 'packages' are not yet youth-focused (MacQuarrie 2014). Policy makers, researchers and scientists in sub-Saharan Africa, have repeatedly emphasised the importance of adolescent youth-friendly health services (AYFS) and that these services must not only be "friendly but also supportive, providing a wide range of services and information (Brittain, Williams *et al.* 2015). AYFS must be geared to their needs, giving AGYW the opportunity to participate in decisions affecting their health (Geary, Webb *et al.* 2015). Youth-friendly services should be accessible, affordable, confidential and non-judgmental (Saber, Ming *et al.* 2018). They should not require "parental consent and should not be discriminatory" (Tylee, Haller *et al.* 2007).

Dating back to the early 1990's, when HIV acquired and accumulated the highest rates of infection among young people, studies have discovered that health care facilities that are not youth-friendly are a barrier to HIV prevention (Geary, Gómez-Olivé *et al.* 2014, Schriver, Meagley *et al.* 2014, Tanner, Philbin *et al.* 2014, Lee and Hazra 2015). Recommendations for creating youth-friendly services were made and highlighted as vital to reducing the number of new infections (Huntington *et al.* 1990; Bohmer & Kirumira, 1997; Hughes & McCauley 1998; Mfono, 1998; WHO; 1999; Speizer *et al.* 2000; WHO. 2001; (Tylee, Haller *et al.* 2007); Delany-Moretlwe *et al.* 2015).

Nonetheless, in the South African context, there is a scarcity of research available signifying the success of implementing youth-friendly services (Geary, Webb *et al.* 2015). The NFI programme is the only recorded programme formed in recognition that a successful sexual health intervention must be supported by health services that accommodate the needs of young people. Many NFI programmes have been implemented in South Africa, particularly in KZN involving the community and adolescent girls (Baloyi, 2006). It was found that adolescent girls made use of the NFI service, however, the numbers of adolescent girls becoming pregnant and contracting STI's did not decrease. There was a feeling that the HIV counselling and testing services were not adequately utilised (Baloyi, 2006).

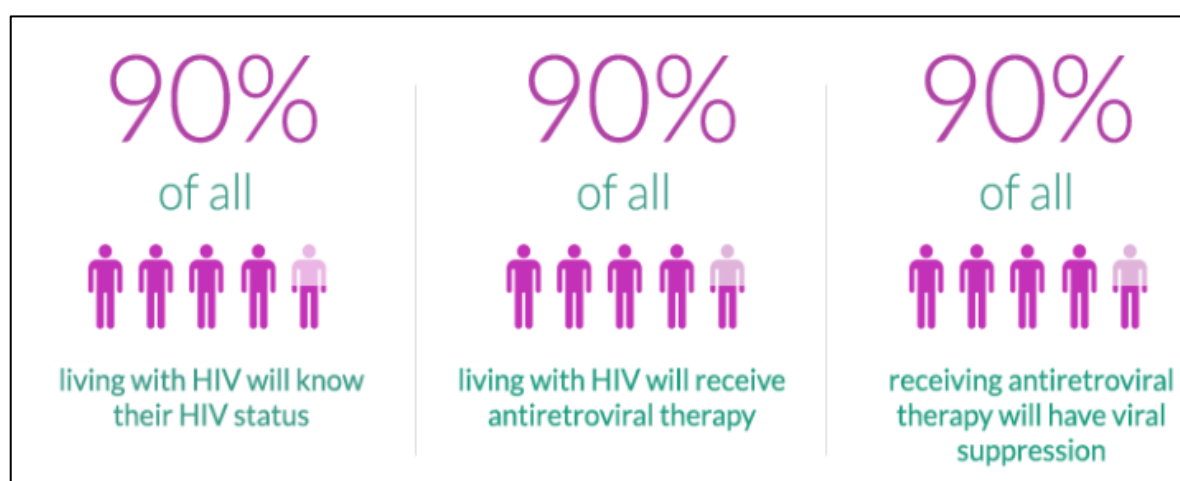
Given the disproportionate burden of HIV incidence among AGYW, HIV and SRH services need to be tailored to their specific needs (Senderowitz 1999, Mmari and Magnani 2003, Erulkar, Onoka *et al.* 2005, Geary, Gómez-Olivé *et al.* 2014, Brittain, Williams *et al.* 2015, Callie Simon 2015, Reif, Bertrand *et al.* 2016, James, Pisa *et al.* 2018, Saberi, Ming *et al.* 2018). It is highlighted that “the availability, accessibility, and acceptability of health care services for young women significantly impact their use of prevention methods, which in turn influences their risk for pregnancy and HIV infection” (Holt *et al.* 2012: 284). As a systematic intervention, AYFS aimed to create an environment for the effective uptake of HIV prevention tools and contraceptive options available for AGYW.

Adolescent youth-friendly services in context of the 90-90-90 goals

In response to HIV epidemic, UNAIDS (Joint United Nations Programme on HIV/AIDS) has committed to the ambitious 90-90-90 goals of ending the AIDS epidemic by 2020 (see Fig 1.3). The 90-90-90 strategy is an attempt to get the HIV epidemic under control and is based on the principle of universal testing and treating. The “test and treat” approach is centered on detecting HIV in infected individuals early and immediately initiate treatment in order to suppress the viral load. The onward transmission of HIV will be prevented and this will have an impact on HIV incidence at the population level. This approach requires healthcare services to detect HIV in individuals who are infected and asymptomatic (re). Healthcare services are therefore an important element in addressing the HIV and AIDS epidemic, young people need to know their HIV status, and receive SRH services to protect themselves against

sexually transmitted disease. This is particularly important for key population groups such as AGYW. HIV testing needs to be accessible to people. Access to these services needs to be prioritized by ensuring that all communities have healthcare services that have the capacity to service communities. Thus, it necessitates taking HIV testing into the community, and requires new and innovative ways to get people tested for HIV infection, more especially among key populations at high risk of infection.

Figure 1.3 Diagram presenting the UNAIDS 90-90-90 target



Source: (AVERT, 2019)

The second objective of the 90-90-90 goals involves ensuring that individuals diagnosed with HIV are placed on antiretroviral therapy (ART) immediately. Notably, HIV infected and asymptomatic individuals may not adhere to treatment because they seem to be healthy. There is thus need for adequate counselling and support to enlighten high risk populations like AGYW about the benefits of early initiation of ART and adherence. All these health services are made available in PHC clinics in South Africa. Effective and safe delivery of medical care for HIV requires a sequence of diagnostic tests, assessments, treatment delivery, support and monitoring. This care continuum has been termed the 'HIV treatment cascade'. The cascade can be used to illustrate and measure the effectiveness of a country's ART programme.⁵Cascades report various stages, including total HIV positive people, diagnosed, linked to care, retained in care, treatment eligibility, on ART, adherence to treatment, retention post ART initiation and viral suppression.

There are gaps that adequately highlight that in HIV diagnosis and provision of ART, which may be unattainable under the ambitious UNAIDS 90–90–90 goals given the current trends (UNAIDS 2014, Lee and Hazra 2015). However, the goals only make sense if HIV testing is performed under acceptable conditions and appropriate interventions to ensure linkage to care after testing are put in place. For adolescent youth-friendly services that aim at providing SRH services that are ‘user-driven’, the World Health Organisation (WHO) suggests that adolescent girls and young women need to be given the platform to define their own problems and make suggestions towards establishing them in ways that address issues that increase their risk of HIV infection and offer appropriate HIV prevention methods (WHO, 2012).

Study location

Vulindlela the epicentre of HIV transmission.

The study location is situated in what has been called the HIV and AIDS hub, where HIV prevalence rates are higher than most contexts in South Africa. The highest HIV prevalence rates in South Africa occur in KwaZulu-Natal (KZN) (Shisana, Rehle *et al.* 2014, Kharsany, Frohlich *et al.* 2015). The study location is a rural area in KwaZulu-Natal called Vulindlela (see figure 1.4). Vulindlela is a sub-district in the uMgungundlovu Municipality within KwaZulu-Natal. This context is largely made up of farmlands, traditional rural settlements, and informal and peri-urban living characterized by high burdens of HIV rates (Kharsany, Frohlich *et al.* 2015). In Vulindlela, by the age 16, one in every ten women who go to the clinic for SRH services are already infected with HIV and this increases to one in three by age 20 and one in two by age 24 (Karim, Baxter *et al.* 2017). Vulnerability among AGYW in South Africa and other countries is mostly located in rural communities (Gregson, Nyamukapa *et al.* 2002, Wang and Wu 2007, Wamoyi, Wight *et al.* 2010, Kharsany, Frohlich *et al.* 2015, Ranganathan, Heise *et al.* 2016).

Rurality and health care in Vulindlela

To further illustrate the depiction of rural communities and health, in South Africa, infant mortality rates due to teenage pregnancy in rural areas are 1.6 times that of urban areas. Rural adolescents are 77% more likely to be underweight or under height for age; 56% of rural South Africans in comparison to urban areas live more than 5 km

from a health facility (Strasser 2003). It raises the notion that there should be health programmes like AYFS which actively seek to reverse the rural-urban drift with the health care system for key populations like AGYW. Furthermore, 75% of South Africa's poor and disadvantaged populations live in rural area, with concentration of poverty, low health status and high burden of viruses like HIV and diseases like AIDS (Strasser 2003). As a simplification, lifestyle-related illnesses are more common in the rural areas. The peaks and troughs of the economic cycle tend to impinge more directly on rural communities in South Africa, with economic downturns often placing severe pressure on these communities (Strasser 2003). Research conducted in Vulindlela over the past five years depicts these conditions, where most young women face experience economic pressure that leads to age disparate relationships with older male partners (Naicker, Kharsany *et al.* 2015, Kharsany and Karim 2016, De Oliveira, Kharsany *et al.* 2017).

This area encompasses farmlands and traditional settlements, informal and peri-urban living (Kharsany, Frohlich *et al.* 2015). Vulindlela is a rural community with a population of about 150 000 Zulu-speaking people, there are 16 primary healthcare clinics (PHC) in this area and 60 community-based organizations that are interested in providing HIV prevention home-based services (Kharsany, Frohlich *et al.* 2015). The Vulindlela area is characterized by high burdens of HIV incidents, in 2012 it was estimated that HIV prevalence in this area was close to 40% in women aged 20-24 years and exceed 50% in women aged 25-34 years (CAPRISA, 2015).

The geography and the environment of rural communities in comparison to urban environments is unique. But rurality is commonly understood when compared to urban communities, where facilities and infrastructure like schools and clinics are accessible. Recent research on the dynamics of young people's relationships in rural communities like Vulindlela found that sexual relationships were characterised by gender inequality, unequal decision-making and poor communication and that peer pressure was a significant factor in the decisions AGYW made in relation to their sexual behaviour and reproductive health (Leclerc-Madlala 2002; Wood and Jewkes 1997). "Ruralities," as multifaceted lived experiences and ideas, are core to the identity of many rural community-based young women (Marsden 2006). The term 'rural' remains an elusive concept, howbeit (Marsden 2006) understands rurality as a signifier which is

transformative, capable of changing behaviour. Additionally, the concept of rurality affords the researcher the opportunity to illustrate the setting and context in which the study will be conducted. Furthermore, this offers an outline of the research participants in this study.

The transformative nature of rurality serves both to inform and to delimit the effectiveness of intervention programs designed for behavior and social change. It is unsurprising, given the urban-focused understanding of sexuality, that health care in the rural areas remains beset with problems and challenges simply not considered within policy, theoretical, and pragmatic initiatives (Chisholm, 2004). AGYW living in rural settings, find themselves understood within the confinements of poverty, unemployment, inadequate access to health care, high rates of school dropout, early childbearing presenting a route for upward social mobility and transactional sex (Mkhwanazi 2010, Stoebenau, Nixon *et al.* 2011, Ranganathan, Heise *et al.* 2018)

Figure 1.4 Image showing the location of the study as priority sub-District for HIV prevention among AGYW



Source: (Karim, Baxter *et al.* 2017)

The study will take a participatory approach (Creswell 1998, Dutta 2008, Creswell 2009, Babbie 2011, Dutta 2011) to engage with AGYW in order to gain insight into their views and perspective about what they consider youth-friendly services. For AYFS services to be effective, encouraging AGYW to utilise SRH services provided for them in primary health care clinics, their inclusion in the design of AYFS is crucial. Research studies, highlighted in chapter two of this study show that the current

structure and the organisation of SRH services often does not encourage young women to attend primary health care services for SRH services. This study therefore, locates itself within the participatory design. HIV prevention among AGYW, who are recorded the worst affected and only group that still has an increase in HIV infection (UNAIDS, 2016) is critical in altering the current epidemic discourses and ensuring epidemic control in Southern Africa.

It should be noted that the underlying objective of participation is empowerment of marginalised communities who in this study are AGYW. These are key concepts that will be discussed in the methodology and theoretical chapter in this study. Gaining insight into AGYW's perceptions about youth-friendly service has the potential to enable the primary health care clinic to be a safe space to receive SRH service, it will assist nurses to know what the users want and can tailor their services to meet AGYW's need. Perhaps, their perspectives can inform health policy makers to respond to the first two 90-90-90 goals appropriately concerning AGYW as a key population group.

Research Aims and Objectives

This study has three main objectives:

- 1. To investigate the way primary health care clinics offer youth-friendly HIV and SRH services for adolescent girls and young women (AGYW) in Vulindlela.**

Numerous studies have revealed that AGYW are neither well-received nor comfortable in mainstream family planning clinics, which are mostly government-owned maternal and child health/family planning (MCH/FP) facilities (Bearinger, Sieving *et al.* 2007, Biddlecom, Munthali *et al.* 2007, Cowan and Pettifor 2009, Kuruvilla, Bustreo *et al.* 2016, Commission 2019, Nkosi, Seeley *et al.* 2019). Many of the existing studies regarding young people's reception at the clinic have focused on provider's reactions to them (Johnston, Harvey *et al.* 2015, Saberi, Ming *et al.* 2018). Therefore, this study offers a user perspective on what AGYW want for services to be youth-friendly for them. By first, understanding how primary health care clinics in Vulindlela are youth-friendly or not youth-friendly for AGYW, this study hopes to obtain

greater insight from AGYW who are users of the clinics. This will enable the researcher to deduce whether the youth friendly strategy will be competent for AGYW.

2. To identify the current strategies employed to make the primary health services youth friendly for AGYW in primary health care clinics in Vulindlela.

Adolescent sexual and reproductive health forms a major proportion of the global burden of sexual ill-health of AGYW (Roxo, Mobula *et al.* 2019). SRH services have traditionally focused on adult women of reproductive age, often neglecting the needs younger women. Identifying the strategies that clinics are currently employing to make SRH services youth-friendly is imperative, considering that comprehensive SRH services for AGYW should be tailored to the needs of adolescents and youth, based on the recognition of the specific challenges that they face. Once we distinguish the strategies being implemented and what each strategy is meant to achieve, it will be evident whether new strategies are required or whether the existing one's should be improved.

3. To explore the potential of a youth-friendly services model in understanding SRH care among AGYW.

The mission statement stipulated in the (2017) National Adolescent and Youth Health Policy's is to improve the health status of young people through the prevention of illness, the promotion of healthy lifestyles, and the improvement of the health care delivery system by focusing on the accessibility, efficiency, quality, and sustainability of adolescent and youth-friendly health services (AAYFS). While the experiences and needs of young people are at the centre of this policy, sexual reproductive health does not result solely from individual behaviours. There are structural and systemic contributions that can hinder and limit the effectiveness of health among youth. Multiple studies that have been conducted acknowledge the World Health Organisations (WHO) recommendations that AAYFS must be those that are equitable, accessible, acceptable, appropriate and effective. However, there are few studies that have evaluated these recommendations in South Africa, particularly in rural contexts.

Although this study's aim is not to evaluate the WHO recommendation for effective AAYFS, the researcher in this study aims to explore potential the potential of AAYFS among AGYW in Vulindlela can contribute to strengthening this intervention for SRH services.

Research Questions

This study has three research questions:

1. In what ways are primary health care clinics offering HIV and SRH services for AGYW in rural KZN youth-friendly?
2. What are the current strategies employed to make HIV and SRH services youth- friendly in primary health care clinics in rural KZN?
3. What potential does youth-friendly services have in understanding the uptake of HIV prevention tools and SRH care tools among AGYW in rural KZN?

Organisation of Thesis

The research will be organised as follows:

Chapter one provides the reader with the background and overview of the study. Giving a brief overview of the statistical prevalence of HIV and SRH related issues among AGYW like unplanned pregnancy. The chapter highlights the critical position of AGYW within the HIV continuum, supported by contributing factors that have positioned this key population negatively. This chapter introduces the reader to the main research aims and objectives, articulating the significance of the study. It contextualises the development of AYFS and its role in HIV prevention and SRH care among AGYW. Lastly, it gives context to the theoretical framework employed in this study.

Chapter two reviews the literature related to the research area, documenting some of the arguments and findings about the current status of HIV infection, prevention and available methods. It catalogues and explains the concept of youth-friendly services and its importance in the HIV prevention response for AGYW. It highlights previous research studies that have acknowledged and evaluated AYFS as an effective strategy for HIV and SRH services for AGYW

in primary health care clinics. The chapter conveys that, despite biological, structural and behavioural interventions that have been previously implemented, barriers to HIV and SRH care services in South Africa remain.

Chapter three surveys the theoretical framework that underpins this study. The culture-centered approach (Dutta 2008) and Purnell's cultural competency model (Purnell 2002) are closely described in terms of how they relate to this study. CCA centers on culture, agency and structure within health communication, advocating for culturally specific solutions to health care issues like HIV and SRH. Purnell's cultural competency model forms part of transcultural nursing theory. The model unpacks the critical role of culturally competent health care nurses in primary health care clinics. The model highlights key domains that health care nurses should understand influence patients behaviour. The consideration of these domains is the strategy to provide culturally competent HIV and SRH services. The foundational perspective of the theories foreground the research methodology applied in this study.

Chapter four outlines the methodological procedures that were followed in the execution of the study. It explains the methodological approach which guided the research design. The chapter explains the participatory worldview and the participatory action research design, which were the theoretical foundations for data collection. The process of data collection and data analysis is outlined, with the research trustworthiness and ethical accommodations made in the study as this study was conducted with some AGYW below the age 18. The ontological and epistemological insights of the study are further elaborated in this chapter.

Chapter five presents the visual and verbal data collected. The data collected was threefold: PhotoVoice workshops, focus groups and interviews in order to answer the research questions. This chapter presents all the visual and verbal data according to the key themes

Chapter six offers an analysis of the key research findings. The initial analysis for the visual findings was firstly sifted using the SHOWED strategy. Findings discussed in relation to the literature reviewed, CCA and Purnell's CC model. This chapter aims to understand the findings of the study from the theoretical perspective of the CCA and the CC model.

Chapter seven highlights the contributions made in this study, It highlights the need for a more context driven and localised approach to the successful use of AYFS by AGYW in Vulindlela. The chapter explains the surveillance model that should be employed in a community in order for AYFS to be effective. It draws from the findings, theory and the literature review. Lastly, the chapter concludes the findings of this study and highlights the limitations experienced.

Chapter eight reviews the research process and the significance of the findings. It also provides recommendations for further research. An amalgamation of these chapters results in an intricate bricolage⁵ which serves to connect the parts (chapters) to the whole (thesis).

Chapter two: Literature Review

Introduction

For the majority of young South Africans, sexual activity starts in the mid-teens, with an estimated national average age of first intercourse at 15 years for girls and 14 for boys 16 (Shisana, Rehle *et al.* 2014). Studies in South Africa reveal that nearly one-third of 15–19-year-olds and almost two-thirds of 20–24-year-olds reported having been pregnant, with the overall rate for 15–19-year-olds being 15.5% (Karim, Kharsany *et al.* 2014, Kharsany, Frohlich *et al.* 2015, Simbayi, Zuma *et al.* 2019). Just as important is the finding that 65% and 71% of the pregnancies among the young women reported unplanned and unwanted (Odimegwu, Amoo *et al.* 2018).

More than 17 000 of these teenage pregnancies were located in KwaZulu-Natal alone (Shisana, Rehle *et al.* 2014, Odimegwu, Amoo *et al.* 2018, Manyapelolo, Van den Borne *et al.* 2019). In addition, adolescents' knowledge of sexuality and reproductive health is generally poor (Dixon-Mueller 2008), and a substantial number have indicated a need for more information on such issues as pregnancy, relationships and sexually transmitted infections (STIs) (Chandra-Mouli, Mapella *et al.* 2013). In addition to the need for more information, there is evidently a need for youth-friendly services. In spite of the high prevalence of HIV, STIs and teen pregnancy, many young people do not use public health services in South Africa, and have reported barriers when they have attended clinics (Mbeba, Mkuye *et al.* 2012, Bogart, Chetty *et al.* 2013, Geary, Gómez-Olivé *et al.* 2014). As in other countries, the barriers reported by young people relate to access and quality, including the attitude of staff, the time of the service, confidentiality, embarrassment at being seen in the clinic waiting room with adults from their community, and not understanding their diagnosis or treatment (Bogart, Chetty *et al.* 2013, Kranzer, Meghji *et al.* 2014, Delany-Moretlwe, Cowan *et al.* 2015)

There is an urgent need to meet the HIV prevention and sexual and reproduction health (SRH) needs of adolescent girls and young women (AGYW), particularly those who are unable to negotiate monogamy and condom use. Young women (15-24 years) and adolescent girls (10-19 years), in particular, account for a disproportionate number of new HIV infections. In 2016, new infections among AGYW aged (15-24) were 44%

higher than men their age (AVERT 2018). The incidence rates among this key population have remained high and several studies have presented this as a public health challenge (Abdool, Abdool *et al.* 1991, Karim, Kharsany *et al.* 2014, Mansoor, Karim *et al.* 2014, Mastro, Sista *et al.* 2014, Kharsany, Frohlich *et al.* 2015, Naicker, Kharsany *et al.* 2015, Kharsany and Karim 2016, De Oliveira, Kharsany *et al.* 2017). This suggests that the already existing HIV prevention and SRH interventions have not been effective in curbing the epidemic (MacPhail & Campbell, 2001). Therefore, HIV prevention among AGYW is critical in altering the current epidemic discourses and ensuring epidemic control in Southern Africa. Adolescent youth-friendly services (AYFS) within healthcare clinics has been recommended as a programme that can facilitate optimal uptake of HIV prevention technologies and other sexual and reproductive health (SRH) related preventative methods like contraceptives among AGYW.

Firstly, this chapter reviews literature on AGYW vulnerability in the context of the HIV epidemic in South Africa. As a health communication scholar, the researcher explores some of the communication strategies to effectively engage AGYW about HIV prevention and SRH services in primary health care clinics. Past models of communication have often assumed a more linear process whereby interventions are designed for sending messages to a receiver through a channel, where the receiver is assumed to be passive, and difference in contexts and demographics are ignored (Melkote and Steeves 2001, Gumede 2017). These were individualist behaviour change strategies, that often failed to account for contextual, social and other various factors that are part of the individuals community and society (Durden and Govender 2012). In HIV health communication research, (McKee, Bertrand *et al.* 2004) have proposed that communication should be strategic, meaning that it should combine various elements, including linkages to other programme elements and level that stimulate positive and measureable behaviour change among the intended audience (Gumede 2017). Developments in health communication have resulted in a shift in focus from behaviour change communication, which focuses on the individual, to social change communication, which takes into consideration the cultural context of those being targeted in health communication campaigns, and which integrates media, interpersonal communication and advocacy (Dutta and Basu 2007, Govender 2011).

Secondly, literature reviewed in this chapter is on sexual and reproductive health (SRH) services in South Africa. In the context of HIV prevention, tracking health care services in South Africa, this chapter will uncover the progression of AYFS in primary health care clinics. This chapter also highlights the global and national responses to AGYW vulnerability to HIV and the need for SRH care among AGYW. This context, positions the chapter to critically discuss the AYFS programme and its role in primary health care clinics for AGYW in South Africa. This chapter reviews literature on AYFS as a response to the HIV and SRH needs of AGYW, overall addressing the main research question in this study.

South African overview of HIV and AIDS

In 2017 an estimated 36.9 million people were living with HIV (including 1.8 million children) with a global HIV prevalence of 0.8% among adults (UNAIDS, 2018). Since the start of the epidemic, an estimated 77.3 million people have become infected with HIV and 35.4 million people have died of AIDS-related illnesses (AVERT, 2019). The vast majority of communities living with HIV are located in low- and middle- income countries, with an estimated 66% living in East and Southern Africa See table (1.1) (AVAC, 2019). Despite the significant progress in the HIV and AIDS epidemic, Sub-Saharan Africa still bears the brunt of this public health challenge. Moreover, the healthcare systems in high burden contexts in Sub-Saharan Africa have been greatly affected as demand for prevention and treatment continue to increase (Naidoo, Adeagbo *et al.* 2019). In 2017 there were 1.8 million new infections globally, and Sub-Saharan Africa accounted for two thirds of these estimates, and young people in Sub-Saharan Africa accounted for one third of these estimates (Mojola and Wamoyi 2019, Skovdal 2019).

Sub-Saharan Africa is a hyper-epidemic setting with persistently high HIV incidents rates despite numerous interventions, and AGYW are disproportionately affected, with 7000 weekly new infections estimated (Mojola and Wamoyi 2019, Skovdal 2019). A projected 12.2% of the population, approximately 6,8 million South Africans, are currently believed to be living with HIV and AIDS (AVERT, 2019). In South Africa, KwaZulu Natal has been termed the HIV and AIDS hub with HIV prevalence is highest among AGYW. For example, in Vulindlela, by age 16, one in every ten women who

go to the clinic for antenatal services are already infected with HIV and this increases to one in three by age 20 and one in two by age 24 (Karim, Baxter *et al.* 2017).

HIV and AIDS has escalated from being a public health challenge to multi-faceted issues that permeates all levels of Southern African society requiring a multi-disciplinary response. Sub-Saharan³ regions indicate that AGYW between the ages of 15 to 24 are at higher risk of HIV infection and experience vulnerability to other SRH issues compared to their male counterparts (UNAIDS, 2016, WHO 2016; (Karim, Churchyard *et al.* 2009, Shisana, Rehle *et al.* 2014). HIV incidence rates among AGYW have remained high in South Africa; UNAIDS (2016) estimates that AGYW make up 70% of new infections among young people in sub-Saharan Africa suggesting that the already existing prevention interventions have not been effective in curbing the epidemic in this population group (Aral and Peterman 1998, MacPhail and Campbell 2001, Airhihenbuwa, Ford *et al.* 2014, Hall, Fottrell *et al.* 2014, Dellar, Dlamini *et al.* 2015).

In order for HIV prevention methods to be effective among AGYW, support structures such as health care services⁴ need to be accessible and youth-friendly for AGYW given the disproportionate rates of HIV infection. Moreover, AGYW have been cited to have high unplanned pregnancy rates, various sexually transmitted diseases, and other sexual and reproductive health challenges in South Africa (Karim, Kharsany *et al.* 2014). However, this population group usually experiences limited access to SRH services, including stigma, lack of youth-friendly services and parental consent policies, making this a key group in the global 90-90-90 goals (Kranzer, Meghji *et al.* 2014, UNAIDS 2014, Davies and Pinto 2015).

Condom use among AGYW aged 15 to 24 years has been reported to dropped significantly from 66.5% in 2008 to 49.8% in 2017, this means that more and more

³ Defined here as including eight countries: Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.

⁴ Health care services, mean a service provided by a health worker to a patient aimed at preventing a health problem, or detecting and treating one. It often includes the provision of information, advice and counselling

AGYW are engaging in risky sexual activity, making them more vulnerable to HIV infection, and unplanned pregnancies (Naidoo, Adeagbo *et al.* 2019).

The points highlighted above suggest that AGYW SRH needs require urgent attention in South Africa. HIV prevention and SRH services that are adolescent youth-friendly, contextually relevant and culturally sensitive are important in South Africa. However, AGYW seeking HIV prevention and SRH services continue to face barriers in accessing these services particularly in rural communities in South Africa. Cited barriers include, discrimination, ill treatment from healthcare professionals, lack of confidentiality and privacy, inconvenient operation hours, fear of parents finding out about accessing SRH services, and other social challenges that hinder them accessing SRH services (Braeken and Rondinelli 2012, Geary, Gómez-Olivé *et al.* 2014, Schriver, Meagley *et al.* 2014, Geary, Webb *et al.* 2015, Mulaudzi, Dlamini *et al.* 2018, Naidoo, Adeagbo *et al.* 2019).

AGYW at the centre of the HIV epidemic: a rural concentration

HIV risk and vulnerability among AGYW in South Africa and other countries is mostly located in rural communities (Gregson, Nyamukapa *et al.* 2002, Wang and Wu 2007, Wamoyi, Wight *et al.* 2010, Kharsany, Frohlich *et al.* 2015, Ranganathan, Heise *et al.* 2016). The geography and the environment of rural communities in comparison to urban environments is unique. But rurality is commonly understood when compared to urban communities, where facilities and infrastructure like schools and clinics are accessible. Research on the dynamics of young people's relationships in rural communities like Vulindlela found that sexual relationships were characterised by gender inequality, unequal decision-making and poor communication and that peer pressure was a significant factor in the decisions AGYW made in relation to their sexual behaviour and reproductive health (cf. Leclerc-Madlala 2002; Varga 1999, 2003; Varga and Makubalo 1996; Wood, Maforah, and Jewkes 1998; Wood and Jewkes 1997, 1998). "Rurality's," as multifaceted lived experiences and ideas, are core to the identity of many rural community-based young women. Therefore, the term 'rural' remains an elusive concept, howbeit (Marsden 2006) understands rurality as a signifier which is transformative, capable of changing behaviour. The transformative nature of rurality serves both to inform and to delimit the effectiveness of intervention programs designed for behavior and social change.

The province of KwaZulu-Natal is at the epicentre of the epidemic. In four of its eleven districts, HIV prevalence is highest among AGYW (Dellar, Dlamini *et al.* 2015, Kharsany, Frohlich *et al.* 2015, Karim, Baxter *et al.* 2017). For example, in Vulindlela, by age 16 one in every ten women who go to the clinic for antenatal services are already infected with HIV and this increases to one in three by age 20 and one in two by age 24 (Karim, Baxter *et al.* 2017). It is unsurprising, given the urban-focused understanding of sexuality, that health care in the rural areas remains beset with problems and challenges simply not considered within policy, theoretical, and pragmatic initiatives (Chisholm, 2004). AGYW living in rural settings, find themselves understood within the confinements of poverty, unemployment, inadequate access to health care, high rates of school dropout, early childbearing presenting a route for upward social mobility and transactional sex (Mkhwanazi 2010, Stoebenau, Nixon *et al.* 2011, Ranganathan, Heise *et al.* 2018).

Risk behaviors of AGYW: what makes them vulnerable?

AGYW face the dual risk of contracting HIV and teenage pregnancy at an early age (Zuma *et al.* 2010). The statistical evidence of the prevalence of HIV among AGYW indicates the complexity of adolescents' sexual and reproductive needs in the context of the HIV epidemic. SRH is broad and it encompasses a variety of services. It requires that researchers and health care practitioners also understand adolescent sexuality and behaviour. The vulnerability of dual risk among AGYW in South Africa creates an environment where understanding their perceptions of sexuality, and the influences these have on their SRH, is imperative (Coetzee 2017). Thus "HIV prevalence in adolescent communities provides a reasonable proxy for incident HIV infections" (Kharsany *et al.* 2014: 956). Specifically, adolescent girls aged 15 to 19 years who have acquired HIV, acquire the virus five to seven years earlier than their male counterparts, with a "three- to- four-fold higher incidence rate" (Kharsany *et al.* 2014: 956).

It is for this reason that the AIDS epidemic has been identified as a "gendered epidemic" in South Africa (Hoosen and Collins, 2004: 488). It raises the question of why AGYW are so vulnerable to HIV infection. In order to comprehend fully the complexity of sexuality, "a sound understanding of the local epidemic is required as

well as the bio-behavioural nexus that renders AGYW more vulnerable to HIV infection” (Dellar, Dlamini and Abdool Karim, 2015: 68). Considering the increased risk of AGYW contracting HIV, as well as the risk of falling pregnant, one has to consider the influence of perceived risk on the sexual behaviour of adolescents. “A requirement for translating knowledge into behaviour change is a feeling of personal vulnerability to HIV infection” (MacPhail and Campbell, 2001: 1619).

In the South African National HIV Prevalence, Incidence and Behaviour Survey (Shisana, Rehle *et al.* 2014), the researchers identified early sexual debut, age-disparate relationships, multiple sexual partners and poor condom use as the main behavioural determinants in the spread of the HI virus and teenage pregnancy among adolescents. The cause of vulnerability in adolescents is difficult to elucidate; however, research suggests certain prominent structural, social and biological factors that increase risk, specifically in adolescent females (see figure 2.1) (van der Riet and Nicholson, 2014; Dellar, Dlamini and Abdool Karim, 2015; Naicker *et al.* 2015). Specifically, these are “age-disparate relationships, transactional relationships, limited schooling, experience of food security, experience of gender-based violence, increased genital inflammation” (Dellar, Dlamini and Abdool Karim, 2015: 64).

Socio-behavioural factors

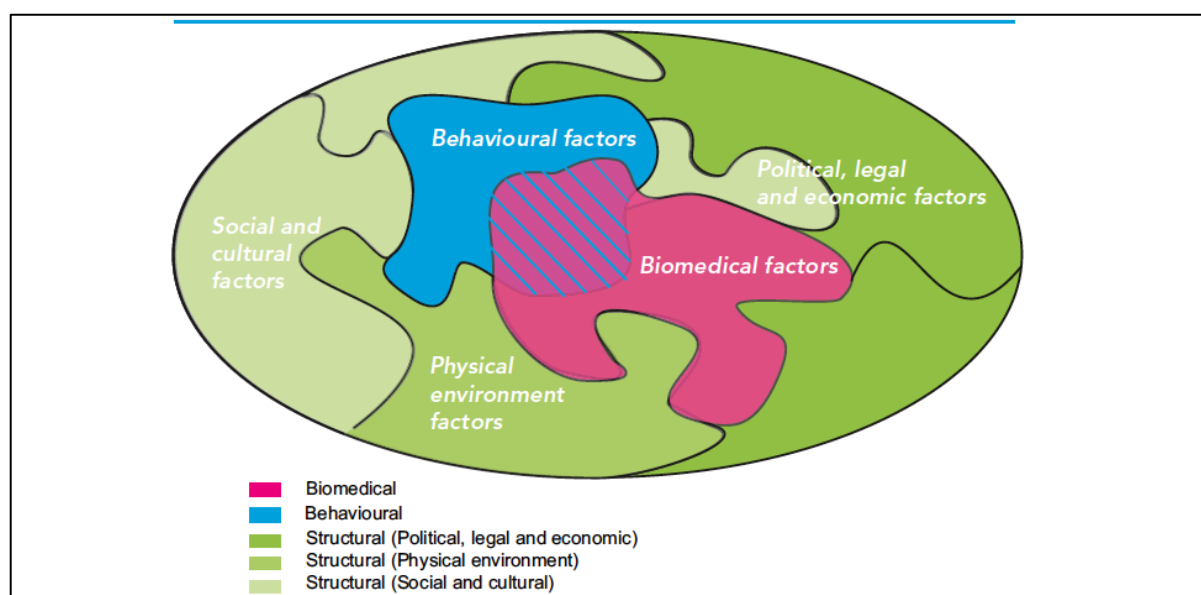
Socio-behavioural factors that are seen to increase the risk of adolescent females contracting HIV include the high levels of intergenerational relationships between young women and older men, coupled with the lowered ability to negotiate condom use due to gender-related power dynamics (Dellar, Dlamini and Abdool Karim, 2015; Naicker *et al.* 2015). This is similar with teenage pregnancy, Bankole *et al.* (2007) undertook a detailed analysis of knowledge of correct condom use and consistency of use, among adolescents in Burkina Faso, Ghana, Malawi and Uganda. One of the main findings of this study showed that age difference between partners is a major determinant of consistent use of contraception (Bankole, Biddlecom *et al.* 2007). Another study revealed teenage pregnancy as a *development* problem and a *health* problem (Govender 2011). Seeing teenage pregnancy as a development problem would also result in communities, civil society and government addressing it as a larger problem of poverty, inequality and gender relations. On the other hand, teenage

pregnancy as a health problem focuses on the sexual decisions of individuals as an approach to address behaviour change (Govender 2011). Acknowledging this creates a place and a space for a clearer understanding that factors are linked and dependent on each other.

“We also recognize that sexual behaviour is ‘widely’ diverse and deeply embedded in individual desires, social and cultural relationships and environmental and economic processes hence making the process of evaluation enormously complex” (Odutolu 2005)

Within the South African context, researchers have often confined factors that contribute to unplanned and unwanted pregnancies within four categories; social, economic, cultural and political. Although they are conventionally disconnected, these factors are interdependent. This interdependence can be described as an *ecosystem*; showing the complex set of structures, policies, cultures and relationships that form our understanding of teenage pregnancy and HIV prevalence.

Figure 2.1: Representing the interacting causes of HIV risk and vulnerability



Source: (UNAIDS, 2010)

To further illustrate this, Flanagan *et al* (2013) provided a comprehensive diagram highlighting how sexual activity and lack of contraceptive use place AGYW at immediate risk of unplanned pregnancy and possibly, HIV acquisition.

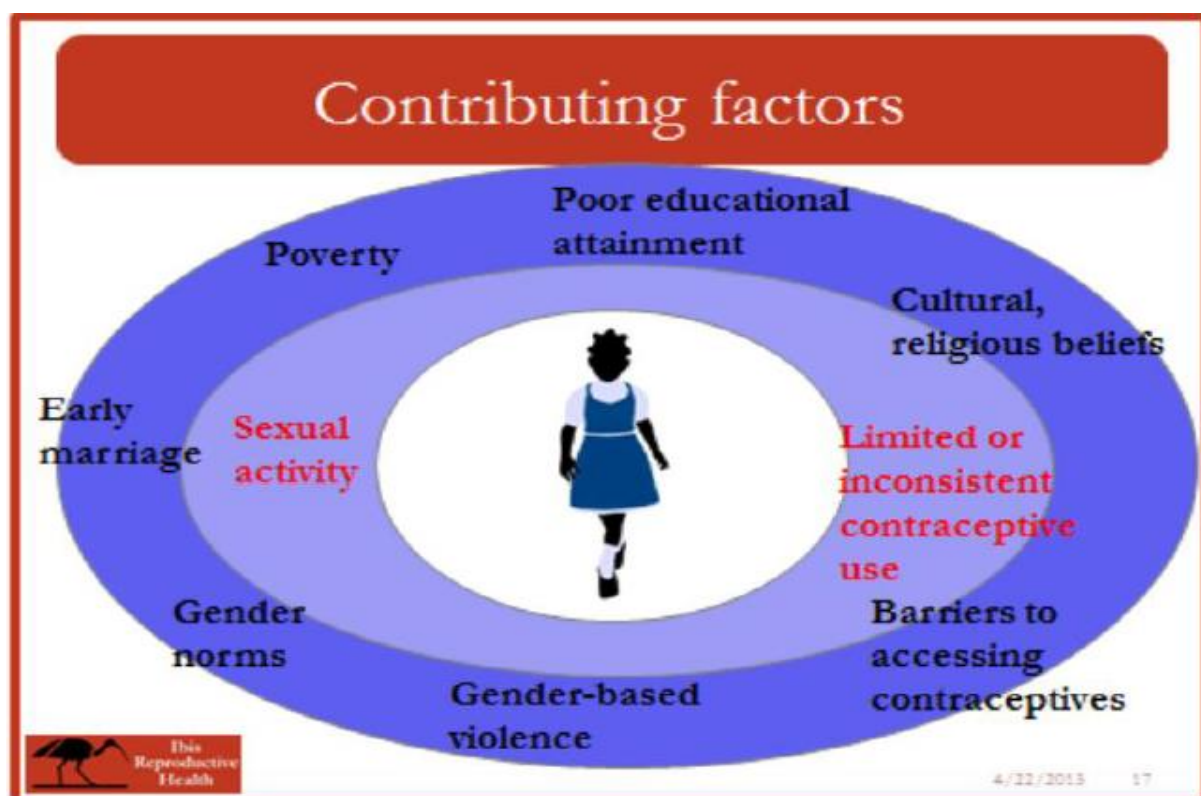
‘Sugar Daddy – Blesser syndrome’

“I do love him but at the same time, food has to be on the table.” (Selikow and Mbulaheni 2013). Arguably the most convincing driver of the agesex disparity in HIV acquisition observed in sub-Saharan Africa is the high prevalence of intergenerational relationships between young women and older men (Gregson, Nyamukapa *et al.* 2002, Pettifor, MacPhail *et al.* 2008). The aggregating prevalence of HIV with increasing age means that, *ceterius paribus*, a young girl engaging in a sexual relationship with an older man is at much higher risk of HIV acquisition compared to a young girl engaging with a male peer (Shisana, Rehle *et al.* 2014). Further, a young woman engaging in a relationship with an older man may be less likely to negotiate condom use given the gender-power dynamics in the southern African setting, further augmenting her risk (Gregson, Nyamukapa *et al.* 2002, Pettifor, Measham *et al.* 2004). Consistent with these data, a number of studies have demonstrated that engagement in an age disparate or intergenerational relationship is strongly associated with increased HIV prevalence in young women (Gregson, Nyamukapa *et al.* 2002). Understanding the complex factors that drive adolescent girls and young women (AGYW) to engage in sexual relationships with older men is challenging, but may be critical in terms of adequately addressing the prevention needs of this key population.

Findings from Bankole, Ahmed *et al.* (2007) showed that age difference between partners was the major determinant of inconsistent use of contraception. Power differentials among relationships between older men and younger women have led adolescent girls to become passive partakers who do not have the “capacity to protect themselves against sexually transmitted diseases like HIV” (Wood and Jewkes 1998, Dunkle, Jewkes *et al.* 2004). Beyond engagement in age-disparate relationships, other risk factors for HIV infection in young women include early sexual debut, few years of schooling, food insecurity, loss of a family member, and experience of gender-based violence (Pettifor, Rees *et al.* 2005, Dixon-Mueller 2008, Karim, Kharsany *et al.* 2014, Dellar, Dlamini *et al.* 2015). Many of these factors may mediate their effects on HIV

acquisition via increasing the relative value of financial capital available through engagement in transactional relationships with older men (Dunkle, Jewkes *et al.* 2004, Weiser, Leiter *et al.* 2007). However, independent pathways of risk mediation are also likely to exist. Food insecurity, for example, may also make young women biologically more susceptible to HIV (Weiser, Young *et al.* 2011).

Figure 2.2: Interdependency of factors contributing to HIV and teenage pregnancy



Source: Flanagan *et al.* (2013)

Engagement in age-disparate relationships has also been identified as a central factor in shaping the understanding of sexuality and the increase of HIV risk in young women (Harrison *et al.* 2001; Dellar, Dlamini and Abdool Karim, 2015; Kharsany *et al.* 2015; Evans *et al.* 2016). According to literature, there are different types of relationships that AGYW have with older partner. In their study, (Stoebenau, Heise *et al.* 2016) distil three prominent paradigms observed in the literature toward presenting a unified conceptualization of transactional sex. “Sex for basic needs,” the first paradigm, positions women as victims in transactional sexual relationships, with implications for interventions that protect girls from exploitation. In contrast, the “sex for improved social status” paradigm positions women as sexual agents who engage in transactional sex toward attaining a middle-class status and lifestyle (Selikow, Zulu *et al.* 2002, Stoebenau, Heise *et al.* 2016). “adolescent girls said that they perceived their partners loved them because they gave them gifts of clothing and money” (Wood and Jewkes 1998, Stoebenau, Nixon *et al.* 2011). Finally, a third paradigm, “sex and material expressions of love,” draws attention to the connections between love and money, and the central role of men as providers in relationships (Wamoyi, Wight *et al.* 2010, Stoebenau, Heise *et al.* 2016, De Oliveira, Kharsany *et al.* 2017, Ranganathan, Heise *et al.* 2018).

Contrary to the belief that the male ‘provision’ is an act of love, Zygmunt Bauman (2013) describes relationships under modernity as being contingent and temporary. He discusses that in a liquid modernity characterised by consumerism and technology, relationships become objects of consumption and love becomes liquid and disposable (Bauman 2013). This is similar to the culture of consumerism highlighted by Selikow, Zulu *et al.* (2002) that has forced adolescent girls into the confinement of a glamourised expensive lifestyle that is unaffordable to them. Bauman (2013) argues that not only has the concept of sex become a commodity for material possessions among young women but that the notion of *love* has also been diluted. There are important commonalities in the structural factors that shape the three paradigms of transactional sex including gender inequality and processes of economic change. Therefore, there are three continua stretching across these paradigms: deprivation, agency, dialogue and instrumentality (Stoebenau, Heise *et al.* 2016).

Cultural Perspectives

The aspect of culture in understanding the factors that influence teenage pregnancy has previously been overlooked. Interventions and behaviour change strategies have previously substituted the cultural context of people and replaced it with cultures and traditions alien to their own communities and societies. Although there has been a movement towards more context specific strategies, with researchers highlighting the importance of participation (Cardey, 2006; Airhihenbuwa, 1995); to understand the cultural context in which people live can sometimes go beyond knowing their cultures in an abstract manner, but may cause researchers to first observe the lifestyle within a community when trying to understand behaviour change.

“Cultural and contextual conditions should be appreciated far more, because they play an important and often decisive role in how people make meaning of their lives in general, and in particular, how negotiations and decisions relating to sex (uality) are made” (Petersen, 2009:100).

Recently research shows that the constraints of culture and traditional constructions are part of the factors that are perceived to have influenced teenage pregnancy. Robert Morrell and Lahoucine Ouzgane (2005) associate these traditional constructs to the historical background of South Africa, where male virility was measured by how many sexual partners one has, historically this was within polygamous marriages (Morrell & Ouzgane, 2005). The patriarchal divide; the power that being a man gave them the right to choose to exercise power over women is still evident even in contemporary sexual relationships (Morrell and Ouzgane 2005). This is supported by Jean Baxen & Anders Breidlid (2009) who discusses how women have been socialised from an early age to be subordinate and submissive to men, due to how relationships were shaped historically (Baxen and Breidlid 2009).

“In many societies, women lack control over their bodies and, for the most part, over decisions about their lives”. (Petersen, 2009:101). Due to this, the sex act itself has become the site of multiple power differentials” (Holland *et al.*, 1991:1).

Eaton *et al* (2003) additionally discusses discourses that surround the subordination of women and reveal two main themes relating to male sexuality: biologically determined “need”, and sexual “rights”. The claim that it is in man’s nature to want many partners, and that staying with one woman goes against the essence of being a man (Eaton *et al.* 2003). Some women come to believe this, too. Due to the patriarchal nature of African cultures, most decisions affecting females and their reproductive health are in the hands of males, leading to some women covertly using contraception without the knowledge of their spouses (Ncube, 2011). The notion that masculinity implies having unprotected sexual practices with numerous partners is particularly well-developed in South Africa (Eaton *et al.* 2003). Likewise, youth justify their impulsive, unprotected sexual practices through a discourse of biology and (Eaton *et al.* 2003). The discourse of “rights” appears in the way young men claim ownership of their sexual partners (Eaton, Flisher *et al.* 2003). This behaviour is supported by the social norm that a man has a right to engage in sexual intercourse within a romantic relationship (Eaton *et al.* 2003).

There are multiple factors that influence the understanding of sexuality among AGYW. This study has specifically highlighted HIV acquisition and teenage pregnancy as key issues affecting AGYW. This study was conducted with women between the ages of 15 and 24 years old, because high rates of HIV infection and unwanted pregnancies are most recorded among them. This means that life-changing decisions about their sexuality and the critical development of their understanding of SRH would be taking place at this age. This study highlights that many preventative tools and methods that have the potential to curb the increase of teenage pregnancy and among AGYW are located in primary health care clinics in many locations in South Africa. This study aims to explore the potential of adolescent youth-friendly services (AYFS) influencing SRH care among AGYW.

Biological complexity

It is generally accepted that women have a higher per-act risk of HIV acquisition after virus exposure than men (Hira, Nkowane *et al.* 1990, Yi, Shannon *et al.* 2013). One important factor in this increased risk, and also in the discrepant results of studies from different cohorts, is a simple matter of surface area. The surface area of the cervico-

vaginal mucosa, the site of initial HIV exposure during heterosexual vaginal sex, is considerably larger than that of the penis and foreskin, with the latter being the site of most HIV acquisition in uncircumcised men (Yi, Shannon *et al.* 2013). Many young women become infected after just a few coital encounters, and on a population level, acquisition seems almost synonymous with sexual debut (Glynn, Caraël *et al.* 2001, Pettifor, Rees *et al.* 2005).

As such, there has been significant investigation into potential biological factors that might augment behavioural risk, and a number of factors have been hypothesised to result in heightened vulnerability to infection in young women, compared both to men and to older women (Yi, Shannon *et al.* 2013). For example, a number of studies focused on serodiscordant couples have highlighted a higher per-act risk of HIV acquisition in women compared to men. A portion of this effect may be attributed to the higher viral load typically observed in men, but the phenomena may also be explained at least in part by physical factors that result in increased exposure to HIV in women, compounded both from the comparatively larger surface area of the cervico-vaginal mucosa and from the increased HIV mucosal exposure time (semen can remain in the female genital tract up to three days post-coitus) (Yi, Shannon *et al.* 2013).

Further, adolescent girls and young women (AGYW) are more susceptible to HIV infection compared to older women, and there are a number of biological factors that have been promulgated to explain this age variability in vulnerability. For example, the immature cervix has a greater proportion of genital mucosa exposed to HIV that is highly susceptible to infection, and young women have relatively high levels of genital inflammation which have consistently been reported to increase HIV acquisition risk (Yi, Shannon *et al.* 2013, Dellar, Dlamini *et al.* 2015). Together these biological factors may create a “perfect storm” of conditions in recently sexually debuted AGYW in Southern Africa making them uniquely vulnerable to HIV infection when exposed to the virus via engaging in unprotected sex with an HIV-positive partner (Karim, Churchyard *et al.* 2009, Yi, Shannon *et al.* 2013, Kharsany, Frohlich *et al.* 2015).

⁵ SEE: <http://www.catie.ca/en/pif/spring-2015/hiv-prevention-within-serodiscordant-couples-changing-paradigm>

Identity Crisis- The transition from childhood to adolescents

As children make the transition from childhood to adolescence and engage in the process of identity formation, their reliance on parents and siblings as the sole sources of influence and decision-making begins to change (Panday *et al.* 2009). Increasing interaction with other role models - best friends, peers, teachers and community members, begin to expand their sphere of influence (Panday *et al.* 2009). Peer attitudes, norms and behavior as well as perceptions of norms and behavior among peers have a significant and consistent impact on adolescent sexual behavior. Studies have shown that when teenagers believe that their friends are having sex, they are more likely to have sex and when a positive perception about condom use is perceived among peers, adolescents are more likely to use condoms and contraceptives (Kirby, 2002; Sieving *et al.* 2006).

“Identity refers to a sense of who one is as a person and as a contributor to society” (Sokol, 2009:5). Identity is what makes one move with direction; it is what gives one reason to be (Sokol, 2009). In line with this study, it is important to understand the state of mind and the heightened emotions caused by the sudden growth and development that adolescents go through. Therefore, the context in which adolescent girls make decisions regarding their sexuality and behavior; is essential in this study. In order to understand some of the socio-economic and cultural factors that influence high rates of teenage pregnancies that are commonly unplanned, this study highlights some of the psychological and cognitive factors that could be of influence low contraceptive use among teenage girls.

For an adolescent girl with adulthood on the horizon, identity formation questions emerge: “Who am I?” and “What is my place in this world?” (Sokol, 2009), and when an individual is able to access their personal attributes and match these with outlets for expression available in the environment, it is safe to say identity has been formed (Sokol, 2009). The formation of identity would mean that a teenage girl develops within a society and within an environment in which she finds herself, with an already existing knowledge of whom she is and where she fits in. She would not be subject to influences within her surroundings, but rather, would be better equipped to be the

catalyst of her own future. This appears to be the perfected image of a teenage girl; however, James Marcia (1980), states that, identity formation does not happen neatly. This is a time when adolescents must relinquish their parents, relinquish childhood ideology and most importantly relinquish the fantasised possibilities of multiple, glamorous life styles. In the ongoing construction of an identity, that which one negates is known; what one affirms and chooses contains an element of the unknown.

In keeping with this study, the researcher is exploring the phase of identity crisis among teenage girls as a possible contributing factor to the low rates of contraceptive use among teenage girls. When attempting to understand issues of behaviour change, knowledge of risk of HIV infection and teenage pregnancy among teenage girls; it is critical that one comprehends how an identity that is not well-formed at this junction can influence the decisions teenage girls make about their sexuality.

'Cliques and Crowds' – Peer Pressure

The social influence to fit in with friends is seen as a big reason why many young people are sexually active (Myers, 2014). In a study on the risk factors related to teenage pregnancy in Cape Town, Jewkes *et al.* (2001) reported that sex often happened because most adolescents perceived that people of their age were sexually active (Jewkes, Vundule *et al.* 2001). Similar findings were reported among adolescent girls in KwaZulu-Natal. While peers encourage sexuality among friends, pregnancy itself is highly stigmatized as it is regarded as a poor showing of female decorum (Jewkes, Vundule *et al.* 2001). The study also reported that while constructions of femininity require women to be chaste and adhere to sexual fidelity, girls often feel pressure from friends to maintain multiple sexual partnerships as a means to gain peer group respect (Kaufman, De Wet *et al.* 2001). Similarly, (Wood, Maepa *et al.* 1997) reported that girls who were sexually inexperienced were excluded from friendship circles when issues of sexuality were discussed because they were regarded as 'children'.

The 2003 RHRU survey also provides some indication of the degree of peer influence on sexual behavior. While 68% of youth reported that they received no pressure from friends to have sex, 10% reported that they received a lot of pressure to have sex. Females (74%) were more likely than males (61%) to report no pressure at all to have

sex. In addition, 29% of teens aged 15-19 years thought that all of their friends were sexually active and an equal percentage reported that half or more of their friends were having sex. Although friends (40%) are the least trusted source of information about HIV (Kaiser Family Foundation & SABC, 2006), 72% of young people have talked to their friends about HIV, far greater than conversations with teachers, partners, siblings and health workers (Pettifor *et al.* 2004). Peer pressure further takes to be the reason why young men feel they should not use condoms when engaging in sexual practices.

Self-esteem

It is postulated that generally, a person with poor sexual self-concept may rely on others for self-confidence; this is often done through having multiple sexual encounters (Eaton *et al.* 2003). Research has found that low self-esteem is associated with earlier onset sexual activity and having more sexual partners (Myers, 2014; Eaton *et al.* 2003; Perkel, Strebel, & Joubert, 1991; DiClemente, 1990). A more general driver of teenage pregnancy is thought to be a lack of self-esteem, self-efficacy and vision for the future (Myers, 2014). It is generalised that young women who are most likely to successfully use contraception are those who had well-defined plans for themselves, 'who know what they want' in life and who have clear educational goals (Myers, 2014). Young women who are assertive ('rather than pleasing men') and confident are said to be less influenced by peer pressure (Myers, 2014).

There is also an indication that young people with low self-esteem may be more concerned about what their parents think of them and with avoiding displeasure or rejection from partner than are people with more positive, self-affirming self-concepts (Eaton *et al.* 2003). A person with low self-esteem is therefore more likely to think that condoms and any other method of contraceptives are offensive to their partner (Eaton *et al.* 2003). They may think that using condoms make their partner think they are dirty, to be embarrassed about using condoms and to have a negative attitude towards condoms (Eaton *et al.* 2003). Low self-esteem seems to undermine abstinence, monogamy and condom use.

Sarah Hoosen and Anthony Collins (2004) introduce an important aspect in understanding the issue of self-esteem. The 'Discourses of love'; they postulate that the notion of love makes it difficult for women to ask questions about fidelity that might threaten the basis of their relationships (Hoosen & Collins, 2004). Sexual practices are constructed as an expression of devotion where paradoxically both protected sexual practices and unprotected sexual practices could be expressions of romantic love (Hoosen & Collins, 2004). On one hand, love is expressed through unprotected sexual practices as a form of intimacy. On the other hand, love could be expressed through sexual practices with a condom. Furthermore, trust is an important aspect of romantic love which makes it difficult to broach the subject of risk, as this would entail breaching the implicit expression of trust in the fidelity of the other partner's mind (Hoosen & Collins, 2004). Trust and love are explanations that are used for not engaging in safe sexual practices, even though some women are aware that their partners are unfaithful to them (Hoosen & Collins, 2004). The discourse of love entrenches the subordination of women by supporting women's silence around talking about sex. This is one of the factors that have exacerbated teenage pregnancy in South Africa.

HIV Prevention interventions for AGYW: A combination approach

The burden of HIV infection among AGYW continues even with existing tested HIV prevention methods. Since the beginning of HIV, researchers and health communication practitioners have developed and implemented various interventions to curb the HIV infection among AGYW and these prevention interventions have progressed over time. These HIV prevention interventions extend from biomedical prevention innovations, behavioural changes and structural interventions (Hosek and Pettifor 2019). The UNAIDS proposed the combination strategy as an HIV prevention approach that addresses all three layers of HIV prevention, that is, biomedical, behavioural and structural interventions (Hankins and de Zaluendo 2010). The combination of all three interventions is believed to have a sustainable impact on curbing the rise of new HIV infections among key populations like AGYW in communities.

Global strategies informing HIV prevention and adolescent health

The number of adolescents dying due to AIDS-related illnesses tripled between 2000 and 2015, the only age group to have experienced a rise (UNICEF 2017). In 2016,

55,000 adolescents between the ages of 10-19 had died through AIDS-related causes (UNICEF 2019). AIDS is now the leading cause of death among young people in Africa and the second leading cause of death among young people worldwide. In particular, young women (less than 25 years of age) in African countries make up about half of all people currently infected with HIV. Sub-Saharan Africa has suffered the greatest impact of this disease, (WHO 2009, WHO and Unicef 2015, UNICEF 2017, UNICEF 2019). Multiple governments and international organizations have signed up to commitments to reduce the rates of adolescent pregnancy, STIs and HIV. International organisations such as UNAIDS and their partners advocate for governments to work towards global targets within their national strategic plans.

Sustainable Development Goals (SDG)

In 2015 the Millennium Development Goals (MDGs) were replaced by 17 Sustainable Development Goals (SDGs), each with specific targets to be achieved by 2030 (UN 2015). Under the SDG framework, the three MDGs relating to health were replaced by the following, overarching health goal (WHO 2015):

SDG 3: Ensure healthy lives and promote wellbeing for all at all ages(including universal access to HIV prevention services, sexual and reproductive health services and drug dependence treatment and harm reduction services) (UNAIDS 2017). SDG 3 contains the following targets: (i) target 3.3: end AIDS as a public health threat by 2030; (ii) Target 3.8: achieve universal health coverage, access to quality health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all. However, a number of other SDGs also relate to the HIV response. These are; *SDG 4: Quality education*, including targets on comprehensive sexual and reproductive health (SRH) education and life skills; *SDG 5: Gender equality*, including targets on sexual and reproductive health and rights (SRHR) and the elimination of violence, harmful gender norms and practices; *SDG 10: Reduced inequalities*, including targets on protection against discrimination, and the empowerment of people to claim their rights and enhance access to HIV services; *SDG 16: Peace, justice and strong institutions*, including reduced violence against key populations and people living with HIV (UNAIDS 2017)

UNAIDS Fast-Track strategy

Launched in 2014, the UNAIDS Fast-Track strategy (UNAIDS 2014) outlined plans to step up the HIV response in low-and middle-income countries to meet the SDG 3 target to end AIDS by 2030 (AVERT 2018). The strategy acknowledges that, without rapid scale-up, the HIV epidemic will continue to outrun the response (UNAIDS 2014). To prevent this, it outlines the need to reduce new HIV infections and AIDS related deaths by 90% by 2030, compared to 2010 levels. To achieve this, the Fast Track strategy sets out targets for prevention and treatment, known as the 90-90-90 targets (UNAIDS 2014, Davies and Pinto 2015). This includes, reducing new annual HIV infections to fewer than 500,000 by 2020 and to fewer than 200,000 by 2030 – ending AIDS as a public health threat (UNAIDS 2014).

The 90-90-90 strategy

In response to HIV epidemic, UNAIDS has committed to the ambitious 90-90-90 goals of ending the AIDS epidemic by 2020, these goals purpose to get 90% of all people living with HIV to know their status by 2020, ensure 90% of all people diagnosed with HIV will receive antiretroviral treatment (ART), and ensure 90% of people on ART achieve viral suppression⁶ (UNAIDS, 2016). The 90-90-90 strategy is an attempt to get the HIV epidemic under control and is based on the principal of universal testing and treating. The “test and treat” approach is centered on detecting HIV in infected individuals early and immediately initiate treatment in order to suppress the viral load. The onward transmission of HIV will be prevented and this will have an impact on HIV incidence at the population level. This approach entails that the health services detect

⁶ Viral suppression is when a person’s viral load – or the amount of virus in an HIV-positive person’s blood – is reduced to an undetectable level.

HIV in individuals who are infected and asymptomatic. Thus, it necessitates taking HIV testing into the community, and requires new and innovative ways to get people tested for HIV infection, more especially vulnerable populations like AGYW.

The second objective of the 90-90-90 goals involves ensuring that individuals diagnosed with HIV are placed on antiretroviral therapy (ART) immediately. Notably, HIV infected and asymptomatic individuals may not adhere to treatment because they seem to be healthy. There is thus need for adequate counselling and support to enlighten AGYW about the benefits of early initiation of ART and adherence. The 90-90-90 goals are highlighted to illustrate that even the strategies that are developed as a global response, through policy and government still require implementation at a community level. What is important for this study is the understanding that AGYW are at the center of the HIV epidemic, therefore requiring SRH services that are equitable, accessible, acceptable, appropriate and effective in order curtail their vulnerability (WHO, 2012).

It is highlighted that “the availability, accessibility, and acceptability of health care services for young women significantly impact their use of contraceptive and HIV prevention tools, which in turn influences their risk for pregnancy and HIV infection” (Holt, Lince *et al.* 2012). Even though a multisectoral global response is underway for AGYW, it is imperative that the South African health system takes a leading and strategic role in preventing (WHO 2009). In addition to providing health-care services, the health sector should provide AGYW with information and counselling that could help reduce their vulnerability and risk (World 2012).

South African strategies informing HIV prevention and adolescent health

Flowing from this global commitment to safeguard the sexual and reproductive health of adolescents, several policy instruments at a national level have been adopted.

In South Africa, *the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014-2019)* was adopted by the Department of Social Development (DSD) in 2015. This framework provides guidance on action to ensure that adolescent sexual and reproductive health and rights are prioritised, in order to curb unwanted negative SRH outcomes for adolescents in the country. This

framework advocates for an approach that involves multiple stakeholders in multiple sectors to address adolescent pregnancy, and states that schools, hospitals, clinics, traditional leaders, community-based organisations, the community, government and the family and caregivers must all be involved in such efforts. The framework further makes recommendations for all sectors involved, including parents, to be capacitated with knowledge and skills to be able to communicate effectively with adolescents on issues of sexuality.

The *National Adolescent & Youth Health Policy (AYHP (2016-2020))* was adopted by the National Department of Health (NDOH), with aims to provide comprehensive, integrated sexual and reproductive health; Test and treat for HIV/AIDS and empower adolescents and youth to engage with policy and programming on youth health. This policy document highlights the importance of youth involvement when designing and developing programmes tailored for them.

More recently, in 2017, the *National Adolescent and Youth Health Policy (AYHP)* was adopted by the National Department of Health (NDOH), with one of its aims being to guide the designing and implementation of health programmes and services that enhance health and well-being amongst adolescents and youth (NDOH, 2017). In this policy document, the Department of Health (DOH) acknowledges that health promotion depends on providing functional and youth-friendly healthcare services.

This study aims to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW. Stemming from the AYHP 2017, this study is interested in understanding AGYW's experiences youth-friendly of HIV and SRH services at the clinic. Studies show, that most programmes designed for youth, their effectiveness is often not evaluated by them (Geary, Gómez-Olivé *et al.* 2014, Schriver, Meagley *et al.* 2014, Geary, Webb *et al.* 2015).

Adolescent youth-friendly services

Adolescent youth-friendly services in other countries

Internationally, there is a growing recognition that AYFS are needed if adolescents are to be adequately provided with preventative and curative health care (Sovd *et al.* 2006). Other countries worldwide have introduced youth-friendly services and have integrated it within their health care services. In the United States (US) currently, adolescents reported that their main reason for visiting health care clinics was because it is a “teen-only” clinic that allowed them to freely communicate their health needs without other clinical users. In addition, the services were rendered to them without cost (Sovd *et al.* 2006). Similarly, in Sweden, youth clinics have been responding to the health needs of young people; and young people are satisfied with the care provided (Goicolea *et al.* 2016). In Haiti, the implementation of youth-friendly services within their primary health care system improved retention immediately after HIV testing, assessment of ART eligibility and ART initiation by 61% among adolescents (Reif, Bertrand *et al.* 2016).

In Norway, primary health care clinics adopted the concept of user-driven youth-friendly service in one of their HIV clinics (Berg, *et al.* 2015). They discovered that providing HIV treatment and other SRH services fails to meet the real needs of HIV positive patients and those seeking health care (Berg, *et al.* 2015). “We talk about medication and CD4 counts, but not the individual human challenges” (Berg, *et al.* 2015:735). Thus, the clinic approached patients, encouraging them to become involved on a user board that would consider the services patients wanted (Berg, *et al.* 2015). This could have been successful due to the support structures that the country offers towards the advancement of health care services at a macro and a micro level. There could be policies that support the involvement of users towards creating youth-friendly services. Rigmor Berg and colleagues record that the Norway health system is guided by policy that states that the involvement of users is fundamental to efforts to improve the quality of health care; user involvement is considered democratic imperative, of intrinsic value (Berg, Weatherburn *et al.* 2015).

Within the African context, countries like Kenya and Botswana are also gradually responding to the need of youth-friendly services (Erulkar, Onoka &, 2005; Mohamud,

2008; UNFPA, 2016). Although the concept of youth-friendly services has been acknowledged, studies evaluating the 'youth friendliness' and what makes the clinic more or less 'youth-friendly' have not yet been conducted (Thomé, Malm *et al.* 2016). South Africa in recent years have introduced health policies that integrate user perspectives within the health system, adopting some principles from the user-centered approach. Adolescents in South Africa cited that the most important factor that prohibits young people from visiting a clinic was provider and staff attitude towards young people (Reif, Bertrand *et al.* 2016). The attitudes of health care providers at the clinic demonstrates that the involvement of users has not yet translated into the design of youth-friendly services in a comprehensive way in South Africa (Tylee *et al.* 2007).

Adolescent youth-friendly services (AYFS) in South Africa

The concept of a "youth-friendly" approach, that is, tailoring health services to address the developmental needs of young people and the unique barriers they face, with the aim of promoting greater access to and use of health services, has received increased attention (Brittain, *et al.* 2015). Sexual and reproductive health services specifically tailored to AGYW are a fairly recent public health initiative (Denno, Hoopes *et al.* 2015, Kaufman, Smelyanskaya *et al.* 2016, Naidoo, Adeagbo *et al.* 2019). Previously, young people were not considered to need reproductive health services because of the way society viewed the norms of adolescent sexuality (Coetzee 2017). Significant social change has taken place that has prompted programme planners and managers to re-evaluate the assumptions of adolescent HIV and adolescents' SRH needs.

It is considered that "adolescent health care is distinct from both paediatric and adult health care because of the physiological and psychosocial transitions that occur during this period" (Jaspan *et al.* 2009: 9). Furthermore, the HIV and SRH needs of adolescents were put at the forefront of reproductive health care services as the alarming increase of HIV infection in adolescents became apparent (Senderowitz 1999). It was for this reason that it was identified that AGYW require "comprehensive, integrated services that respond to their specific developmental needs" (Delany-Moretlwe *et al.* 2015: 29).

AYFS have been implemented for over two decades in low- and middle-income countries (LMIC). While studies of AYFS are limited both in number and in their ability

to assess the impact of AYFS on health outcomes, sufficient evidence exists to suggest that AYFS can increase young people's use of SRH services when they include three major components: (1) training for health care providers (on youth-friendly service provision and core competencies for delivering adolescent health services); (2) improvements in facilities to increase access and quality of services for young people (e.g., lowering user fees, organizing services to improve client flow, and increasing privacy), (3) and community-based activities to cultivate an enabling environment and increase demand (Tylee, Haller *et al.* 2007, Mavedzenge, Luecke *et al.* 2014). Furthermore, young people themselves consistently prioritize privacy, confidentiality, and respectful treatment by providers as the most important attributes of quality health services.

Efforts in recent years have focused on not only ensuring health service availability but also making its provision adolescent friendly, that is according to the WHO quality of care framework (2015), to be considered youth-friendly, health services for young people should be:

1. *Accessible*
2. *Acceptable*
3. *Appropriate*
4. *Equitable*
5. *Effective*

These efforts aim to increase the ability and willingness to obtain services, particularly among those adolescents who need them the most (Denno, Hoopes *et al.* 2015). Below is a detailed list of adolescent-friendly characteristics that could contribute to making health facilities and other points of health service delivery more adolescent-friendly. They are organized according to the five broad dimensions of quality listed in (Figure 2.2). This list was created from a longer list of characteristics developed at the WHO Global Consultation in 2001⁷ and in subsequent discussions.

⁷ World Health Organization, Department of Child and Adolescent Health and Development. Global consultation on adolescent friendly health services: a consensus statement, Geneva, 7–9 March 2001 (WHO/FCH/CAH/02.18). Geneva, World Health Organization, 2002.

Global health organizations, including the International Conference on Population and Development Plan of Action, the Maputo Plan of Action, and the World Health Organization, (WHO) have called for the development of youth-friendly health services worldwide (WHO 2003, Resnick, Catalano *et al.* 2012). This call perpetuated the development of the adolescent youth-friendly services (AYFS) programme. The focus of the programme is the implementation of a package of interventions, tailored to meet the special needs and problems of AGYW, which includes the provision of information and skills, the creation of a safe and supportive environment, and the provision of health and counselling services (World 2012).

Figure 2.3: World Health Organisation standards of adolescent health youth-friendly services

Nr.	Characteristic
Equitable	
1	Policies and procedures are in place that do not restrict the provision of health services on any terms
2	Health care providers treat all adolescent clients with equal care and respect, regardless of status
3	Support staff treats all adolescent clients with equal care and respect, regardless of status.
Accessible	
4	Policies and procedures are in place that ensure that health services are either free or affordable to adolescents.
5	The point of health service delivery has convenient hours of operation.
6	Adolescents are well-informed about the range of available reproductive health services and how to obtain them
7	Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.
8	HF Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves.
Acceptable	
9	Policies and procedures are in place that guarantee client confidentiality.
10	The point of health service delivery ensures privacy.
11	Health-care providers are non-judgmental, considerate, and easy to relate to.
12	The point of health service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.
13	The point of health service delivery has an appealing and clean environment.
14	The point of health service delivery provides information and education through a variety of channels.
15	Adolescents are actively involved in designing, assessing and providing health services.
Appropriate	
16	The required package of health care is provided to fulfill the needs of all adolescents either at the point of health service delivery or through referral linkages.
Effective	
17	Health-care providers have the required competencies to work with adolescents and to provide them with the required health services.
18	Health-care providers use evidence-based protocols and guidelines to provide health services.
19	Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients
20	The point of health service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.

Source: (WHO, 2012).

Nonetheless, global health organizations like WHO, UN and UNAIDS; including policy makers must consider that AGYW from different races and cultures may express similar or different views about the kinds of health services they require, including

South African AGYW. Health services can be described as adolescent-friendly if they have:

“Policies and attributes that attract youth to the facility or programme, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clientele for follow up and repeat visits” (Dickson-Tetteh, Pettifor *et al.* 2001).

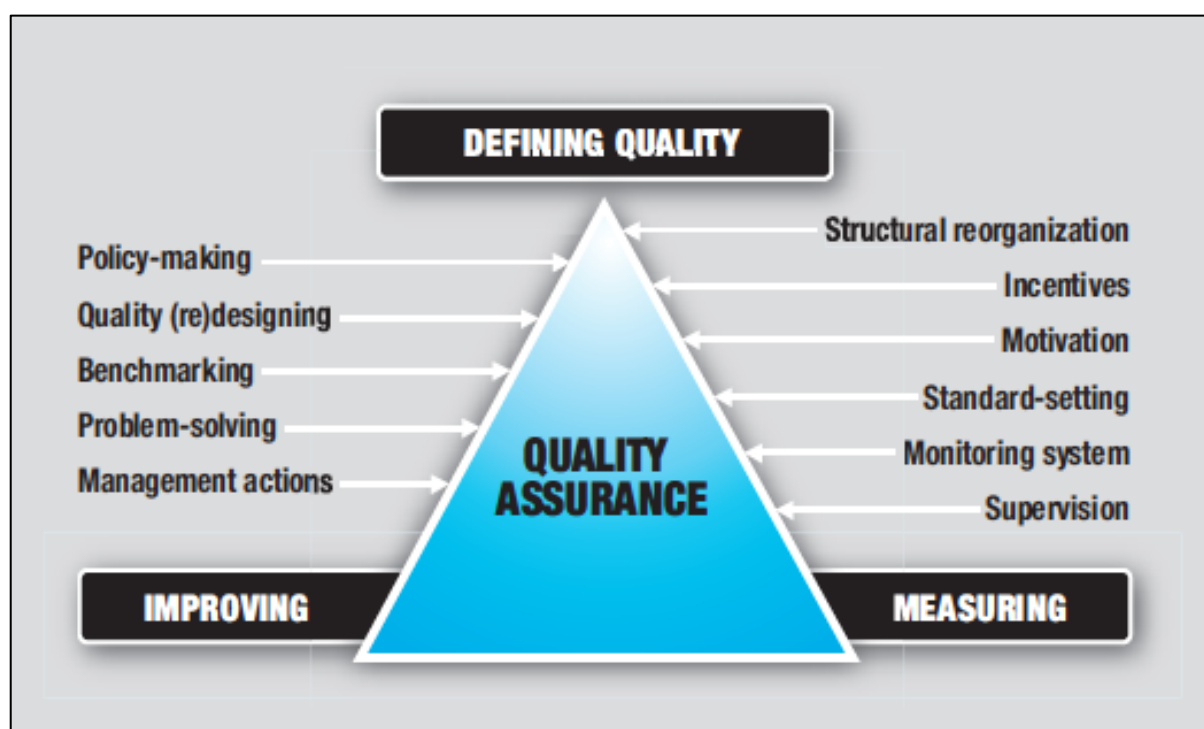
In South Africa, the National Adolescent-Friendly Clinic Initiative (NAFCI) was developed to provide public health service managers and providers with a practical, achievable self-audit and external assessment process to improve the quality of adolescent health services at the primary care level, and to strengthen the public sector’s ability to respond appropriately to adolescent health needs (Dickson-Tetteh, Pettifor *et al.* 2001).

The key objectives of the NAFCI was to make health services more accessible and acceptable to adolescents, to establish national standards and criteria for adolescent health care in clinics throughout South Africa and to build the capacity of health care workers to provide quality adolescent health services (Dickson-Tetteh, Pettifor *et al.* 2001). One of the indicators for the success of the NAFCI was the increased utilisation of public sector clinics by adolescents. Which recent studies have shown, that almost two decades later, the call for adolescent youth-friendly services in primary health care clinics remains (Dickson, Ashton *et al.* 2007, Geary, Gómez-Olivé *et al.* 2014, Geary, Webb *et al.* 2015). Additionally, the aim of the NAFCI was to work with primary health care providers in public health care clinics is so that the majority of young South Africans can access clinical services and information close to their homes (Dickson-Tetteh, Pettifor *et al.* 2001). Therefore, the NAFCI was formed out of the recognition that a successful sexual health campaign must be supported by health services that accommodate the needs of young people. NAFCI recognized that the public health sector is the most sustainable way of providing health services that can reach out to most adolescents (Dickson, Ashton *et al.* 2007).

The NAFCI programme adopted an improvement approach and was designed around four main elements of quality improvements: focus on the client, effective systems/

processes, use of data, and a team approach (Dickson-Tetteh, Ashton *et al.* 2000). The quality triangle (see figure 1) depicts a relationship between defining quality (e.g. setting standards), measuring quality (determining how well the standards are being achieved) and improving quality (implementing a process to achieve the standards). As a result, standards were developed to define “adolescent-friendly” services, tools were designed to measure the quality of the services, and quality improvement methods were introduced to assist in overcoming barriers to providing quality services.

Figure 2.4: Representing the design and focus of the NAFCI programme



Source: (WHO, 2009)

NAFCI was a quality improvement approach. Quality improvement focuses on client needs as well as relying on data to make improvements in the system. This approach was facilitated by management; it was not management-driven. The driving force was a team, which is inclusive of youth; clinic staff and the community working together to achieve the goal (Dickson-Tetteh, Ashton *et al.* 2000). These quality teams were working towards responding to the needs of South African youth in order to decrease HIV, teenage pregnancy and STIs. The NAFCI was not a vertical programme; it was a quality improvement approach that benefits all clients who use the services. The tools and skills taught were universal and comprehensive rather than vertical (Geary,

Webb *et al.* 2015). At the same time, focusing on youth was necessary to address specific health-care needs and the looming issues of the HIV epidemic (Glynn, Caraël *et al.* 2001, Dellar, Dlamini *et al.* 2015, Hargreaves, Delany-Moretlwe *et al.* 2016).

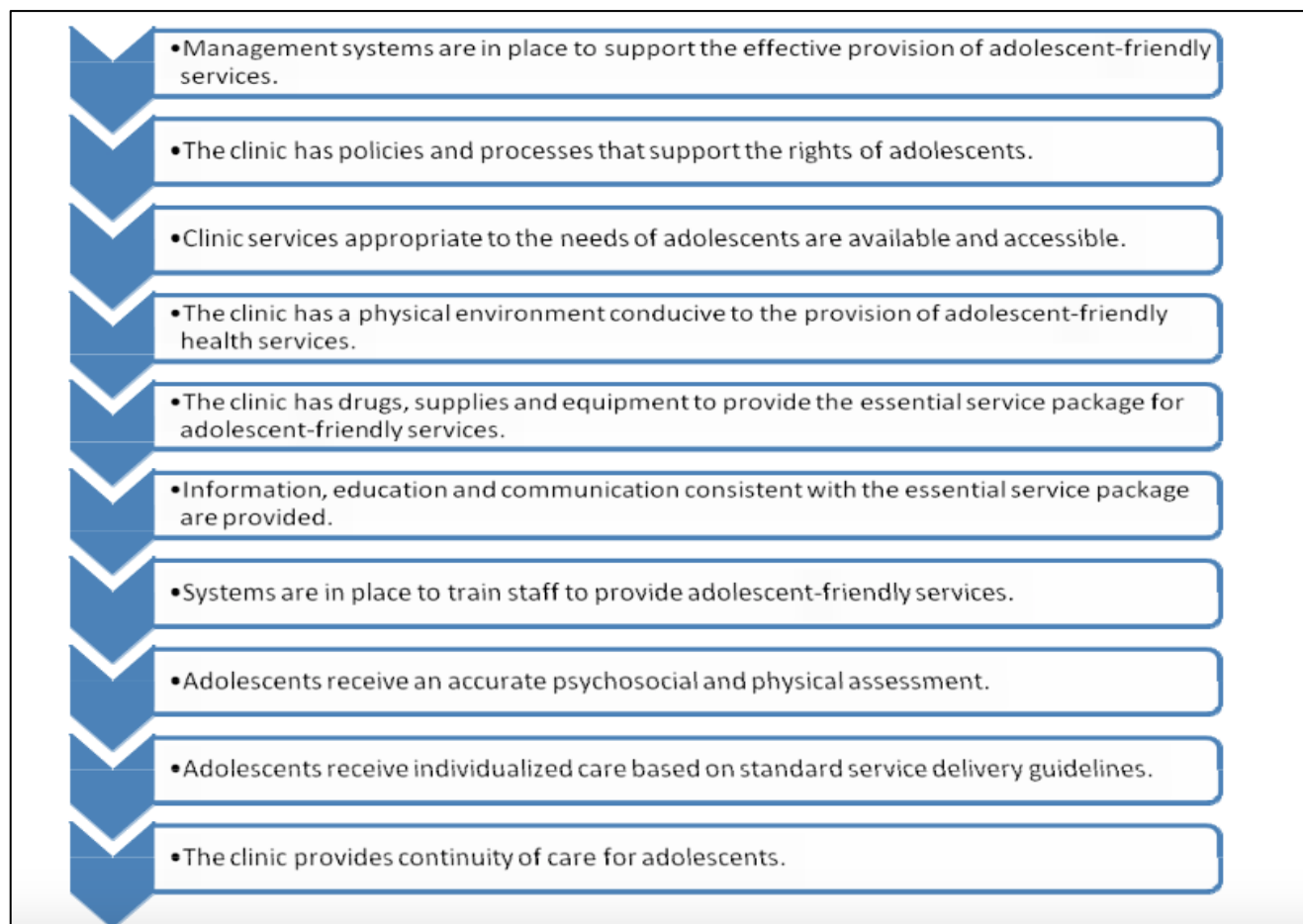
Although the NAFCI relied on a participatory approach, using national and international consultation as well as focus groups with adolescents, to design the programme and develop the standards to determine whether or not a clinic could be defined as adolescent-friendly for adolescent-friendly health services (See figure 2). What was missing from the inception and implementation of the NAFCI programme was the recognition acknowledgement of the cultural context of the young people the programme was designed for. Although various health services, like HIV testing and other SRH related services are made available for young people. Cultural factors also constitute an important aspect when it come to the use of health care services (Tsawe and Susuman 2014). Within the South African context, culture is an important concept that influences the way people live, as well as their belief systems. Therefore:

“Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts” (Airhihenbuwa and Webster 2004).

Ali Mazrui defines culture as ‘a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society’ (Mazrui 1986). Robert Hahn emphasizes the role of culture and context in relation to sickness and healing, and highlights the use of language in the understanding of illness concepts (Hahn 1995). Furthermore, Howard Brody posits that one’s cultural belief system influences one’s social roles and relationships when one is ill (Brody 2002). Finally, Deborah Lupton (1994) postulates that the practice of medicine is a cultural production, particularly with respect to the focus on the body rather than the contexts that define and shape the body (Lupton 2012). Therefore, the surveillance of

AGYW values and beliefs and the adoption of cultural competence in youth-friendly HIV and SRH services is critical.

Figure 2.5: representing the NFCI standards of adolescent youth-friendly health services



Source: (WHO 2009)

Challenges of service delivery in South Africa.

Over the years, several changes in law and policy were carried out to cater specifically for the sexual and reproductive needs of men and women, ensuring they had access to the appropriate services. Later, a focus was placed on adolescent sexual and reproductive health service, through which, in 1999, the National Adolescent Friendly Clinic Initiative was launched. There have been significant achievements within SRH services in South Africa; however, enormous challenges that remained in the system that were inherited from the apartheid government (Bohmer and Kirumira 1997,

Bender 1999, Dickson-Tetteh, Pettifor et al. 2001). These challenges are still seen impacting on service delivery within South Africa. The weaknesses in the broader health care system have led to shortcomings in new policies and services being implemented in primary health clinic.

It is from this understanding that one can establish that “the roots of a dysfunctional system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in policies from periods of the country’s history, from colonial subjugation, apartheid dispossession, to the post-apartheid period” (Coovadia *et al.* 2009: 817). The trajectory of health, specifically SRH and HIV prevention, within the South African health system is deeply rooted in the historical context that underwrites South Africa. This study seeks to respond by allowing AGYW, to contribute towards change. Part of changing the system is to create platforms where vulnerable populations like AGYW can begin to share ideas and their experiences when accessing SRH and HIV prevention methods available at the clinic. The link between the social structures of the past and the reproductive health issues of today cannot be separated, thus the success of current family planning programmes remains relative (Vukapi, 2015). Decades of policies, legislations and laws have influenced the effectiveness of sexual and reproductive health within South Africa, highlighting it as an unresolved dilemma still today.

Studies consistently show that sexually active AGYW (married or unmarried) face many barriers to obtaining SRH services and products to prevent HIV and pregnancy (Biddlecom, Singh *et al.* 2007, Bankole and Malarcher 2010, Abdul-Rahman, Marrone *et al.* 2011, Decker and Constantine 2011, Godia, Olenja *et al.* 2014). Addressing these barriers within programmes and policies is likely to improve the quality of services for all people who need contraception and HIV prevention and is of particular importance to AGYW.

Despite the government’s efforts to change the laws and policies around the accessibility of HIV and SRH in South Africa, barriers to services still remained post-apartheid (Tylee, Haller *et al.* 2007, Burger and Christian 2020); Alli *et al.* 2013; Frohlich *et al.* 2014). Coupled with the complexities of the past and the lack of financial and human resources, SRH problems such as HIV and teenage pregnancy rates are

increasing in the post-apartheid era. Many barriers limit AGYW's access to these essential services; sometimes excluding them from using formal health services altogether (Baggaley, Doherty *et al.* 2015). This study seeks to include AGYW in designing youth friendly primary health care clinics within their communities. Clinics that will enable AGYW to respond to the various HIV prevention methods and SRH services provided for them.

The negative perceptions of health care workers towards AGYW's sexuality, literature states that SRH and HIV prevention services in public health care clinics were underutilised by AGYW because they often feel unwelcomed in clinics. AGYW often encounter providers who are judgmental, who treat them rudely and who deny them services by placing restrictions on preventative methods such as condoms based on age (Annabel, 2005). Adolescents perceived health care workers as unfriendly and uninterested (Ramathuba *et al.* 2012b). Multiple studies have alluded to this as a barrier (Huntington and Schuler 1993, Mfono 1998, Mmari and Magnani 2003). It is upon this premise that this study seeks to listen to the voices of AGYW through participation and inclusion in designing youth-friendly clinics, and defining for themselves on how youth friendly health care nurse should be like when rendering SRH and HIV prevention services at the clinic.

Health care workers' cultural beliefs strongly impacted on how they treated adolescents – the belief that women shouldn't have sex before marriage, for example (Holt *et al.* 2012). Therefore, it was established that addressing the problematic relationship between nurses and adolescents within youth friendly SRH and HIV prevention would ultimately impact positively on effective use of HIV and SRH services among young South Africans (Holt *et al.* 2012; Geary *et al.* 2014; Geary *et al.* 2015). This brought about the national implementation of Adolescent and youth-friendly Services (AYFS) through public health care facilities in South Africa. Therefore, this study is located within this call for AYFS in primary healthcare clinics. Calling for AGYW to be at the center of service design and implementation of programmes aimed at for them.

Conclusion

This chapter has presented and discussed literature relevant to AGYW as a key population most vulnerable to HIV and other SRH related issues and AYFS as intervention that can relieve the HIV and SRH related issues like teenage pregnancy among AGYW. The AGYW's experiences of AYFS and the HIV and SRH services globally and in South Africa have been discussed. As a critical foundation, the background of AYFS and what the programme was meant to accomplish among AGYW was accounted for in this chapter. The chapter argued the multidimensional understanding of HIV risk factors among AGYW and the need for effective interventions among this key population. The chapter highlighted multiple factors, specifically that contribute to AGYW vulnerability, these are characterised by structural, behavioural and biomedical factors. Further exploring how these factors impact on their interaction with HIV and SRH services. Furthermore, this chapter identified some of the challenges in health care in South Africa, and discovered the problematic nurse-adolescent relationship, where health care workers posed as a barrier to HIV and SRH services. This highlighted the need for culturally competent nursing for health care nurses when delivering HIV and SRH services for AGYW.

Chapter Three: Theoretical Framework

“The theoretical framework introduces and describes the theory that explains why the research problem under study exists” (Abend 2013).

Introduction

This study has outlined that adolescent sexual health is built on the foundation of recognizing and providing confidential, high quality services that are youth-friendly (Apter *et al.* 2004). More importantly, given the disproportionate burden of HIV incidence among adolescent girls and young women (AGYW), this study has highlighted in previous chapters, that adolescent youth-friendly services (AYFS), has been implemented in primary health care clinics in South Africa as a strategic response for the HIV and SRH needs of AGYW. This study seeks to understand the perceptions of AGYW about the effectiveness of the HIV and SRH services provided for them in the clinic through the AYFS programme. The researcher is interested in their discernments of through active participation and dialogue.

Active participation involves direct engagement and inclusion, which underpins the theoretical rendering in this chapter. The Culture-Centred Approach to health communication, as put forward by Mohan Dutta (2008) is the theoretical lens through which this study is framed. The key constructs of the Culture-Centred Approach to health communication; *culture*, *structure* and *agency*, lend themselves well to the exploration of the key questions that are asked in this study. In this chapter, Dutta's (2008) Culture-Centred Approach to health communication permits the researcher to actively engage in a dialogical process with the research participants. The aim for dialogue is to answer the research questions proposed in this study in a way that not only extends insight for the health communication field, but that also results in research participants being the catalysts of change.

This chapter will delve into the origins, characteristics, functions and applications of CCA, highlighting the importance of culture, agency and structure as influential factors that must be considered in the AYFS programme for AGYW. Furthermore, this study is interested in exploring the ways in which the current HIV and SRH service in primary

health care clinics in Vulindlela are adolescent youth-friendly or not for AGYW. This is focused on the HIV and SRH service provision they receive and experience as users of the clinic. Therefore, HIV and SRH service also involves the health care nurses, who are responsible for providing health care services to AGYW. Health care nurses are part of what makes the clinic effective for AGYW, and they are required to have the necessary competencies to work with AGYW and provide them with the required health services (WHO, 2012). (World 2012). The competencies of health care nurses also require them to provide evidence-based protocols and guidelines to provide health services. Therefore, Purnell Model (Purnell 2002) of Cultural Competence (CC) was deemed relevant in this study as it endeavours to enhance patient care and well-being through culturally competent nursing. The CCA and Purnell's CC value the role of culture if health services will be rendered by nurses and received by patients appropriately.

These theories can be viewed as related; each build upon the groundwork of the preceding. Ultimately, in primary health care settings, and within the AYFS programme, the nurse is the one who administers care and is at the patient's side for the majority of their time receiving care. Purnell's objective is for nurses to immerse themselves in cultural context of the patient and to implement a style of care parallel to what the patient deems suitable according to his or her cultural expectation. These theories were used as a guide to frame within the data collection and data analysis process. This study aims to combine a nursing model with CCA, an approach within cultural studies, in order to explore the potential of user driven AYFS for HIV and SRH services among AGYW. CCA highlights culture and structure as influencers of individual behaviour, and Purnell Model of Cultural Competence places emphasis on nurses as the direct care providers to be prepared to function with transcultural nursing knowledge and competencies to ensure beneficial outcomes to people of different cultures. For without such preparation in transcultural nursing, nurses will be greatly handicapped, disadvantaged, and culturally ignorant to help people of different lifeways, beliefs, and values. These two theories were used together in order to establish a culture-centered and a culturally competent design of AYFS in HIV and SRH for AGYW.

Culture-Centered Approach (CCA)

This section of the chapter explores the chronological overview of the CCA in health communication, focusing on the shift from a dominant approach to a culture-centred approach in health communication. The CCA is built upon three cornerstones: *culture, structure and agency*. The three cornerstones of the CCA offer this study the lens to understand the user perceptions of AGYW about AYFS in primary health care clinics in Vulindlela and its potential to influence them to visit the clinic for HIV and SRH services. Many studies outside of South Africa have proved that AYFS is able to effectively attract young people, meet their needs comfortably and responsively, and also succeed in retaining young clients for continuing SRH care (Mmari and Magnani 2003, Erulkar, Onoka *et al.* 2005, Desiderio 2014). Nevertheless, within the South African context, particularly in rural communities like Vulindlela, agency must be handed over to AGYW to become actively involved in the manner HIV and SRH services are offered in the AYFS programme within the clinic. The AYFS programme cannot take up the 'one-size' fits all model. It must be cognisant of the uniqueness of rural communities and the socio-cultural and environmental factors that constitute the community and possibly influence behaviour. Key members like AGYW need to be given the platforms to create their own meaning and in turn communicate those meanings so that programmes like AYFS can be context specific and effective for them. Therefore, in order to progress in stimulating the comfortability, responsiveness of AGYW in rural communities and succeed in retaining them as clients in the primary health care clinic. It is imperative to understand AGYW's meaning of AYFS in primary health care clinics in Vulindlela.

The Culture-Centered Approach in communicating health

Health communication is a multifaceted field that encompasses the diverse approaches and processes through which information is exchanged between health care providers, educators, and advocates and intended beneficiaries (Vermund, Van Lith *et al.* 2014). The content, medium, and style of the messaging must suit different societal contexts because audiences differ as to their assumptions, attitudes, self-efficacy, and receptivity to messages from health practitioners (Vermund, Van Lith *et al.* 2014). Therefore, culture, language, religion, education, gender, age group, socioeconomic status, level of trust, degree of social isolation or integration, social norms, and other elements in a person's background and social context shape a

person's behavior and their response to key health messages (Vermund, Van Lith *et al.* 2014). Therefore, members of stigmatized or marginalized subpopulations may respond differently to messages than would persons from the majority subpopulation (Vermund, Van Lith *et al.* 2014). This accounts for the importance of hearing the voices of AGYW from rural contexts, to understand their own perceptions about HIV and SRH services in primary health care clinics and how they want to receive these services. The overarching objective in this study has been an exploration of AYFS within primary health care clinics for HIV prevention and SRH care among AGYW, and how AGYW in rural Vulindlela can be given the platform to define for themselves what makes the clinic youth-friendly or not. It has been mentioned earlier, that AYFS has already proven effectiveness and efficacy among AGYW in other countries (Tylee, Haller *et al.* 2007, Reif, Bertrand *et al.* 2016, Thomée, Malm *et al.* 2016). These results as strategy to package HIV and SRH services in a way that is suitable for AGYW as clients in primary health care clinics.

In mainstream communication scholarship, communication is typically focused on one context of communication; interpersonal or mass communication. Health communication however, encompasses many different contexts of communication. For example, in health communication the *intrapersonal communication* perspective tends to focus on people's attitudes, beliefs, values, and feelings about health-related concepts and messages (Wright, Sparks *et al.* 2008). *Interpersonal communication* focuses on how relationships, for example, those between health care nurses and patients, impact health. Whereas, organisational communication, is concerned with features of the health organisations such as hierarchies and the information flow in the organisation (Wright, Sparks *et al.* 2008). *Intercultural health communication* on the other hand highlights the unique role that culture plays in terms of how individuals understand health as well as how intercultural differences affect health care relationships (Wright, Sparks *et al.* 2008).

Dutta and Basnyat (2008) explain that the utilisation of a culture-centered approach to health communication is a culture-driven process, which engages in meaning-making through dialogue with community members. The term culture consists of one's values, beliefs, norms, and practices; it lends to the creation of our identity; and informs our respective worldviews Hopson (2011:23). With this in mind, together researchers and

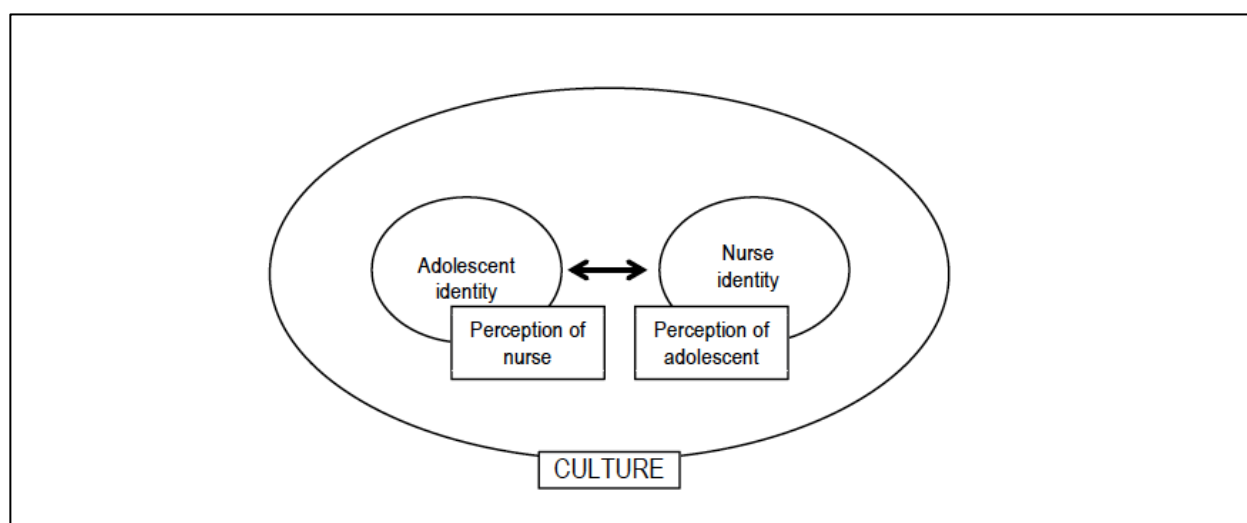
AGYW co-create meaning regarding communicative experiences within a specific cultural context. The goal of the culture-centered approach involves “foregrounding the voices of cultural trans individuals to open up legitimate spaces for marginalized group members” to share personal narratives within the context of their lived experiences (Dutta & Basnyat, 2008:443).

Moreover, Koenig, Dutta, Kandula, and Palaniappan (2012) explain that these voices are important, in the South African context, AGYW are becoming more complex to understand due to the changes they experience, causing this population to become more diverse and more challenging to understand. Thus, it becomes vital for practitioners to explore how cultural context impacts how “health meanings are constructed and employed in practice” (Dutta, 2008:1). Therefore, the user driven narratives of AGYW in this study are key for understanding how to improve health-practitioner communication about HIV prevention and SRH care in a diverse cultural society (Basu & Dutta, 2009). Research examining AGYW-practitioner communication from a culture-centered approach, that centers AGYW’ communication experiences, is likely to help scholars and practitioners to understand this unique population, meet their health needs, and improve their overall health outcomes.

With this culture-centered contextualization in mind, this study situates individuals as cultural bodies who transport their personal identities, social identities, and cultural experiences into the healthcare environment (Allen, 2011; Hopson, 2011). This is especially true for AGYW in communication with practitioners (SEE FIG 3.1). Personal identity refers to individuals’ opinions and interpretations of themselves, the identity they declare, and overall characteristics they correlate with their individuated self (Ross and Castle Bell 2017). Social identity is formed during interactions with cultural and ethnic group members including age, class, race, region, occupation, sexual orientation, and gender identities. Identity also incorporates health identity (Ross and Castle Bell 2017). Health identity refers to the overall sense of self in terms of the physical, mental, and emotional, and it also includes one’s personal and social identities (Ross, Scholl, & Castle Bell, 2014). Indeed, identity is complex and messy (Hopson, 2011). Identity is “a discursive text read by interactants. There are various meanings attached to [individual’s] bodily texts; [and] individuals behave differently toward foreign or unfamiliar bodies [they] encounter in public or private spaces”

(Jackson, 2006:2). This is true for AGYW within the health context. In this study, the researcher contends that improving AGYW-practitioner communication is part of making HIV and SRH health care facilities youth-friendly for AGYW. This AGYW-practitioner communication involves understanding how such communication also impacts their personal, social, cultural, and health identities.

Figure 3.1 Diagram representing the role of identities in nurse-adolescent relationship negotiation



Source: (Adapted from Dutta, 2008:97)

We need to keep moving toward a combination of youth-friendly and youth-focused healthcare, driven by AGYW's narratives, achieved through healthy co-cultural communication, and foregrounded through a culture-centered approach. Such progress will aid in the development of AGYW's, social, and health identities. Ultimately, AYFS in for HIV prevention and SRH services awareness will grow as the needs of AGYW become more prominent in the healthcare field (Ross and Castle Bell 2017). As noted in the introduction, the CCA is founded on the principles of listening to the voices of the margins that have hitherto been unheard in policy and programming circles (Dutta, 2008; Dutta-Bergman, 2004). These erasures of the voices, and personal, social and health identities from the margins are tied to the continuing disenfranchisement of the margins through top-down programs that are often out of touch with the lived experiences of the marginalized (Dutta, Anaele *et al.* 2013). Therefore, essential to addressing SRH and HIV disparities are the processes

of dialogue and listening that foreground community voices at sites of knowledge production and implementation (Dutta-Bergman 2004).

The Shift from a Dominant Approach

Increasing attention has been placed on studying health communication within the cultural context in which it is placed, in order to create the climate for multicultural health communication structures (Airhihenbuwa, 1995; Basu and Dutta, 2007; Dutta, 2007; Dutta, 2008; Dutta and Basu, 2011). The CCA offers a descriptive approach to health; which is interested in understanding that communicating about health involves negotiating shared meanings embedded in 'socially constructed identities, social norms and structures (Dutta, 2008:55). However, in order for one to understand the foundations of CCA, one needs to understand the transition from a dominant approach in health communication towards a participatory approach.

The dominant approach in health has also been referred to as the biomedical model. Across a set of papers published between 1960 and 1980 (Engel 1960, Engel 1977, Engel 1979, George and Engel 1980). George Engel articulated an influential questioning of the historically dominant model of medicine, the biomedical model. He outlined the limitations of such approach and called for the need of a new, patient centered medical model which he labelled as the biopsychological model. The biomedical model found that "ill health is a physical phenomenon that can be explained" (Du Pré 2000). Protagonists of the biomedical model claim that its achievements more than justify the expectation that in time all major problems will succumb to further refinements in biomedical research (George and Engel 1980). Nonetheless, the crippling flaw of this model was that it did not include the patients and their attributes as individuals.

The model left no room within its framework for the socio-cultural, psychological and behavioural dimensions of a person's health, yet in the everyday work of health care practitioners, particularly in primary health care clinics, the prime object of study is a person. The Western biomedical model required that disease be dealt with as an entity independent of socio-cultural behaviour (Engel 1977). Under the dominant approach, communication was viewed as a linear, top-down communication process, where beliefs, information and knowledge were transmitted from the core sectors to the

subaltern spaces (Guha, 2001, Spivak, 1988). In this model, health interventions like AYFS are limited to healthcare providers “transferring their knowledge and to prescribing a solution (Schiavo 2013). By simply prescribing solutions, the biomedical model fails to take into account variables such as social habits, culture, or psychological state, all of which are directly correlated to individuals’ health (Schiavo 2008). In contrast, the biopsychological model is interpersonal in its approach, recognises that health is “influenced by people’s feelings, their ideas about health, and the events of their lives” (Du Pré 2000).

Substantiated by the biopsychosocial model, the CCA challenges the dominant model and incorporates context when developing an understanding of health (Archipoli 2010). It is anchored on the work of Collins Airhihenbuwa (1995). Airhihenbuwa criticises this Western medical paradigm for its failure in tapping into the rich culture of the marginalised communities, arguing that health communication theorising should be motivated by culture (Dutta and Basnyat 2008). As with this study, Airhihenbuwa (1995) argues that health communication programmes should be planned, implemented and evaluated within the context of the relevant culture. In other words, health programmes must take cognisance of the socio-cultural beliefs and value systems prevalent in a particular community.

Criticisms towards the dominant approach to health communication highlighted the erasing of marginalised voices from the discursive sphere. Through critical analysis of the dominant approach to health communication, four key criticisms were identified: individualism, cognitive bias, decontextualization and bias towards the expert position (Dutta-Bergman, 2005; Dutta, 2008). Firstly, the dominant approach was focused at the individual level (Dutta 2008). Behaviour change health campaigns were aimed at the individual, where the decision-making process was accounted to an individual’s attitudes, beliefs and cognition, excluding the collective cultural context that guides and informs the decision-making process (Dutta-Bergman, 2005). Secondly, the dominant approach aimed to retain control and status quo within health communication. This was achieved through bias towards the expert position. Rather than engaging with marginalised groups, health communication research remained within the ivory towers (Dutta 2008). Void from health communication campaign design was the involvement of community members in identifying and defining health

problems and possible solutions (Dutta and Basu 2007). This revoked agency from community members, where 'experts' were assumed to have the knowledge and ability to examine the beliefs, values and practices of those they researched (Dutta 2008).

Drawing from HIV and AIDS campaigns as an example, the dominant approach would aim to change an individual's sexual behaviour by encouraging safe sexual practices, but it would not take into consideration the "socio-economic status, access to resources, the shifting cultural norms, community-wide decision networks, issues of gender inequality and relationship negotiation" which greatly impact on the decision-making process of all individuals (Dutta, 2008: 50). "Health as conceptualised in the dominant approach is typically removed from the context that surrounds it" (Dutta, 2008: 53). Basing campaigns on rational thought eliminated the idea that some decisions are made on the spur of the moment, where rational thought doesn't take place.

As mentioned earlier, the dominant approach aimed to influence the audience to change their behaviour by arguing the rational thought behind certain decisions (Coetzee 2017). This again annihilated the cultural and contextual influences that impact on rational thought processes (Dutta-Bergman, 2005; Dutta, 2008). Related to this was the decontextualization imposed by the dominant approach. The dominant approach did not take into account the constraints that may negatively affect the decision-making process of an individual. It was argued that communication needs to be bottom-up (Airhihenbuwa and Webster 2004). which is pertinent to this study. The researcher in this study argues that communication concerning adolescent youth-friendly services (AYFS) must be user-driven and patient centered. In order to understand the structural context that surrounds AGYW, which ultimately impacts on their ability to make effective SRH decisions.

The Need for a Culture-Centred Approach

Health and risk are constituted globally amid structures of unequal flow of labour, capital, commodities, and communication, shaped by the material inequalities in the distribution of resources (Graham 2004). Globalization, the accelerated flow of imports and exports, people, services, and capital across spaces, has been accompanied by large inequalities in economic access to resources; inequalities in access to health opportunities, health resources, and health care services; and inequalities in health outcomes (reflected in mortality and morbidity rates) (Beckfield, Olafsdottir *et al.* 2013). Disparities in health outcomes observed within and across nation states are shaped by economic inequalities, noting the structural determinants of health, the inequities in access to health services, as well as the local-national-global policies that constitute health (Dutta 2019). The CCA examines the communicative processes by which marginalization takes place in global contexts and the ways in which health risks and vulnerabilities are constituted amid material inequalities in distributions of resources (Dutta 2008). CCA was built upon the criticism highlighted by Airhihenbuwa (1995) and Dutta-Bergman (2004), seeking opportunities to co-construct health narratives within marginalized communities.

With an emphasis on the processes of erasure of diverse voices, the CCA asks the question: What are the processes, strategies, and tactics through which the voices of subaltern communities are erased? The access to communicative spaces, platforms, strategies, and tools is shaped within material structures, thus shaping messages, processes, and discourses within the agendas of powerful political, social, and economic actors with economic access to resources (Dutta 2019). The disenfranchised, with limited access to the communicative spaces and to the spheres of voicing, are often absent from the discursive spaces where health policies and programs are discussed, the sites where interventions are planned, and the processes where communicative strategies targeting them are carried out (Dutta and Pal 2011, Dutta 2019). The agency of the subaltern is erased from the sites of recognition and representation where policies are debated, decided upon, implemented, and evaluated (Dutta 2008). In line with this study, adolescent girls and young women (AGYW) are frequently the target of public health policies and programs (Penazzato, Lee *et al.* 2015).

The goal of these interventions is to change behavior in the hope of preventing related health problems, such as sexually transmitted infections. Although societal-level interventions, such as policies, have proven to be effective in some areas of public health related to adolescents (van Sluijs, McMinn, & Griffin, 2007; Catalano *et al.*, 2012), there is concern that their effectiveness can be limited (Santelli *et al.*, 2006; Lovato, Sabiston, Hadd, Nykiforuk, & Campbell, 2007). This study suggests that when AGYW are included as advocates for their own health and well-being, policies and health programs designed and developed for them could be more effective. This requires a paradigm shift from the utopian realm of a “perfectly inclusive” world vision, to recognize how health interventions have excluded marginalized populations like AGYW. The voice, dignity, value and importance of AGYW, should not only be an ethical norm and moral imperative, but also as a societal goal, and ultimately, a practice (DESA 2009). Voices of communities from the margins emerge at discursive sites through the framework of communication as listening (Dutta 2014).

The CCA foregrounds strategies for listening to voices that have hitherto been erased (Dutta 2014). Through strategies of listening, locally grounded understandings are placed within the discursive spaces of policy formulation and program development. In understanding the health experiences of communities that experience poor health outcomes, the emphasis is on creating spaces for listening that foreground local experiences, interpretations, and understanding. Alternative imaginations of the political economy of health are rooted in the voices of local communities at the margins, foregrounding contextually embedded interpretive frames for organizing health, healing, and curing. The presence of subaltern voices brings forth alternative imaginations of health, offering new frameworks that point toward alternative ways of structuring health, economics, and politics. The CCA resists the marginalization of the subaltern sectors through the foregrounding of opportunities for local grassroots participation, in the definition of problem configurations and in the corresponding articulations of locally meaningful solutions.

The CCA in this study offers no prescriptions but seeks to listen to the voices of the AGYW to find ways through AYFS- an approved strategy to improve the SRH of adolescents and youth – can be effectively implemented in primary health care clinics in Vulindlela. By so doing, the AGYW in Vulindlela will be enacting their agency to

negotiate established policies (or structures) that may be responsible for low acceptance and response of AYFS in this community. Cultural context is located at the centre of the CCA, emphasizing the meanings that are co-constructed by the researcher and cultural participants” (Dutta, 2004: 56). The CCA examines how health communication theories have systematically erased the cultural voices of marginalized communities in their constructs of health. It explores the interaction between culture and structure that create conditions for marginality (Dutta, 2011). “The absence of cultural considerations is accompanied by the absence of the voices of cultural communities that have typically been treated as the subjects of health communication interventions, drawing upon a top-down Westcentric biomedical narrative” (Dutta and Basu, 2011: 329). For example, health campaigns were often designed in the First World, in order for them to be implemented in the Third World, thus being intrinsically removed from context, culture and community (Coetzee 2017).

This further perpetuated the top-down Eurocentric biomedical narrative within health communication (Dutta and Basu, 2011). Airhihenbuwa & Webster (2012) confirm that, the behaviour of an individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV and AIDS prevention and control efforts.

Theoretical evidence of the culture-centered approach

Theoretically, CCA is rooted in critical theory, cultural studies, postcolonial theory and subaltern studies (Dutta, 2008). Within CCA, the concepts of power, ideology, hegemony and control that underpin culture-centred health communication scholarship are drawn from critical theory, with added emphasis on “the social constructions of knowledge and practices” (Dutta, 2011:10). According to Fuchs (2015:1), critical theory is “an approach that studies society in a dialectical way by analysing political economy, domination, exploitation, and ideologies”. Whereas the dominant theory previously used communication as a top-down, linear model, CCA examines how knowledge is used in order to maintain power and control, thus perpetuating the status quo. Moreover, critical theory is interested in understanding the role of social structures in restricting the experiences of the underprivileged class, through the use of ideology and hegemony. It aims to disrupt power by engaging with marginalised groups who have previously been left out of the discursive space. Where

critical theory raises questions around ideology and hegemony, cultural studies is interested in how knowledge is socially constructed by the elite.

The CCA then draws upon cultural studies scholarship “with its emphasis on the social constructions of discourse and on the culturally situated nature of health narratives”. (Dutta, 2008: 10). Whereas, previously, the dominant approach voided cultural sensitivity, CCA acknowledges the influence of culture in the social construction of everyday experiences and power relations. Cultural studies are aligned with critical theory in that it maintains a focus on power structures and how they are maintained within the social discourse. Postcolonial theory is said to “offer an antithesis to European superiority as embedded in colonial violence, socio-political domination, economic exploitation, and racism” (Kubota & Miller, 2017:10). Culture-centred health communication scholarship explores the “dichotomies of the First and Third World, the North and the South...to see how these dichotomies play out in who gets to decide the health agendas” and further questions the “values underlying this dichotomy...” (Dutta, 2011:11). Postcolonial theory is “fundamentally transformative in seeking to alter those knowledge structures that erase the stories of violence inherent in global neo-colonial configurations and create spaces for listening to the voices of subaltern sectors of the globe” (Dutta, 2011: 5).

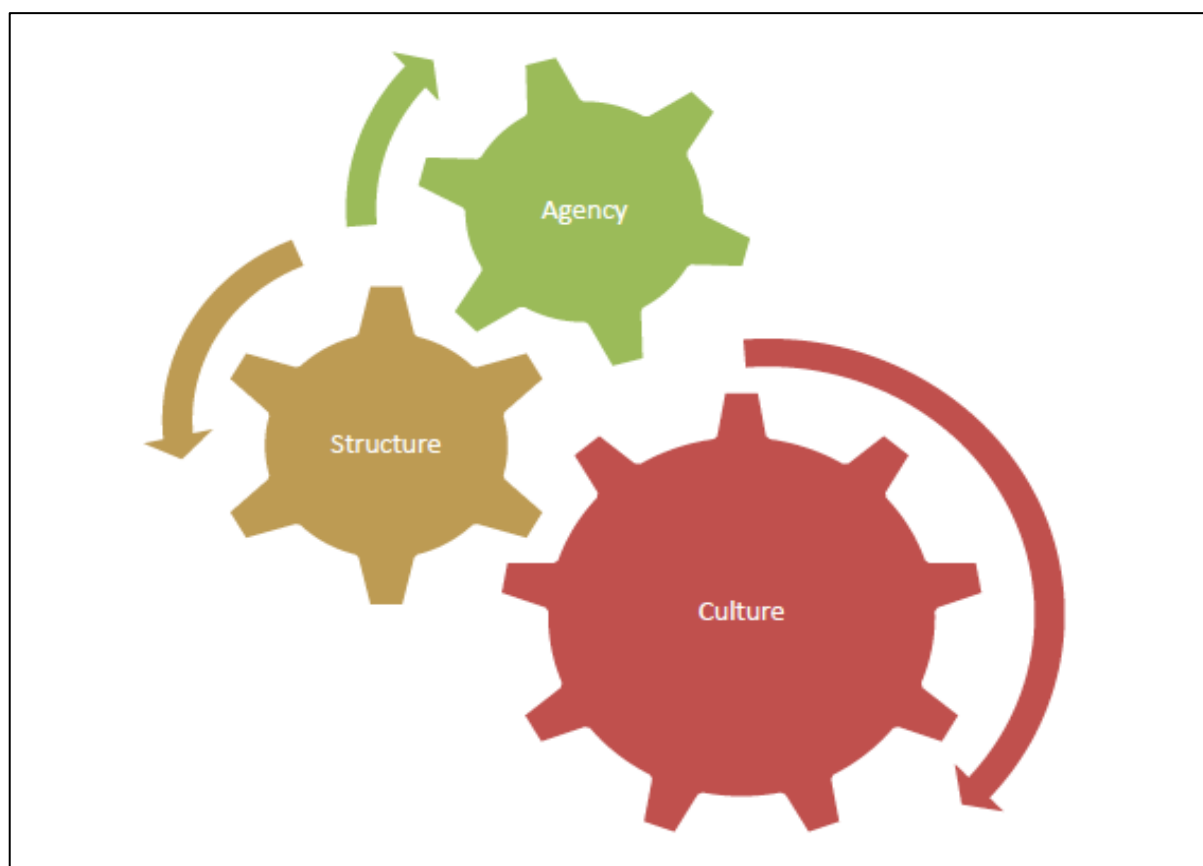
Furthermore, subaltern theory is guided by “the desire to rewrite the narratives that constitute the discursive spaces of history by listening to locally situated voices that have been systemically erased” (Dutta, 2011: 7). Subaltern means of lower rank, but Spivak has widened its scope and attributed the term to the literature of marginality and suppressed groups (Spivak 2005). The essence of subaltern studies is the questioning of the absence of the voices of marginalised communities in development discourse (Guha, 2001). The CCA interrogates this absence of the subaltern voice by creating “discursive openings for co-constructing narratives of health through dialogue with subaltern communities” (Dutta, 2011: 12). The presence of subaltern voices in discursive spaces offers alternative logics of political and economic organizing that challenge the commoditization of health as private property and suggests ideas of health rooted in community life, sustainable practices, and cooperative economies.

Together, these theories work towards redefining the research space in order to create dialogue within marginalised groups. Where previously the dominant approach silenced subaltern groups, CCA acknowledges the need to engage with these groups in order to create effective health communication campaigns. The aim is to create alternative discursive spaces that challenge hegemony of the knowledge elite. Where the traditional approach focused on an expert understanding of health problems, CCA advocates “engaging in dialogue with cultural members” (Dutta, 2008: 45). It is from this theoretical understanding of CCA that the three cornerstones of the approach are identified: culture, agency and structure.

The three cornerstones

CCA examines the dynamic interaction of three concepts: culture, agency and structure (See figure 3.1). Each of these concepts plays a role in how communities understand and experience health. Recognising this, CCA suggests a critical analysis of each concept in community narratives. The CCA espouses an interdependent relationship between a people’s *culture*, *structures* that enhance or limit their possibilities, and enactment of their *agency* to negotiate these structures. Therefore, the CCA is the interaction of these three key concepts by which it “creates openings for listening to the voices of marginalised communities, constructing discursive spaces which interrogate the erasures in marginalised settings and offer opportunities for co-constructing the voices of those who have traditionally been silenced by engaging them in dialogue” (Dutta, 2008: 5).

Figure 3.2: The culture-centred approach to health communication



Source: (Dutta 2008)

Culture

Within CCA, the concept of “culture” is the local interpretation of health based on the values, beliefs and practices of the area (Archipoli 2010). It is understood as a complex network of meanings which is in a constant state of flux (Dutta, 2011; Dutta, 2014). Multiple definitions of culture permeate the discourse on CCA. Among these is one by Mazrui (1986: 239) who defines culture as “a system of interrelated values active enough to influence and condition perception, judgement, communication, and behaviour in a given society.” Culture is “the communicative process by which shared meanings, beliefs, and practices get produced” (Dutta, 2011: 11). It is important to acknowledge that culture is at the core of the CCA because “it is the strongest framework for providing the context of life that shapes knowledge creation, perceptions, sharing of meanings, and behavior changes” (Dutta, 2011:11). Conceptually, culture as represented in the CCA, is framed with reference

to the local contexts within whose confine's health meanings are shaped and understood. Dutta and Basu (2008: 561) conceptualise culture as "a dynamic communicative process that leads to social, economic, and political structure characterised by a system of values that influences attitudes, perception, and communication behaviours". The dynamic communicative nature of culture is fundamental to this study, as it places culture as the central communicative tool through which health is understood and communicated (Airhihenbuwa and Obregon, 2000). The CCA places emphasis on the significance of designing and implementing health programs that are compatible with key stakeholders' cultural framework (Airhihenbuwa, 1995). Culture, which distinguishes one group from another, provides the communicative scaffolding through which health is given meaning, where health and illness are embedded within cultural beliefs, values and practices (Dutta-Bergman, 2004; Dutta, 2008; Dutta and Basu, 2011).

This study is focused on highlighting adolescent youth-friendly services (AYFS) in primary health care clinics that are user driven for AGYW in Vulindlela, a rural community in KwaZulu-Natal burdened by the HIV epidemic and other SRH issues (Kharsany, Frohlich *et al.* 2015). The social and cultural factors contribute to who AGYW are and how they perceive SRH care should be. Where the dominant approach stated that culture was unchanging and static, CCA acknowledges the dynamic and fluid state of culture (Coetzee 2017). The CCA generally questions the dominant ideology of health care systems, particularly how it favours the interest of those who wield power within a social system (Dutta, 2008). The dominant approach often created skewed power relations between the gatekeepers and custodians of health interventions and those whom the interventions are created for. It is a fact that gatekeepers such as policy makers, health practitioners and programme developers have hegemonic power, which seems consistent with Laverack's characterization of the medical model. Laverack argues that "the medical model serves to protect the legitimate and expert power of the professional" (2004 :40). In the terms of Michel Foucault, "hegemonic power is that form of power-over that is invisible and internalized such that it is structured into our everyday lives and is often taken for granted" (Laverack, 2004:38; also see Dutta, 2008). Laverack posits that where power differentials exist, it is necessary for the dominant stakeholder to foster the collective empowerment of the less powerful.

Structure

The concept of “structure” is the existing capacity and resources within a community, such as health facilities, health providers and transportation. In other words, structure relates to the various facets of a social establishment that can either limit or enhance the capacity of cultural members to pursue health choices and adopt health-related behaviours. By definition, “structures are the institutional frameworks, ways of organising, rules and roles in mainstream society that constrain and enable access to resources” (Dutta, 2011:9). Structure encompasses a wide spectrum of services critical to the healthcare of cultural participants such as medical and transport services, diet and shelter among others. Structures that impact on the lives of subaltern communities operate at several levels; these are micro-, meso, and macro levels (Dutta, 2011).

Furthermore, structure has the ability to constrain or enhance the possibility of cultural members in marginalised communities to take control of their own health. On the other hand; it can hamper them from fulfilling their health needs by determining the quality of health choices that are made accessible. This is compounded by the fact that “marginalised communities have minimal access to basic health care resources and to the mainstream communication platforms on which they could articulate their questions and concerns” (Dutta (2008:13). Marginalised communities thus neither have a voice in the dominant health communication structures, nor a say in the formulation of health policies. It is from this perspective that the CCA places value on listening to the voices of the marginalised as a way of enabling them to enact agency in addressing their health concerns. Indeed, Airhihenbuwa *et al.* (2000) argue that health communication efforts must take into consideration the social and physical environmental factors that impact on individual roles and expectations as these affect their health behaviour. They further point to five contextual domains that are an intrinsic part of the environment of a community, that is, socio-economic status, government and policy, culture, gender and spirituality (ibid). CCA values community participation in renegotiating culturally insensitive structures so that they are aligned to the unique needs of their cultures (Shumba and Lubombo 2017). It is from this perspective that CCA is used in this study.

Agency

Agency refers to the capacity of people to interact with structures in order to create meanings (Dutta, 2008:61). Such meanings provide scripts for the marginalised, not only to interact with the structures but also to sustain and transform them. The concept of agency reveals the dynamic processes individuals, groups, and communities engage in as they interact with the structures whose impact is either to constrain or enhance the lives and health of cultural members. Through agency, these cultural members are able to demonstrate their potential to actively participate in influencing health agendas and provide relevant solutions to different health problems they might be confronted with. They engage in a dialogue which is based on the premise that cultural participants are engines of change, and can meaningfully engage with the structures.

According to Dutta (2008), the process of dialogic engagement with cultural members in order to gain a deeper understanding of their interpretation of health, constitutes the core of the CCA. Therefore, through agency, platforms are created for those whom Frantz Fanon (1972) terms “the wretched of the earth” to engage “in the co-construction of meanings and in actions based on these meanings” (Dutta, 2008: 87). Through the use of art-based participatory action research, this study aims to create a dialogic environment where the voices of adolescent females can be heard, where they have the agency to identify and define youth-friendly services, by highlighting SRH related issues and concerns that they face on a daily basis. “The participatory, dialogic approach empowers marginalised communities to talk about their existential realities, trial and error experiences, perceptions, needs and capabilities” (Basu and Dutta, 2007: 188).

As evidenced from the foregoing, the relationship between culture, structure and agency is interwoven. In other words, the CCA seeks to enhance people’s capacity to engage, from their own perspective, with structures that encompass their lives in order to create discursive spaces to transform these structures. This engagement thus takes place within a cultural context, where culture is conceived as “the local contexts within which health meanings are constituted and negotiated” (Dutta, 2008:7). In light of the foregoing, it can be argued that there may be no better framework within which this

study can be meaningfully understood. It is thus important to end the chapter by explaining the applicability and relevance of this approach in the context of this study whose objective is to explore perceptions of AGYW hold about the youth-friendly services. For this study, the three key concepts of the CCA (structure, culture, and agency) outlined above are arguably useful in providing an understanding of how South African policies on adolescent youth-friendly services with AGYW interact with the culture of AGYW in rural Vulindlela.

This study explores a user driven approach to adolescent youth-friendly services in health-care clinics in Vulindlela and its role in SRH among adolescent girls and young women (AGYW). Exploring user driven youth-friendly services will involve understanding the experiences of AGYW at the clinic; discovering from the users what makes the clinic youth-friendly.

According to Dutta (2008), the process of dialogic engagement with cultural members in order to gain a deeper understanding of their interpretation of health, constitutes the core of the CCA. Therefore, through agency, platforms are created for individuals to engage “in the co-construction of meanings and in actions based on these meanings” (Dutta, 2008: 87). As evidenced from the foregoing, the relationship between culture, structure and agency is interwoven. In other words, the CCA seeks to enhance people’s capacity to engage, from their own perspective, with structures that encompass their lives in order to create discursive spaces to transform these structures. This engagement thus takes place within a cultural context, where culture is conceived as “the local contexts within which health meanings are constituted and negotiated” (Dutta, 2008: 7).

The three intertwined concepts gather meaning through their interaction with one another. It is the interplay of these concepts: structure, culture and agency that open spaces for discourse concerning health within communities (Archipoli 2010). Structures provide the background for cultural stories and experiences to be shared, and they are the context within which health culture is conceptualised. Agency is the ability of individuals to act within and change health contexts. It is the interaction of the three concepts that provide that framework for applying the CCA to user driven AYFS.

Applying the Culture-Centered Approach

CCA is the interaction of culture, structure and agency, where communication is situated at the intersections (Dutta, 2014). Structures within cultural communities are outworked through the local contexts in which they are situated. This means that “structural features gain meaning through the contexts of the local culture, thus creating a site for the articulation and sharing of meaning” (Dutta, 2008: 7). Within this study, the structural features of primary health care, particularly adolescent youth-friendly services (AYFS) are given meaning through the inclusion of adolescent girls and young women (AGYW). This study explores user-driven AYFS in primary health care clinics and its role in influencing AGYW to visit the clinic for HIV prevention and SRH services. The concept of user driven has been explained in this study as the inclusion of AGYW in the design of AYFS in the clinic. This is the real-life experiences of AGYW concerning health care facilities and health care workers, evaluating whether they aid or inhibit their visit for HIV prevention and SRH services in the clinic. At the same time, culture offers the foundation for structure, such that structures are reified and challenged through the circulation of cultural meaning systems (Dutta and Basu, 2011). “It is through the articulation of new meanings that cultures create points of social change” (pg. 330). It will be through the articulation of new meanings of what AGYW perceive HIV prevention and SRH services that social change will be created.

At the core of CCA is structure and culture is agency. This is enacted where community members struggle with the structural constraints that face them (Dutta, 2008; (Dutta and Basu 2011, Dutta 2014). “Agency offers an opportunity to situate the lives of marginalised individuals, key populations, and mostly rural communities in the realm of their active engagement in living with and challenging the structures that constrain their lives” (Dutta and Basu, 2011: 331). Through the use of dialogue, this study hopes to give agency to AGYW, as they have the capacity to be actively involved in identifying health-related challenges experienced in their community, and consequently also have the opportunity to actively confront the structures within their community. This finally produces a cosmos where communicating for social change has an opportunity to be carried out. “From the standpoint of praxis, the culture centred approach stresses the need to develop respect for the capabilities of members of marginalised communities to define their health needs and to seek out solutions that fulfil their needs” (Dutta and Basu, 2011: 331). The core of CCA in this study is

understanding that AGYW have the ability to identify their HIV prevention and SRH needs and the ability to be catalysts in providing their own health-related solutions to problems they face. This is also at the center of AYFS. This study advocates for AYFS within primary health care clinics to be to a discursive space where AGYW can facilitate the process of solving their own challenges and describe and prescribe their own solutions. Therefore, CCA values community participation in renegotiating culturally insensitive structures so that they are aligned to the unique needs of their cultures (Shumba and Lubombo 2017). It is from this perspective that the cultural competence model to health care, will be applied in this study.

Cultural Competence

Healthcare professionals are now more aware of the challenges they face when providing healthcare services to a culturally and racially diverse population. Cultural competence is broadly defined as a set of congruent behaviours, attitudes and policies that come together in a way that enables effective service provision in cross-cultural situations (Cross *et al.* 1989; Issacs & Brnjamin, 1991; Brittain *et al.* 2015). In health care, cultural competence describes the ability of systems to cater for patients with diverse values, beliefs and behaviours; this includes tailored service delivery that meets patients' social, cultural and linguistic needs (Betancourt, Green *et al.* 2002). Initially, cultural competence focused mostly on racial and ethnic differences (Butler, McCreedy *et al.* 2016). More recently, it has been expanded to other marginalized population groups who are at risk for stigmatization for reasons other than race and ethnicity and/or who have differences in health care needs that result in health disparities. AGYW comprise some of these other populations.

Culture competence implies the existence of a shared culture. A culturally competent healthcare, provides health care to patients with diverse values, beliefs and behaviours. It requires an understanding of the community being served as well as the sociocultural influences on individual health beliefs and behaviours (Betancourt, Green *et al.* 2002). It further requires understanding how these factors interact with the health care system in ways that may prevent diverse populations such as adolescent girls and young women (AGYW) from obtaining quality health care (Betancourt, Green *et al.* 2002).

In line with this study, firstly, it is important to highlight that (Betancourt, Green *et al.* 2002) broadly define cultural competence and is employed in this section of the chapter as an introductory summary to cultural competence. There are several frameworks and models of cultural competence to cultural competence and health care): *Cultural Competence Model Culhane-Pera*, (1997); *Model of Cultural Competency Campinha-Bacote*, (1999); *Taxonomy for Culturally Competent Care Lister*, (1999); *Model of Culturally Competent Health Care Practice Papadopoulos*, (1998) and the *Model for Cultural Competence Purnell*, (2002), who broadly refer to cultural competence as the ability of health care systems to cater for patients with diversity and sensitivity, such as patients with disability (Lipson & Steiger 1996, Purnell 2002, Campinha-Bacote 2003).

Cultural competence frameworks go beyond the broad the health 'system' but acknowledge that in order for a health system to be competent, the knowledge and the skills of nurses require to care for patients from different cultural backgrounds. These frameworks are based on the premise that since an individual's cultural background affects several aspects of their lives, for example language, beliefs, religions and family structures, nurses need to develop an understanding of cultural diversity and apply this knowledge to the care of patients from different cultural backgrounds (Jirwe, Gerrish *et al.* 2009). This cultural diversity is also understood as transcultural nursing (Leininger, McFarland *et al.* 1987). Most of the authors of these frameworks use the term 'cultural competence' to refer to the multicultural knowledge base nurses need together with the ability to apply such knowledge in practice within health care settings (Leininger, McFarland *et al.* 1987, Jirwe, Gerrish *et al.* 2009).

The second important perspective this chapter reviews in cultural competence is that most of the cultural competence frameworks discussed above were developed outside of the African and South African context. Most frameworks of cultural competence are North American (Lipson and Steiger 1996, Purnell 2002, Campinha-Bacote and Campinha-Bacote 2003) although some have been developed in the UK (e.g. Papadopoulos *et al.* 1998) and New Zealand (Ramsden 2005), there are not many that have been contextualised within the African context, particularly in South Africa

and rural communities like Vulindlela. A concept analysis of North American frameworks of cultural competence identified their predominantly anthropological roots with an emphasis on culture (Burchum 2002). Five main components are common to these frameworks, namely *cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural sensitivity*. By contrast the framework (Papadopoulos, Tilki *et al.* 2004), from the UK emphasises not only cultural dimensions but also addresses discrimination and disadvantage experienced by people from migrant backgrounds.

A similar focus on discrimination is evident in the frameworks from New Zealand (Polaschek 1998, Ramsden 2005), although here the emphasis is on the disadvantaged position of indigenous communities. Ramsden (2005) emphasises the importance of addressing prejudices and institutional racism to overcome power relations inherited from the time of colonialism.

In a detailed analysis of conceptual frameworks of cultural competence, Jirwe *et al.* (2006) identify a model made up of four themes common to all frameworks: *an awareness of diversity among human beings; an ability to care for individuals; non-judgemental openness for all individuals; and enhancing cultural competence through a lifelong continuous process*. The model has been applied in different contexts, and continued to share these common themes. For example, in North America, the model placed less emphasis on racism and other forms of discrimination compared with those who have applied it in the United Kingdom (UK) and New Zealand. In North American and UK, cultural competence is considered primarily within the context of encounters between nurses and patients from different cultural backgrounds, whereas in New Zealand, cultural competence takes a much broader view of culture by identifying all encounters between nurses and patients as cross-cultural. Therefore, conceptual frameworks for cultural competence reflect the sociocultural, historical and political context in which they were developed (Jirwe, Gerrish *et al.* 2006).

South Africa has a growing multilingual and multicultural population of approximately 55 million people, and faces service delivery challenges due to a shortage in skilled health professionals. Many health care facilities still depict distinct racial and ethnic characteristics that date back to the *apartheid* era, and there are reports of racial

intolerance or preferential treatment at some facilities. There is limited literature in South Africa on cultural competence or on how to train health professionals to provide culturally competent care (Matthews and Van Wyk 2018). If, as Jirwe *et al.* (2009) suggest, conceptual frameworks reflect the context they were created in it cannot be assumed that frameworks developed in other countries are applicable to nursing in South Africa where the healthcare system and cultural diversity of the population are different (Jirwe, Gerrish *et al.* 2009). Arguably, there is a need to identify the core components of cultural competence which are considered important to provide appropriate care to South Africa's multicultural population. Moreover, existing frameworks of cultural competence in nursing have been developed by nurse academics as a 'theoretical' and 'intellectual' enterprise. The frameworks are, however, not derived from practice, but rather the theorists' conceptualisation of practice (Jirwe, Gerrish *et al.* 2009). There is evidence that practising nurses find conceptual frameworks difficult to apply to their everyday practice (Colley 2003). It follows that if nurses are to develop cultural competence, the knowledge, skills and attitudes forming the core components of cultural competence should be relevant to practising nurses, not just to nurse researchers (intellectuals).

It was important to first highlight the background of cultural competence and how it is applied in health care. The exposition of development and application gives premise for this study to explain how it will be employed. Purnell Model of Cultural Competence (Purnell 2002) is employed in this study, as a theoretical framework.

Purnell Model of Cultural Competence (PMCC)

Purnell's model of cultural competence was developed in the United States, as an organising framework to guide cultural competence among health care workers, including nurses (Purnell 2002). It offers a basis for individual's providing care, to gain knowledge around concepts and features that relate to various cultures in anticipation of assisting the performance of culturally competent care in clinical settings (Purnell 2002). The model has been recognised as a way to integrate transcultural proficiency into the execution of nursing (Albougami, Pounds *et al.* 2016). Cultural competence has been described as a process, which is constantly occurring and through which one slowly advances from lacking knowledge to developing it (Purnell 2002, Purnell and Paulanka 2003).

According to this model, an individual begins as unconsciously unskilled due to their absence of personal knowledge that they are lacking awareness about other cultures. Next, an individual becomes aware of their incompetence due to their acknowledgement that they have insufficient comprehension of other cultures. Individuals then become deliberately competent (through learning about others' cultures) so that they are able to apply personalised interventions (Whitman 2006). Lastly, individuals gradually become unconscious to their competence due to their ability to instinctively provide patients with culturally competent care.

In multicultural societies, it is becoming essential for healthcare professionals to be able to provide culturally competent care due to the results of enhanced personal health (Suh 2004) as well as the health of the overall population. The greater the overall knowledge a health practitioner has about cultures, the better their ability is to conduct evaluations and in turn provide culturally competent suggestions to patients. Purnell's model of cultural competence requires the healthcare worker or health caregiver to contemplate the distinct identities of each patient and their views towards their treatment and care (Albougami, Pounds *et al.* 2016). For example, adolescent youth-friendly services (AYFS) that are user driven in primary health care clinics among AGYW, nurses providing SRH services are required to understand the different identities of AGYW.

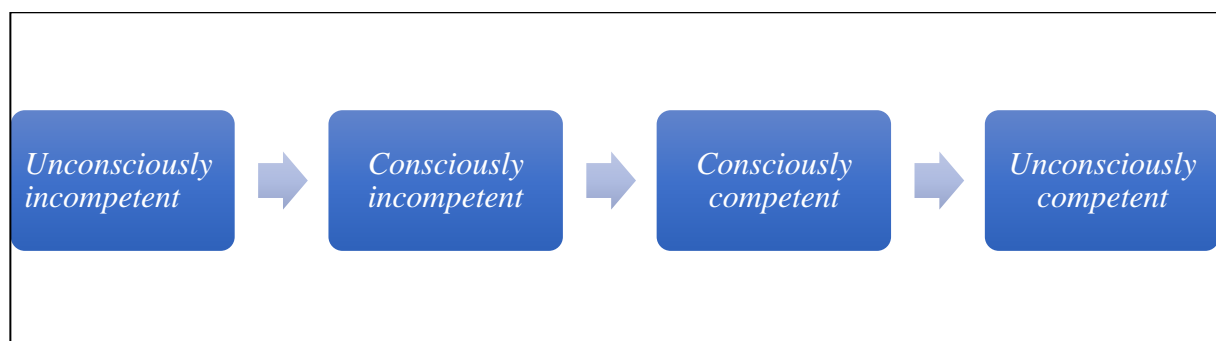
Earlier in this chapter, the researcher in this study situated individuals as cultural bodies who transport their personal identities, social identities, and cultural experiences into the healthcare environment (Allen, 2011; Hopson, 2011). Literature notes that adolescence is a critical age where identities and decision-making skills are developing (James, Pisa *et al.* 2018). Therefore, health care providers need to be prepared to deliver SRH services among an age group that is constantly changing its cultures, values and encounters. Nurses must be competent in organising the clinic in order to accommodate the SRH needs of AGYW. Hence "cultural competence is continuous" (Campinha-Bacote 2002). This study aims to investigate whether primary health care clinics offer youth-friendly SRH services to AGYW.

The Purnell Model for Cultural Competence is a sequence of circles or rings that each contain the development of this awareness of culture and how it continues to expand from the family to the whole world (See Table 3.3). The first ring of the model holds

the person (Harris 2003). The second ring of the model holds the family. The third ring of the model holds the community. The outermost ring of the model holds the global community. There are also different subsections inside each ring of the model that account for changes and evolution in the individual's cultural competence that include occupation, religion, education, politics, ethnicity and nationality, and gender. According to the model, all of these different subsections and circles continue on until the individual is culturally competent or aware (Purnell 2002, Harris 2003). The twelve inner pieces of the model are cultural domains (see table 3.1) that are composed of concepts that should be focused upon when evaluating patients. Each of the twelve domains should not be viewed as separate or diverse entities, instead it should be recognised that they can influence and inform each other and hence should be viewed as unified parts of a whole (Snider 2012).

The Purnell model explains that culture is the unconscious ways learned within our families, in which we develop our behavior, values, customs, and thought characteristics that guide our decision making and the way we view the world around us (Purnell 2002, Harris 2003). Cultural Competence is the process of becoming aware of our culture, and how we communicate that awareness to the rest of the world.

Figure 3.4 Diagram illustrating the stages of cultural competence

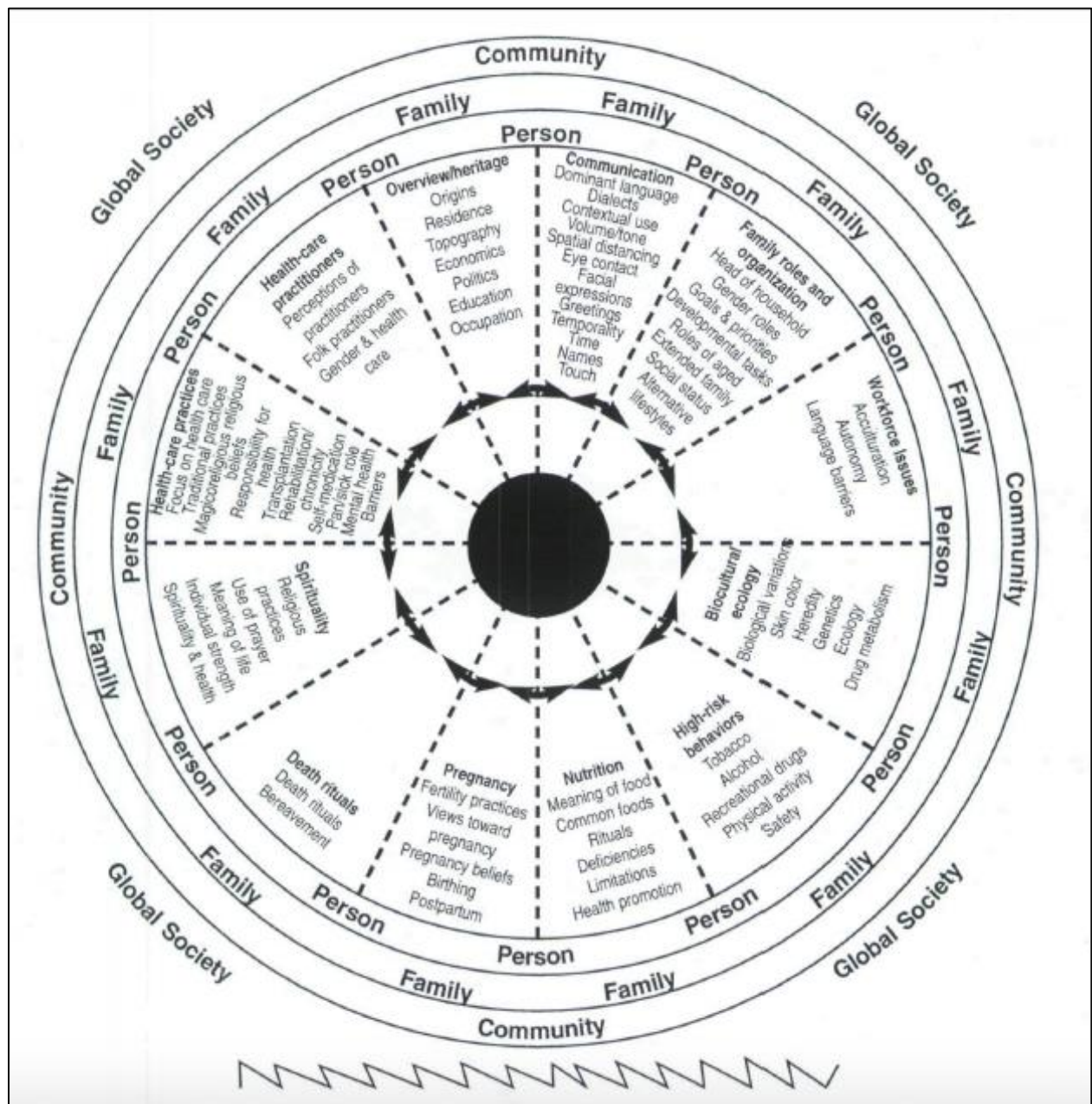


Source: (Adapted from (Purnell 2002)

Healthcare providers can use this same process to understand their own cultural beliefs, attitudes, values, practices, and behaviors. The purpose of the model is to provide a framework for all nurses, to define circumstances that affect a person's cultural worldview in the context of historical perspective. The model interrelates

characteristics of culture to promote congruence and facilitate the delivery of consciously sensitive and competent health care (Purnell 2002). Once a primary health care system is culturally competent, it is able to devise strategies to identify and address cultural barriers community members face when accessing primary health care for SRH care. What is pertinent about this model is the growth and increase in competence, (Purnell 2002) postulate that cultural competence for health care nurses starts from the *Unconsciously incompetent*, to the *Consciously incompetent*, thereafter, the nurse becomes *Consciously competent* and finally becomes *Unconsciously competent*.

Figure 3.4 The Purnell Model for Cultural Competence



Source: (Purnell 2002).

This study is particularly interested in the ability of care to fit into individual cultural values and beliefs. As mentioned in previous sections of this chapter, the aim of this study is to investigate whether primary health care clinics offer youth-friendly HIV and SRH services for AGYW in Vulindlela. This study has acknowledged that for HIV and SRH services to be youth-friendly, it is important to involve nurses who are the primary care givers in primary health care clinics. The concept of culturally congruent care is

an integral part of cultural competence. As highlighted in this theory, it is only possible when the nurse and the client creatively design a new or different care lifestyle for the health or well-being of the client. This again speaks to the user driven approach to adolescent youth-friendly services (AYFS) for HIV and SRH services for AGYW advocated in this study. Thus, all care modalities mentioned in this theory require co-participation of the nurse and clients (users) working together to identify, plan, implement, and evaluate each caring mode for culturally congruent nursing care. These can stimulate nurses to design nursing actions and decisions using new knowledge and culturally based ways to provide meaningful and satisfying wholistic care to individuals, groups or institutions.

It is crucial to acknowledge that, although this study aims to understand the role of AYFS in influencing HIV and SRH care among AGYW. One cannot ignore the impact *culture-specific care* and *culturally congruent care* will have on the effectiveness of AYFS in HIV and SRH services for AGYW. The modalities advocate for co-participation (Leininger, McFarland *et al.* 1987), where the nurse and clients (users) work together to identify, plan, implement, and evaluate each caring mode for culturally congruent nursing care. As with the CCA, culture is placed at the understanding of how individuals identify their care requirements, as these are influenced by their larger socio-cultural environment.

Table 3.1: The twelve domains of the inner circle within Purnell’s cultural competency model.

Domain	Meaning
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<i>Overview/heritage</i>	This domain refers to concepts such as one's origin that are vital in the aptitude of an individual in understanding both themselves and their patients.
<i>Communication</i>	This construct relates to the interactions an individual has been exposed to throughout their life and socialization process, for example with family, peers and the wider community. It also conveys the importance of an individual's ability to provide verbal cues such as volume and non-verbal cues such as body language and eye contact.
<i>Family roles and organisation</i>	This domain refers to hierarchies and structures existent within families that may be dependent on gender or age, which have the ability to influence not only family interactions but also the way in which an individual both communicates and acts.
<i>Workforce Issues</i>	Workforce issues denotes the way in which aspects present within a workplace such as language barriers, may have an effect on an individual and their sense of being and belonging.
<i>Biocultural ecology</i>	The concept of biocultural ecology relates to disparities that exist between the diverse range of racial and cultural groups such as biological variations, which need to be considered to gain a greater understanding and appreciation for other cultures.
<i>High-risk behaviours</i>	High-risk behaviours like consumption of alcohol are vital to consider as they exist within all cultures but the degrees to which they are used and subsequent impacts fluctuate.
<i>Nutrition</i>	Nutrition should be considered due to variations that exist between different cultures such as food intake and the values of certain foods.

<i>Pregnancy and childbearing</i>	This concept is important for an individual to understand whilst providing culturally competent care due to the presence of diverse cultural beliefs and pregnancy. There are also various practices and traditions that exist within ethnocultural groups that need to be respected when providing care.
<i>Death rituals</i>	This domain is fundamental in the deliverance of culturally competent healthcare, as the care provider must recognise patients' opinions towards death, and their customs towards occasions such as burial ceremonies.
<i>Spirituality</i>	Spirituality is essential to consider in the acquisition of knowledge about others' cultures and their practices, for example an individual's views and habits of prayer.
<i>Health care practices</i>	This domain should be considered in the provision of culturally competent care, as practices like organ transplantation require the comprehension of an individual's situation and necessity for care as well as cultural considerations.
<i>Health care practitioner</i>	This concept should be considered when providing an individual with care due to there being varying opinions and views that are existent among cultures, for example in relation to health care providers.

Source: (Purnell and Paulanka 2003)

Contextualising the need for Transcultural Nursing through Cultural Competence

In the previous chapters in this study, adolescent girls and young women (AGYW) between ages 15-24 are highlighted as a key population most vulnerable to HIV risk infection and other SRH related issues like early and unwanted pregnancies (Kharsany, Frohlich *et al.* 2015). It was further presented that the historical foundation of sexual reproductive health (SRH) services, governed by policies and laws in South Africa, has directly impacted on the attitude and perceptions of AGYW towards risky

sexual behaviour, which has in turn impacted on how adolescents engage with SRH services. Despite the government's efforts to change the laws and policies around the accessibility of HIV and SRH services in South Africa, barriers to services still remained post-apartheid (Tylee, Haller *et al.* 2007). Coupled with the complexities of the past and the lack of financial and human resources, SRH problems such as HIV and AIDS and teenage pregnancy rates were increasing in the post-apartheid era. Specifically, laws on access to SRH services for adolescents were designed to increase the use of contraceptives among young South Africans; however, literature identified that, despite their legal right, adolescents found that health care workers created a barrier to effective sexual and reproductive health (Mbeba, Mkuye *et al.* 2012, Chandra-Mouli, Mapella *et al.* 2013, Kaufman, Smelyanskaya *et al.* 2016). Due to the negative perceptions of health care workers towards adolescent sexuality, SRH services in public health clinics were underutilised. Adolescents perceived health care workers as unfriendly and uninterested (Ramathuba *et al.* 2012b; (Mbeba, Mkuye *et al.* 2012). This ultimately impacted negatively on the HIV prevalence and adolescent fertility control among adolescents in South Africa, as SRH services were hindered.

The stigmatising of AGYW sexuality and sexual behaviours by nurses led to the unwillingness to acknowledge adolescents' experiences, which ultimately undermined the effectiveness of contraception (Wood and Jewkes, 2006) and HIV prevention methods available for them (Bogart, Chetty *et al.* 2013). Health care workers' cultural beliefs strongly impacted on how they treated adolescents – the belief that women shouldn't have sex before marriage, for example (Holt *et al.* 2012). Furthermore, a lack of specific youth-friendly training and dedicated space for youth services were reported as a barrier to sexual and reproductive health services (Dickson- Tetteh *et al.* 2001; Geary *et al.* 2014). The underlying gap in the health care system's ability to deliver age-appropriate services for adolescents became evident with the increasing rate of SRH problems in South Africa (Mburu *et al.* 2013). These barriers needed to be addressed in order to curb the high HIV (STI) and adolescent fertility rates. Central to this was improving the adolescent-nurse relationship. Therefore, it was established that addressing the problematic relationship between nurses and AGYW would ultimately impact positively on effective contraceptive use among AGYW South Africans (Holt *et al.* 2012; Geary *et al.* 2014; Geary *et al.* 2015). This brought about the national implementation of adolescent and youth-friendly services (AYFS) through

public health care facilities in South Africa, as a national response first as a space that can facilitate optimal uptake of HIV and SRH services among AGYW (Reif, Bertrand *et al.* 2016) and address the problematic adolescent-nurse relationship.

Since nurses remain the largest health care providers in South Africa, they have a unique opportunity to learn about individual cultures and providing health care within their environmental contexts. The central purpose and goal of the transcultural nursing theory is for nurses to focus on promoting and maintaining the cultural care needs of individual patients. “Nurses who are prepared in transcultural nursing know how to identify and provide for diverse cultures. They learn ways to discover and provide safe and meaningful care to people of diverse cultures” (Leininger, McFarland *et al.* 1987).

Essentially, transcultural nursing provides nurses a new way to learn about and provide culturally congruent and meaningful care to people in various communities. It is a new and different pathway for most nurses from their traditional nursing orientations and modes of helping people. Today nurses must learn about and respect different cultures and their care needs in different life contexts to be transcultural nurses (Leininger, McFarland *et al.* 1987). Therefore, nurses as the direct care providers must be prepared to function with transcultural nursing knowledge and competencies to ensure beneficial outcomes to people of different cultures. For without such preparation in transcultural nursing, nurses will be greatly handicapped, disadvantaged, and culturally ignorant to help people of different lifeways, beliefs, and values. Cultural competence will not be reached.

Conclusion

This chapter has highlighted the need for a culturally specific approach to AYFS in primary health care clinics. As the foundations of CCA and cultural competence with its transcultural approach to nursing practice have been explored, this chapter has highlighted how these theories will be applied to this study. The two theories are not exclusive of each other, but highlight the need for context and localised initiatives both for AGYW and the nurses providing HIV and SRH services in primary health care clinics. As a guiding theoretical framework, these theories will enable a better grasp of AGYW’s understanding of AYFS at the primary health care clinic in Vulindlela. Both theories require active inclusion, dialogue and participation

Chapter Four: Research Methodology

Introduction

The methodology in the study forms the principle of inquiry. For any research study, the methodology provides answers to the 'how' of the research, that is the solution to problems identified and the 'what' as in the methods and tools to be used (Thomas, 2010). During the selection process of methods and tools for research, it is important to choose those methods of data collection that are flexible and also sensitive to social contexts in which the data is gathered (Snape and Spencer, 2003). As a result, to this, the success of any research study, must be premised on the appropriateness of the researchers approaches, the research design and the data collection methods. A research methodology clearly outlines and discusses how the researcher conducted the study in practice in order to respond to the research objectives (Terre Blanche & Durrheim, 1999). This studies research objectives are to (1) To investigate whether the primary health care clinics offer youth-friendly HIV and SRH services for adolescent girls and young women (AGYW) in Vulindlela. (2) To identify the current strategies employed to make the primary health services youth-friendly for AGYW in primary health care clinics in Vulindlela. (3) To explore the potential of youth-friendly services in influencing SRH care among AGYW. This chapter systematically presents the methodology followed in this study and the data collection methods employed to collect empirical data. It also highlights the challenges encountered during data collection. Furthermore, the chapter discusses how the data collected will be presented and analysed in the following chapters.

Learning to Listen and Listening to Learn: Researchers position

As a cultural studies and health communication scholar with research interests in communication for behaviour change, the researcher is interested in people's lived experiences and narratives as to how their social, environmental and structural challenges can be addressed. Investigating youth-friendly services from a user perspective required that the researcher listen to the narratives of AGYW, and health care nurses who provide HIV and SRH services in primary health care clinics. In this study, participants ages ranged from at 15-24year, some of the young girls were still

school going, participating in a study with a 'doctoral candidate'. Thus, the most salient issues that informed the relationships between and among the AGYW, the researcher, and the research assistant who was also a doctoral candidate from the university were related to age, educational status, and social class.

Although the researcher had a brief history of working in health communication projects that included this key population as participants, considering their cultural values and systems, many had never addressed issues of the educational status of the researcher and intern social class. That is not to suggest that the researcher was not challenged by my own "educational status". Thus, the researcher had a set of strategies in place to assist in negotiating age-related and social class issues within the research process. The AGYW's willingness to explore issues of age, education and social class throughout the research process affirmed for the researcher that the possibilities that exist in PAR to create spaces for rich and critical dialogue between youth of 'disadvantaged backgrounds with "OK Black young women" – it was dialogue, inclusion and engagement that contributed to the building of trusting and respectful relationships between the participants, myself, and the rest of the team.

This research is located within the participative paradigm, with its notion of reality as subjective-objective. The participatory paradigm involves an extended epistemology, where the 'knower' participates in the 'known', articulates a world, in at least four interdependent ways: experiential, presentational, propositional and practical (this is explained further in the section below). "To experience anything is to participate in it, and to participate is both to mould and to encounter, hence experiential reality is always subjective-objective" (Heron and Reason 1997). These four forms of knowing, within which, it seems, there is enormous latitude for critical subjectivity. Therefore, inquiry methodology within a participative worldview needs to be one which draws on this extended epistemology in such a way that critical subjectivity is enhanced by critical intersubjectivity. Hence a collaborative form of inquiry, in which all involved engage together in democratic dialogue as co-researchers and as co-subjects (Reason 1994, Heron and Reason 1997, Tomaselli and Dyll-Myklebust 2015)

Positioning the Research

Research Paradigm: Advocacy and Participatory Worldview

The research approach is closely linked to the paradigm of a study. The social science endeavour has been laden with different conflicts of interests and tensions. Among these conflicts include the different worldviews of Positivists (Positivist paradigm) under the quantitative approach and the Constructivists (Constructivist paradigm) under the qualitative research approach. The advocacy and participatory paradigm arose during the 1980's from individuals who felt that the positivist assumptions imposed structural laws and theories that did not fit marginalised individuals in our society or issues of social justice that needed to be addressed (Creswell 2009). Historically, some of the participatory or emancipatory writers have drawn on the works of other philosophers who shared similar worldviews, such as Marx, Harbermas and Freire (Creswell 2009). Some of these philosophers examined that even the constructivist stance did not go far enough in advocating for an action agenda to help marginalised peoples(Creswell 2009).

Guba and Lincoln (1994) have made a very useful contribution to articulating and differentiating competing paradigms of inquiry. They identify and describe positivism, post-positivism, critical theory and constructivism as the major paradigms that frame research. Nevertheless, "we start from and extend the Guba and Lincoln framework to articulate a participatory paradigm" arguing that the constructivist paradigm, as they articulate it, is unclear about the relationship between constructed realities and the original givenness of the cosmos, and that a worldview based on participation and participative realities is more helpful and satisfying (Heron and Reason 1997).

"The constructivist and participatory paradigms are in agreement that it is not possible in linguistic, conceptual terms to give any final or absolute account of what there is. Propositional knowing can only give mediated, subjective and intersubjective, relativistic accounts. The participatory paradigm goes further and asserts that we cannot have any final or absolute experiential knowing of what there is: in the relation of knowing by acquaintance, the experiential knower shapes perceptually what is there" (Heron and Reason 1997).

A fundamental quality of the participative worldview, which it shares with constructivism, is that it is self-reflexive. The participative mind; which Heron (1996) also terms the post-conceptual mind, articulates reality within a paradigm, articulates the paradigm itself, and can in principle reach out to the wider context of that paradigm to reframe it. (Heron and Reason 1997).

A paradigm represents a worldview that defines, for its holder, the nature of the “world,” the individual’s place in it, and the range of possible relationships to that world and its parts. These views influence the choice of method (gathering evidence), ontology (perception of reality) and epistemology (way of knowing) adopted in a study (Guba and Lincoln, 1994: 105-107; Hesse-Biber and Leavy, 2011: 5). These are the responses proponents of the different paradigms. The participatory worldview adds a fourth response proponent 'Axiology', which is omitted from the Guba and Lincoln account above, and which we think is an essential defining characteristic of an inquiry paradigm, alongside ontology, epistemology and methodology, these responses are given in Table 1. The axiological question asks what is intrinsically valuable in human life, in particular what sort of knowledge, if any, is intrinsically valuable (Heron and Reason 1997).

Table 4.1: Representing the response proponents of the participatory worldview

Ontology	Subjective-objective
Epistemology	Critical subjectivity and four ways of knowing (<i>experiential, presentational, propositional and practical</i>)
Methodology	Collaborative forms of action inquiry
Axiology	What is intrinsically worthwhile

Source: Author

Axiology is about the human condition that is valuable as an end in itself. The first three questions the ontological, the epistemological and the methodological - are all about matters to do with truth. What is really, i.e. truly, there? What is the nature of truthful knowledge of it? By what method can the truth be reached? (Heron and Reason 1997). The fourth and axiological question is about values of being, about what human states are to be valued simply by virtue of what they are, "it is in the cultural context that informs knowledge" (Carter and Little 2007). Von Glasersfeld agrees that "we cannot in any way know a 'real' world, and cannot even imagine it, because we can't conceive of anything existing without the notions of space and time, which are our own constructs" (Von Glasersfeld 1991). Hence it is possible and essential to expand awareness to articulate any fundamental way in which we frame our world, for differences of epistemology, methodology, and political perspective are usually based on paradigmatic assumptions.

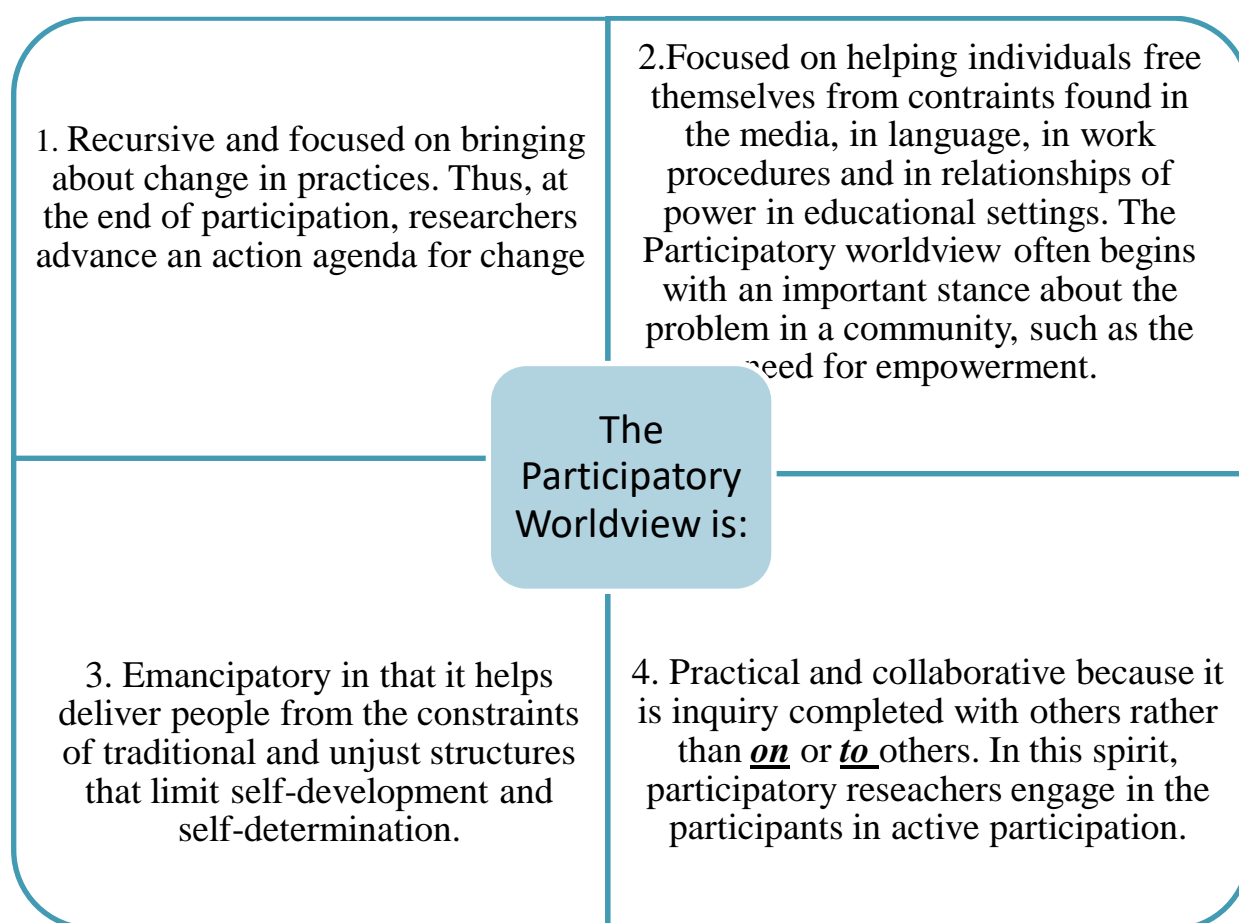
This study is situated in the participatory paradigm because the central premise of the research is engagement, inclusivity and participation of marginal members in a community. While paradigms can be sketched out in simple cognitive terms, their nature is far richer: as Ogilvy points out, they are about 'models, myths, moods and metaphors' (1986). Guba and Lincoln (1994) define a paradigm as a basic set of beliefs or worldview that guides research action or an investigation. Similarly, Denzin and Lincoln (2000), define paradigms as human constructions, which deal with first principles or ultimately indicates where the researcher is coming from so as to construct meaning embedded in data. This worldview is the perspective, or thinking, or school of thought, or set of shared beliefs, that informs the meaning or interpretation of research data. As Lather (1986) explains, a research paradigm inherently reflects the researcher's beliefs about the world that they live in and wants to live in (Lather 1986). It constitutes the abstract beliefs and principles that shape how a researcher sees the world, and how they interpret and act within that world.

A paradigm is the conceptual lens through which the researcher examines the methodological aspects of the research study to determine the research methods that will be used to collect data and how the data will be analysed. This is a critical perspective in this study because of the methods of data collection that were preferred in order to engage and include AGYW in gaining perspectives about youth-friendly

services in primary health care clinics. Paradigms are thus important because they provide beliefs and dictates, which, for researchers in a particular discipline, influence what should be studied, how it should be studied, and how the results of the study should be interpreted. In this study, the researcher's perspective was interested in the inclusion, engagement and empowerment of AGYW by collaboratively exploring how HIV and SRH services can be youth-friendly services for AGYW in the public health clinics. The pivotal point of this study advocates that AGYW should be the catalysts how HIV and sexual reproductive health (SRH) services for them should be delivered in primary health care clinics.

A participatory worldview holds that research inquiry needs to be intertwined with politics and political agenda. Thus, the research contains an action agenda for reform that may change the lives of the participants, the institutions in which individuals work or live, and the researcher's life as well (Carter and Little 2007, Creswell 2009). Moreover, the participatory paradigm allows for specific issues that need to be addressed that speak to important social issues such as empowerment, inequality, oppression, domination, suppression and alienation (Creswell 2009).

Figure 4.1: Principles of the Participatory Worldview



Source: (Creswell, 2009)

Within the participatory worldview, the researcher has the liberty to confront any of the situations highlighted in (Figure 4.1) to make it the focal point of a study. Social concerns are not limited to the above-mentioned issues, they are distinct across different cultures, ethnic groups and communities. The participatory worldview assumes that the inquirer will proceed collaboratively so to not further marginalise the participants as a result of the inquiry (Creswell 2009). It provides a voice for participants, raising their consciousness or advancing an agenda for change for change to improve their lives (Creswell 2009). The voice between researchers and the 'researched' become a united voice for reform and change.

Qualitative Research

This study follows a qualitative approach. Qualitative studies are focussed on exploring and understanding the meaning ascribed to social or human behaviour (Creswell 2009). This approach is used to answer questions about the complex nature of a particular phenomenon (De Vos, Strydom *et al.* 2005). Through qualitative research, the researcher seeks to better understand the complexity of the situation. In order to describe this approach, different scholars have developed various definition: Anselm Strauss and Juliet Corbin describe it as “any kind of research that produces findings that are not arrived at by means of statistical procedures or other means of quantification” (Strauss and Corbin 1990); and Nick Jankowski and Fred Wester, say it “refers to an understanding of the meaning that people ascribe to their social situation and activities” (Jankowski and Wester 1991). According to Aisha Gilliam’s understanding, qualitative methods are most relevant in order to provide detailed, in-depth information, to describe diversity, to determine the quality of content and interventions, to identify unexpected outcomes, to document interactions, and to create response (2005: 2).

The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting (Creswell 1998). It allows the researcher to explore selected issues in “depth, openness, and in detail” (Durrheim, 2006: 47). This is deemed the most appropriate in this study because, it allows for an in-depth and detailed account of what would make HIV and SRH services youth-friendly service in primary health care clinics. Creswell (2009) suggests that qualitative researchers usually collect data in the field, from the site where the participants experience the problem. This data collection process is enhanced by gathering information in a variety of forms such as perusing documents, interviewing participants and observing their behaviour. Qualitative studies allow participants to provide detailed and in-depth descriptions of the event and the associated actions (Babbie and Mouton, 2003). In the process of data collection, the researcher is thus focussed on learning about the meanings that participants attach to the problem and interpreting what they have seen, heard and understood in their experiences (Creswell, 2009). The qualitative approach emphasizes the depth of understanding (Rubin and Babbie 2009).

The overall goal of qualitative research is to access the 'insider' perspective of members of a culture (or subculture), to understand the way people think and make meaning within their social context, and how they express these understandings through communication (Priest, 1996: 103). The aim of a qualitative approach is to understand "the social meaning people attribute to their experiences, circumstances and situations, as well as the meanings people embed into texts and other objects" (Hesse-Biber and Leavy, 2011: 4). Therefore, central to this process is extracting meaning from the data (Hesse-Biber and Leavy, 2011: 4). The qualitative aspect becomes clear by asking and seeking an understanding of reader's personal situation, their lifestyles, the context of reading and their individual interpretation of the magazine's content.

David Silverman argues that the advantage of qualitative research is that it recognise the inherently subjective nature of social relationships. People construe others' behaviour through their own subjective lens of perception, and the others' behaviour, too, is framed within their own subjective and discursive frame of reference. The act of interviewing is a meeting of two subjectivities (Silverman 2006). A similar point was made by Gubrium and Holstein in a convincing rejection of the objective nature or unbiasedness of interview data (Gubrium, Holstein *et al.* 2012). Similarly, Harre argues that since the knower is embedded in the social scene of the interview, they are not independent of the respondent's responses (Harré 1998). The impossibility of objectivity, for these authors, implies that subjectivity must be acceptable and must be understood in depth. Silverman's work is possibly too individualistic to allow properly for the social nature of human subjectivity, but apart from that he makes sound points about qualitative research.

The crux of this study, was to understand how youth-friendly services can influence AGYW to attend the primary health care clinic for HIV and SRH services. It aimed to produce rich, visual and descriptive data of participants' perceptions and understanding, in order to contribute to the broader knowledge of AGYW SRH services in primary health care clinics. Although qualitative approaches have its advantages and disadvantages, qualitative approaches allow understanding for the processes that lead up to actions. It allows the researcher to "present a picture of the specific details in a situation, social setting or relationship" such as the picture and specific details of

HIV and SRH services for AGYW (Neuman, 2011: 39). In this study, the researcher was able to explore and examine the experience of AGYW in Vulindlela when attending the primary health care clinic for HIV and SRH services. It enabled the researcher to see the “world in action” (Denzin and Lincoln 2008).

Table 4.2: Common Advantages and disadvantages of qualitative research relating to this study

Advantages	Disadvantages
Focus is usually on a relatively small sample, allowing for an in-depth investigation into a phenomenon (Neuman 2005). The method was thus relevant in this study as contraception is a very complex subject and similarly, experiences are as varied.	The sample sizes are generally too small for generalizability of the results (Babbie and Mouton 2001)
Allows the researcher to view the behaviour of participants within natural settings, giving room for contextual detail in a study (Guba and Lincoln 1994).	The subjectivity of the process of analysing and interpreting what is observed behaviour can lead to researcher bias. Different researchers may gain different understanding of the same happening (Kawulich 2005).
Qualitative studies provide multifaceted documented descriptions of how people experience a given research phenomenon as emphasis is on understanding and creating meaning of the phenomenon studied (Tuli 2010)	Findings only help in explaining a single phenomenon based on a particular social setting and time. Qualitative studies are thus often difficult to replicate and therefore validate (Myers 2000).

Source: (Creswell 2009)

Research Design: Participatory Research (PR)

A research paradigm informs the research design of a study. As mentioned above, the participatory paradigm is broadly interested in the specific issues such as empowerment, inequality, oppression, marginalization, domination, suppression and alienation (Creswell 2009). This is why participatory research (PR) was the most fitting research design for this study. PR has multiple practices which have led to several labels, some prefer “praxis research”, or “action research”, or “collaborative research”, or “activist research”, or “participatory action research”, or “participatory research” (Stoecker and Bonacich 1992). Although these labels sound different they all are linked on the same fundamental values. As Stoecker and Bonacich (1992) state in their work, PR has two aims; the first aim is democratisation of knowledge creation, meaning that the process of actively involving people in communities whose voices are often not listed to when defining their social challenges and also contributing to possible solutions to their social challenges (Stoecker and Bonacich 1992, Wright, Springett *et al.* 2018). The democratisation of knowledge also includes engaging people from marginalised communities in the research processes which are usually conducted by external stockholders. There is a distinction between "involvement" and "participation" in participatory action research (Altrichter and Gstettner 1993, McTaggart 1997). Authentic participation means that the participants share "in the way research is conceptualised, practiced, and brought to bear on the life-world" (McTaggart (1997:28). This is in contrast to being merely "involved" in PAR, where one does not have ownership over or in the project (McIntyre 2007).

The study borrowed the methodological principles of PR to engage and empower AGYW to be involved in improving conditions in their communities. PR emphasises a “bottom-up” approach that aims to prioritize the locally defined social challenges (Cornwall and Jewkes, 1995). This study employed PR methods because of its ability to involve local community members in the research process, handing over agency. One of the strengths that PR is known to have is in exploring local knowledge and perceptions (Cornwall and Jewkes, 1995). This was an important factor for this study because AGYW invited in this study were invited to contribute their own experiences of SRH and HIV prevention services in primary health care clinics. Participatory research is usually characterised by interactive, reflexive and flexible processes, in contrast to the rigid and linear processes in conventional research (Wright *et al.* 2018).

When research participants participate in the way research is conceptualised, they are able to identify problems that are relevant to them, define how these problems should be solved and have control in designing the research that will help them solve problems that are a reality to them (Coetzee 2017). This study advocates for the active participation of AGYW as cultural members, who have their own beliefs, values and patterns of behaviour according to the Culture Centered Approach where they have the autonomy to take regulate of their HIV and sexual reproductive health services. “Participatory research provides a way for individuals to take part in the process of generating knowledge and advocating positive social change in order to promote more effective health care practices” (Brydon-Miller, 2003: 187). The second objective of PR is social change. Therefore, PR allows participants to identify sexual and reproductive issues relevant to them, as well as define relevant solutions for themselves (Brydon-Miller 2003). PR and PAR share many common features, both draw directly on Freire’s approach.

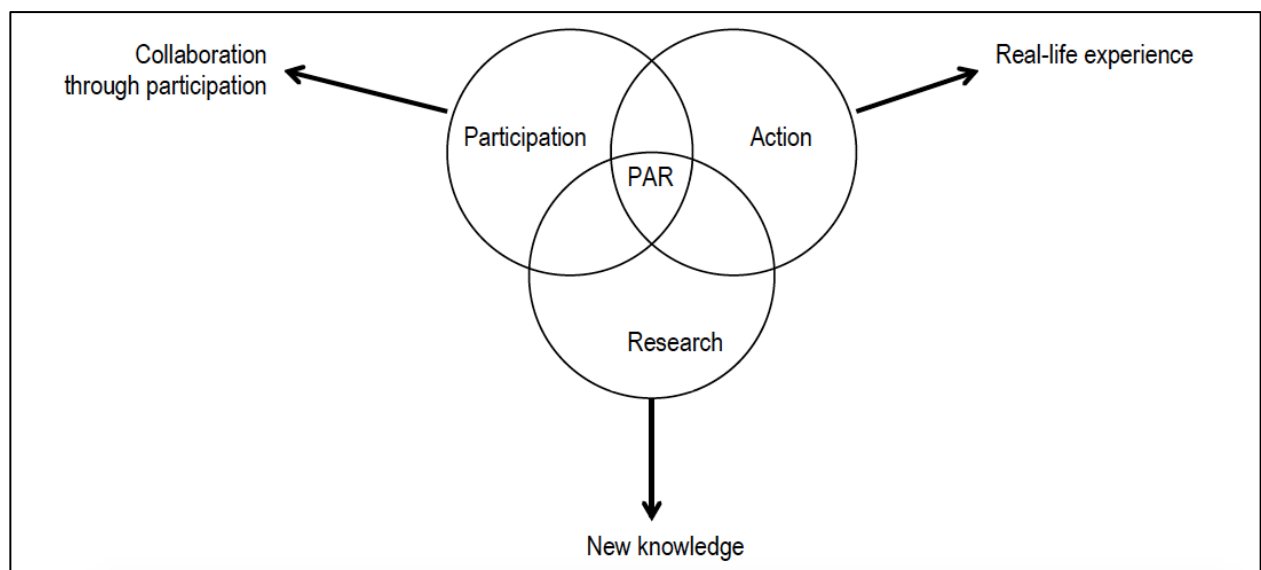
In PAR values (see Figure 4.2), Paulo Freire (1973) describes the process of *conscientization* as a process of “self-awareness through collective self-inquiry and reflection” (Freire 1973, Fals-Borda and Rahman 1991). A participatory approach to research is not only interested in the production of knowledge, but is also a tool “for the education and development of consciousness as well as mobilisation for action” (Babbie, 2011: 333). Freire's theory of conscientization, his belief in critical reflection as essential for individual and social change, and his commitment to the democratic dialectical unification of theory and practice have contributed significantly to the field of PAR. Similarly, Freire's development of counterhegemonic approaches to knowledge construction within oppressed communities has informed many of the strategy’s practitioners use in PR projects. Exploring local knowledge and ideas is one of the strengths of PR (Cornwall and Jewkes 1995). This was central to this study, as AGYW who participated in this study actively shared their local experiences of SRH services in primary health care clinics. PR methods are often used to enable local people to seek their own solutions according to their priorities (Cornwall and Jewkes 1995). This study employed PR methods in addressing the complexities of researching issues around SRH among AGYW. A participatory visual methodology was adopted in this study through the use of photographs. In this study, AGYW reflected on their dream clinic in comparison to the reality of the SRH services they

receive at the clinic. AGYW were able to describe the necessary solutions regarding SRH services that are youth-friendly.

The selection of PVM in this study was to fulfil the need to engage in critical reflection with AGYW about the structural power of dominant classes in health care service delivery in primary health care clinics. PVM corresponds with this study's CCA and CC as a theoretical framework, as it accounts for the action against oppression of marginalised community members (Dutta 2008).

The researcher in this study resolutely selected AGYW under the influence of PAR so that they become catalysts for social change in how HIV and SRH services are delivered for them. The 2019 world AIDS day in South Africa has called for international partners and civil society organisations to support local communities by giving communities a voice (UNAIDS 2019). PR honours and values the knowledge and experiences of people (Reason, 1994). It takes into account three dimensions of research: new knowledge, real-life experience and collaboration through participation. As researchers collaborate with the participants about real-life social phenomena, new knowledge is created that is beneficial for both the researcher (knowledge) and the researched (social change) (Coetzee 2017).

Figure 4.2: Representing Participatory Action Research



Source: (Chevalier and Buckles 2013).

Another critical aspect in PAR is the authentic commitment of the researcher, rooted in the cultural traditions of the everyday person (Reason 1994). It is only through dialogue that the researcher and the participants re-establish power, as to place both parties at the same level of co-constructors. It is through dialogue that the wisdom of the participants is honoured and respected as expert knowledge. The researcher shows a genuine commitment to authenticity by acknowledging that, although he may take the role of the expert researcher, “the popular knowledge of the people [has] a more profound understanding of the situation” (Reason, 1994: 328).

Understanding PAR in context of this study

Participatory Action Research (PAR) has been defined in different ways by many researchers from various fields. It is described as a “radical type of activist research” (Cancian 1996); “a process of research, education, and action” (Hall 1981) and a “community-based” inquiry (Stringer 2013). Based on these perspectives we may define PAR as a qualitative research inquiry in which the researcher and the participants collaborate at all levels in the research process (participation) to help find a suitable solution for a social problem that significantly affects an undeserved community (action) (Creswell, Hanson *et al.* 2007). In the field of Public Health Communication, PAR also differs from most other approaches to research because it is based on reflection, data collection and action that aims to improve health and reduce health inequities through involving the peoples who, in turn, take actions to improve their own health (Baum, MacDougall *et al.* 2006). PAR seeks to understand and improve the world by changing it. At its heart is collective, self-reflective inquiry that researchers and participants undertake, so they can understand and improve upon the practices in which they participate and the situations in which they participate and the situations in which they find themselves (Baum, MacDougall *et al.* 2006). The process of PAR is empowering and leads to peoples having increased control over their lives. What is distinct about PAR is not the methods employed, but the active involvement of the people whose lives are affected by the issue under study in every phase of the process. Central to PAR approaches is their shared commitment to consciously blurring the lines between the researcher and the researched through processes that accent the wealth of assets that community members bring to the process of knowing and creating knowledge and acting on the knowledge to bring about change (Minkler 2000).

In PAR, a major feature is to produce social change (Maguire 1987) and improve the quality of life in communities. Adolescent girls and young women (AGYW) face a variety of different experiences given the diverse political, economic, social and cultural realities within their communities (WHO, 2009). Although, for many, adolescence is a period of learning and building confidence in a nurturing environment, for others it is a period of heightened risk and complex challenges. Because more adolescents currently are reaching puberty earlier and marrying later, they face a longer period of sexual maturity and thus are more susceptible to a wider variety of reproductive health problems (Kharsany, Buthelezi *et al.* 2014). Sexual activity during adolescence (within or outside marriage) puts AGYW at risk of sexual and reproductive health problems. These include early pregnancy (intended or otherwise), unsafe abortion, sexually transmitted infections including HIV, and sexual coercion and violence (WHO, 2009). These are complex challenges that have isolated and stigmatised adolescent girls and young women (AGYW) within their families, schools and communities. Therefore, a user-centered approach to youth-friendly services allows space for AGYW to participate and voice their own views on what the clinic should look like, what it should not. They will be in the forefront of informing how services are delivered to them at the clinic; this can be effectively achieved through PAR.

PhotoVoice: A data collection strategy applied to women's health

Photovoice is also known as an art-based method that was originally articulated for participatory needs in the area of public health and is described as a method that aims to “enable people to record and reflect their community's strengths and concerns” (Rivera Lopez, Wickson *et al.* 2018). As a methodology, art based research mobilises AGYW towards their own empowerment, through promoting participation and self-development (Govender 2013). It creates a platform for flexible and free communication as participants negotiate their level of participation (Coetzee 2017).

The principle foundation of the PhotoVoice process is built on the fundamental tenets inherent in documentary photography, feminist research theory, and Freirian empowerment that in part advocate for all individuals to be involved in the public health conversation (Wallerstein and Bernstein 1988, Wang and Burris 1997). Within

documentary photography, photographic images are used to draw attention to social issues; however, the images are typically taken from the photographer's outsider (etic) viewpoint and may therefore fail to capture the insider's (emic) perspective (Wang and Burris 1997).

The principles of feminist theory specify that no one is in a better position to study and understand the issues of a group than are the people within that group, and that discovery is best promoted through shared experience (Keller and Longino 1996). Although PhotoVoice was developed with specific reference to women, its principles are also applicable to other groups (Wang and Burris 1997). The inspiration for Freirian theory, as in PhotoVoice, is that people should be active participants in understanding their community's issues, facilitated through the sharing of mutual experiences, and become agents of community change (Freire 1973).

PhotoVoice blends a grassroots approach to photography and social action. It provides cameras not to health specialists, policy makers, or professionals, but to people with least access to those who make decisions affecting their lives (Wang 1999, De Lange, Mitchell *et al.* 2007). It is an innovative PR method based on health promotion principles, enabling persons with little money, power, or status to identify, represent and enhance their community through photographs (Wang 1999). From the villages of rural communities to the homeless shelters, people have used PhotoVoice to amplify their visions and experience. PhotoVoice has three goals: it enables people to record and reflect their community's strengths and problems. It promotes dialogue about important issues through group discussion and photographs. Finally, it engages policymakers. It follows the premise that *What experts think is important may not match what people at the grassroots think is important* (Wang 1999). Mitchell *et al.* (2005) argued that photographs can be used as a tool of inquiry, a tool of representation, and a tool for taking action, and, in arguing thus, they suggested the scope of possibility available to anyone working with visual methods.

PhotoVoice has been used in various projects in rural districts of KwaZulu-Natal (Mitchell, DeLange *et al.* 2005, De Lange, Mitchell *et al.* 2007), where HIV prevalence rates were high. The teachers in one school identified HIV-related stigma as a key challenge and so worked with 21 grades 8 and 9 learners, asking them to take

photographs of what stigma looks like in their community, using the follow prompt: "Direct and take pictures of situations of stigmatisation".

The main objective of this study is to to investigate whether the primary health care clinics offer youth-friendly HIV and SRH services for adolescent girls and young women (AGYW). Therefore, understanding the current state of the clinic from AGYW who access varied services will increase understanding of the feasibility of the creating youth-friendly services that are user-driven. PhotoVoice is a participatory methodology that seeks to include participants in the research process and not further alienate them but rather provide a space for them to be co-creators of knowledge.

In line with this study, PhotoVoice will give adolescent girls and young women (AGYW) in Vulindlela the opportunity to reflect on some of the experiences and challenges in the clinic as a community where sexual reproductive health (SRH) is provided. It is crucial that data collected is able to address the research objectives and the overarching research questions proposed in this study. Hence, the researcher adapted some of the principles of PhotoVoice in order to suit the studies research objectives. The researcher prompted participants to capture photographs that were most relevant to them. Photos that would describe their experiences when visiting the primary health care clinic for SRH and HIV prevention services. The photos needed to reflect what the clinic experience is like from the time they walk into the clinic until they exit. Participants were given a specific time frame to go out into the community to capture photographs that carried the most meaning for each individual. This enabled participants to focus their attention when taking photos, thinking deeper about some of the challenges they face. It was necessary for each workshop to be conducted within the community in which participants lived, so that they can easily navigate around. For some participants, their experience of services was most represented within the clinic, while others captured images outside the clinic environment. Participants were given autonomy to move around the entire community.

PhotoVoice enables us to gain "*the possibility of perceiving the world from the viewpoint of the people who lead lives that are different from those traditionally in control of the means for imaging the world (Catalani and Minkler 2010).*" As such, this approach to participatory research values the knowledge put forth by people as a vital

source of expertise (De Lange, Mitchell *et al.* 2007). It confronts a fundamental problem of community assessment: what professionals, researchers, specialists, and outsiders think is important may completely fail to match what the community thinks is important. Most significant, the images produced and the issues discussed and framed by people may stimulate policy and social change. PhotoVoice is a methodology to reach, inform, and organize community members, enabling them to prioritize their concerns and discuss problems and solutions (De Lange, Mitchell *et al.* 2007). Data generated from PhotoVoice is often large and in depth, therefore the researcher in this study narrowed down the number of participants so that we could facilitate the workshop with a smaller group of AGYW and gain more insight.

Study location

Vulindlela the epicenter of HIV transmission.

The study location is situated in what has been called the HIV and AIDS hub, where HIV prevalence rates are higher than most contexts in South Africa. The highest HIV prevalence rates in South Africa occur in KwaZulu-Natal (KZN) (Shisana, Rehle *et al.* 2014, Kharsany, Frohlich *et al.* 2015). KZN, the most densely populated province in South Africa, has been markedly affected by both the HIV and STI epidemic; with a disproportionate burden of STIs and HIV among women (Naidoo, Wand *et al.* 2014). Several studies conducted within various populations of women in KZN have shown high prevalence of HIV (Karim, Kharsany *et al.* 2014, Kharsany, Buthelezi *et al.* 2014, Kharsany, Frohlich *et al.* 2015, Naicker, Kharsany *et al.* 2015, Kharsany and Karim 2016, De Oliveira, Kharsany *et al.* 2017).

The study location is a rural area in KwaZulu-Natal called Vulindlela (see figure 1.4). Vulindlela is a sub-district in the uMgungundlovu Municipality within KwaZulu-Natal. This context is largely made up of farmlands, traditional rural settlements, and informal and peri-urban living characterized by high burdens of HIV rates (Kharsany, Frohlich *et al.* 2015). In Vulindlela, by the age 16, one in every ten women who go to the clinic for SRH services are already infected with HIV and this increases to one in three by age 20 and one in two by age 24 (Karim, Baxter *et al.* 2017). Vulnerability among AGYW in South Africa and other countries is mostly located in rural communities

(Gregson, Nyamukapa *et al.* 2002, Wang and Wu 2007, Wamoyi, Wight *et al.* 2010, Kharsany, Frohlich *et al.* 2015, Ranganathan, Heise *et al.* 2016).

Figure 4.3 Image showing the location of the study as priority Sub-District for HIV prevention among AGYW



Source: (Karim, Baxter *et al.* 2017)

Sampling Method and Recruitment Strategy

Sampling

Sampling refers to the method of selecting certain participants from a larger group of a potential population (Matthews and Ross 2014). The selected participants, the sample, should have shared properties that represent the whole – the population (Bless, Higson-Smith *et al.* 2006). A sampling strategy is used in order to aid the sampling process, namely probability and non-probability sampling. This study utilised a non-probability sampling strategy, specifically a purposive sampling technique. Sampling was purposive, which means that participants were chosen based on their representation of certain characteristics (Boeije 2009). Creswell noted that in qualitative research, “the intent is not to generalise to a population, but to develop an in-depth exploration of a central phenomenon”, which is best achieved by using purposeful sampling strategies (2002:203). Purposive sampling aims to identify a sample of information-rich participants; meaning that it looks for participants who show characteristics that the researcher is interested in (Struwig and Stead 2013). This study took on a purposive sampling technique. Participant characteristics for this study included AGYW who access primary health care clinics in Vulindlela for antenatal care (ANC); Family Planning (FP) and HIV Testing and Counselling (HCT) services. Participants had to be female, between the age of 15 and 24 years old. In purposive sampling, participants are selected based on certain characteristic(s) of interest to the researcher (Struwig and Stead 2013). Participants were chosen based on fulfilling the characteristics needed in order to answer the research questions (Teddlie and Yu 2007).

In the end, the size of the sample, whether small or large, did not seem an issue in the context of qualitative and interpretive investigation. Statistical representativeness, that is, was not a core aim. As Anderson (1998: 45) argues, “sample size in qualitative research has no rules and should be governed by the purpose of the study”. While Anderson may be overstating to say that sample size in qualitative research has no rules, he is correct to state that qualitative studies like the present one should not be necessarily bogged down by sample size stratification matters (Crouch and McKenzie 2006). Still, the researcher will be guided by arbitrary ‘rules’ of qualitative sample size such as the rule that the smaller the sample, “the better the quality of the interaction

with the research participants” (Peil 1995)Crouch and McKenzie, 2006:483; Matthew, 2012). Sampling, usually defines as “the selection of a part to represent the whole” (Peil 1995:23, does not necessarily yield better data by including everyone.

Recruitment strategy

“The reasons for selecting participants included in an qualitative study and the process used to locate and recruit these participants are extremely important issues” (Arcury and Quandt 1999). In this study, the researcher recruited 30 participants from Caluza clinic, Mafakatini clinic and Mphophomeni clinic. Each clinic is represented in Table 5.3, where the researcher specifically recruited participants that were clinic users between the age 15 to 24 years of age. One of the most successful recruitment strategies in qualitative research involves working in partnership with key community members who are trusted by the potential research participants (Felsen *et al.* 2010).

Table 4.3: Table representing the number of participants included in the PhotoVoice workshops and the focus groups.

Name of the clinic	Data Collection Method	Number of AGYW recruited	Number of AGYW invited	Number of AGYW participated
Mafakatini	PhotoVoice and FG	30	10	6
Caluza	PhotoVoice and FG	30	10	7
Mphophomeni	PhotoVoice and FG	30	10	7
		90	30	20

In this study, initial gatekeeper permission was obtained from COMOSAT, a community based non-profit organisation in Vulindlela owned by a local activist for Aids treatment and prevention. The COMOSAT organisation operated as the initial aperture by providing the details of clinic operating managers in all three clinics where this study was conducted. Therefore, initial gatekeeper permission into the clinics was through COMOSAT. The researcher was able to access the clinic OP’s to further

discuss the research study and the recruitment process to the clinic OP's and the nurses who were available to assist the researcher.

Although initial gate keeping was sought through COMOSAT, the researcher required further gate keeper permission from clinic operational managers (OP) to access the clinic environment and the nurses facilitating AYFS in each clinic. Therefore, gate keeping can be seen as a joint collaboration between the researcher and the OP's in each clinic. After the introduction between the researcher and the health care nurses, the health care nurses were tasked by the OP's to direct the researcher to spaces where AGYW would be willing to participate in the study. The recruitment of AGYW was often unstable during the time the researcher was at the clinics. This instability was caused by the lack of experience in participant recruitment by the researcher and knowing how to approach each individual. Researchers that conduct qualitative studies in health-related fields have encountered challenges in recruiting specific target populations, such as low-income or underserved minorities (Namageyo-Funa, Rimando *et al.* 2014).

While some young women would show interest, others were not willing to commit to being part of the study and those that did show initial interest did not register their names on the recruitment screener as an indicator for participation. Another challenge was finding alternate ways to explain the study to those who had trouble understanding. However, from these challenges, the researcher identified two key recruitment strategies. Although faced with challenges, the researcher employed two recruitment strategies: (1) Collaborating with health care providers and community gatekeepers trusted by the participants (Porter and Lanes 2000, Felsen, Shaw *et al.* 2010, Renert, Russell-Mayhew *et al.* 2013, Spratling 2013); (2) Using face-to-face recruitment with participants in clinical settings (Felsen, Shaw *et al.* 2010, Spratling 2013). The collaboration with health care nurses was the first strategy employed in the recruitment of participants in this study. The nurses began with a brief introduction of what the recruitment was about to the AGYW, and who the researcher was. The AGYW were responsive to the health care nurses at the clinic because they were familiar with them as service providers. Health care nurses were instrumental in assisting the researcher to build successful rapport with the AGYW at the clinic, prior communication about the current research study.

Secondly, the researcher approached the AGYW using face-to face recruitment from the clinic waiting rooms, the AYFS centers within the clinic and those that were in the antenatal sections of the clinic to be part of the study. Some of the AGYW initially did not show interest in being part of the study due to other research studies that they were previously conducted in Vulindlela. The researcher stated in Chapter 2 of this study that, Vulindlela is an overly studied researcher area. This could have caused the reluctance of the AGYW when being recruited for this study. Many studies related to HIV and SRH related health issues have been done with AGYW in Vulindlela (Kharsany, Buthelezi *et al.* 2014, Kharsany, Frohlich *et al.* 2015, Kharsany and Karim 2016). From these challenges, the researcher identified two key facilitation strategies to facilitate recruitment successfully: 1) researcher flexibility and 2) building rapport.

In researcher flexibility, the researcher often found it necessary to adapt the protocol to accommodate individual participants' needs. For example, some AGYW were eager to participate but needed the researcher to explain what the study was about in the local IsiZulu language. In such cases, the researcher was required to be flexible, and be able to explain in the manner that would bring understanding. The researcher also had to adapt according to the AGYW's body language and temperament. For example, some of the AGYW expressed anger and some were in a hurry while interacting with the health care nurses, the researcher's further explanation of the study would remain friendly but quicker and more to the point. If the AGYW expressed discomfort, particularly the AGYW accessing antenatal care, the researcher needed to adopt a sympathetic tone of voice when speaking to them, acknowledging their discomfort.

In building rapport, the researcher in this study had to recognise that AGYW in Vulindlela may view being asked to participate as a nuisance, especially since the area is a highly researched area. Some AGYW were already experiencing being stigmatised and discriminated against from local community members for accessing antenatal care for the second time at a young age. Acknowledging these circumstances with an understanding statement, a concerned look, or a provision of more information often helped to build rapport with potential participants (Felsen, Shaw *et al.* 2010). "Small talk proved to be an effective way to engage some individuals who initiated conversations about non-study related topics such as their family, job or current events" (Felsen, Shaw *et al.* 2010). Participating in these

conversations assisted the researcher to gain participants' trust and confidence. Researcher flexibility and building rapport were two strategies employed by the researcher in this study to facilitate the recruitment. Hence, it is important to mention the two strategies that were used to initiate the recruitment process.

Ultimately, the researcher recruited 30 participants in each clinic, using a recruitment screener (see Appendix 12) to record the participant names, cell phone numbers and an alternative number that can be used to reach them. From the 30 AGYW who registered their names to participate in the study, the researcher invited 10 AGYW to be part of the PhotoVoice workshop. Workshops are often kept small in numbers so everyone personal attention and the chance to be heard (Ørngreen and Levinsen 2017). In order to give personal attention to each AGYW in the workshop, the researcher invited 10 participants from the 30 participants that were recruited (see table 5.4). This invitation was done through telephone calls to each participant, confirming their availability to. In all three clinics, it was not all 10 AGYW that were invited to participate in that study that were available. Therefore, table 5.3 represents the number of AGYW recruited in this study, the number invited and the number who participated.

Forms of data collection adopted within this study

Data collection in this study was firstly, with AGYW who access the clinic for HIV and SRH services in Vulindlela. Secondly, data collection was with health care nurses that specifically facilitate the AYFS programme in each clinic. With the AGYW, the researcher administrated: (1) Photovoice workshops followed by (2) focus group discussions and with the nurses (3) in-depth interviews.

Photovoice Workshops

As stated above photovoice blends a grassroots approach to photography and social action. It provides cameras not to health specialists, policy makers, or professionals, but to people with least access to those who make decisions affecting their lives (Wang 1999, De Lange, Mitchell *et al.* 2007). It is an innovative PAR method based on health promotion principles, enabling persons with little money, power, or status to identify, represent and enhance their community through photographs (Wang 1999).

Photovoice workshops were employed in this study, as a method of data collection that would enable AGYW in Vulindlela to represent whether primary health care clinics offer youth-friendly HIV and SRH services.

The workshops took an inductive approach: the researcher worked from a position of discovering possibilities towards empowerment. Table 4.5 represents the number of workshops in each clinic and the number of AGYW that participation. The process of participation was maintained since the AGYW had ongoing opportunities, through informal discussions and group work, to describe some of their positive and negative experiences of HIV and SRH services at the clinic. As these dialogues about challenges and problems developed, they assumed the characteristics of Paulo Freire's participatory pedagogy. Freire (1973) criticised the conventional approach to education, the 'banking method', in which information is transmitted to so-called ignorant people by an external authority (Freire 1973). In opposition to this, Freire advocated a 'problem-posing' approach in which people learn through active participation and dialogical exchange with others.

Table 4.4: Table representing the number of photovoice workshops

Name of the clinic	Data Collection Method	Number of PhotoVoice workshops	Number of AGYW participated
Mafakatini	PhotoVoice workshop	1	6
Caluza	PhotoVoice workshop	1	7
Mphophomeni	PhotoVoice workshop	1	7
	Total Number	3	20

In addition to functioning as a means of dialogue and expression, the workshops employed collaging and drawing also as a method of empowerment for the AGYW. The act of taking photographs, drawing, cutting and pasting, dissolved the boundaries that existed between the AGYW and the researcher, as they visually expressed their

experiences at the clinic. Majority of the young women during the workshops were concerned about the stigma and discrimination that nurses and community members would show if their descriptive experiences of SRH services at the clinic. To simplify the description of the workshop, the researcher uses five stages to present the overall procedure for the workshop:

Stage 1: exploring perceptions of SRH services at the clinic

In the first stage, the researcher introduced the overarching objectives of the study by presenting recent literature about the vulnerabilities faced by AGYW concerning their health and why the government and other stakeholders such as the Department of Health in South Africa have taken an interest in developing strategies and intervention for them as a key population. In order to ascertain AGYW perceptions, the researcher firstly had to introduce herself and the space in which the study would be conducted. The purpose of this, was to foster an environment where all the AGYW could respect each other and understand that each individual has the right to express themselves and what they have experienced at the clinic. The researcher fostered this discussion by using a 'picture me exercise', which allowed all the participants to know and hear personal issues about each and were able to show respect and appreciation.

The study explored the AGYW's perceptions about HIV and SRH services by firstly asking them to design a collage using magazine cuttings and drawing on how they desire HIV and SRH services to be delivered to them at their local primary health care clinics. The researcher asked the AGYW to label their 'dream' clinics and explain to us why they selected that name. Thereafter, the researcher requested that they write about their collage and drawings, adding what it is they 'wish' could be at the clinic that would encourage their visits for HIV and SRH services.

Stage 2: understanding photovoice

The researcher introduced the participants to photovoice by presenting to them a selection of pictures depicting gender-based violence (from previous photovoice studies that have been conducted with university students). Adapting the Photovoice methodology from previous PhotoVoice studies made it easier for the AGYW to understand what photovoice is and what the researcher was expecting from their

participation. Thereafter, the researcher explained what PhotoVoice was and how it has been used before in research with women.

Stage 3: the camera and photographs

In this stage, the researcher introduced the participants to cameras, in this study the researcher used tablets for participants to go into the field to take images of what represents the reality of their personal experience at the clinic within the community (Figure 4.4). They were asked to think of situations where they experience HIV and SRH services that were not youth-friendly, and therefore became directors of their own images. The participants were required to capture images that were most meaningful to them, images that they would be able to explain the depiction, representation and meaning.

Figure 4.4: Image representing participants during the PhotoVoice photography



Source: Author (July, 2018)

Stage 4: exhibition, reflections and presentations

The fourth stage began with what the researcher named an 'image review', where participants reviewed the printed photographs that they captured the previous day (See Figure 4.5). The researcher, asked that the select a maximum of four images each that would 'best' describe their clinic visit, and paste this on a large A2 chart paper in the order they wish to discuss. Thereafter, they had to reflect and write about what they experience when visiting the clinic for HIV and SRH services and how they experience this. This elicitation activity was followed by participants sharing their written responses and experiences with the whole group of participants

Stage 5: debriefing discussion

The last stage was for a debriefing discussion of HIV and SRH services among participants, the intention of this discussion was to allow for deeper understanding as individuals and as a group. Upon completion of the workshop, a group debriefing discussion was conducted directly afterwards with each participant presenting. This discussion allowed for a debriefing on the experiences of the PhotoVoice workshop. This allowed for reflection of the collaborative experiences of the participants, where they discussed their understanding of the workshop individually to the group. The group debriefing session was important, this reassured participants that their personal experiences are part of a collective commonality in regard to the diverse issues they face.

Figure 4.5: Image representing the PhotoVoice presentation



Source: Author (July 2018)

This debriefing workshop was focused on the collective perspective of the participants, rather than the personal. The debriefing discussion emphasised dialogue, agency and voice as identified by CCA. As the participants played an active role in the research process, through dialogue they were able to evaluate their experiences at the clinic when they visit for HIV and SRH services thus giving them a ‘voice’ and creating agency. This study aimed to access the experiences of art-based methodologies as an effective research tool to communicate about sexual and reproductive health.

Focus Groups

Focus groups (FGs) were used to collectively obtain information from AGYW, with a particular focus on HIV and SRH services accessed in local primary health care clinics. As such the data collected from the PhotoVoice workshops take precedence in this study, while data collected from these three focus group discussions are supplementary and additional data collected at the three clinics where this study was conducted are used to further augment the study. Different scholars in the social

sciences have defined FGs in various ways. FGs are defined as a “research technique that collects data through group interaction on a topic determined by the researcher” (Morgan, 1996:130). Key to the above definition are the two constructs of focus group discussions as a data collection method, the primacy of interaction amongst group members, and the active role of the researcher in moderating the discussion.

FG’s rely on the interaction between the group members for data and is useful for ascertaining diversity of opinions within a group. Struwig and Stead (2013) view focus groups as planned discussions that elicit perspectives on a topic in a non-judgmental way and in an accepting, safe environment (Struwig and Stead 2013). FG’s were conducted with AGYW who access the clinic for HIV and SRH services across the three clinics; Mafakatini, Mphophomeni and Caluza.

Table 4.5: Table representing the number of focus groups conducted in this study.

Name of the clinic	Data Collection Method	Number of FG’s	Number of AGYW participated
Mafakatini	Focus Group	1	6
Caluza	Focus Group	1	7
Mphophomeni	Focus Group	1	7
		3	20

In order to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW. The researcher conducted the FG’s guided by a focus group guide with specific questions (See appendix 11) that enabled participants to share their experience and perception of the current state of the clinics. George Kamberelis and Greg Dimitriadis (2005) argue that FG research lies at the intersection of pedagogy, activism and interpretive inquiry, with the researcher making strategic decisions in configuring this intersection (Kamberelis and Dimitriadis 2005). In revisiting this assumption, they reimagine FG’s as a multifunctional prism involving pedagogy, politics and inquiry. “All three FGs functions are always at work

simultaneously, they are all visible to the researcher to some extent, and they both refract and reflect the substance of FG work in different ways” (Kamberelis and Dimitriadis, 2013: 310).

The FGs functioned at a *pedagogic* level as the activity involves collective engagement that promotes dialogue about the group’s interests and welfare, which results in an understanding of the issues that are critical to the advancement of the group’s agency and development [*researcher’s emphasis*] (Kamberelis and Dimitriadis 2013). On a *political* level the FG’s sought to give a ‘voice’ to the subaltern, allowing for “a response to conditions of marginalization or oppression”, with the aim of transforming their conditions of existence [*researcher’s emphasis*] (Kamberelis and Dimitriadis, 2013: 311). Finally, the FG’s function at a level of inquiry that is predisposed to interpretivism, resulting in “rich, complex, nuanced, and even contradictory accounts” of how the participants interpret and ascribe meaning to their lived experiences, these accounts are then used as the engine of social change through communication [*researcher’s emphasis*] (Kamberelis and Dimitriadis, 2013: 312).

There are however, limitations that need to be considered when using FG’s. One such limitation is the fact that these sessions are driven by the researcher’s interests about predetermined issues (Deacon, Pickering *et al.* 1999). This was circumvented by allowing debates and exchanges to flow freely, enabling participants to raise concerns pertaining to them. The propensity of participants to withhold information or influence each other’s responses has also drawn criticism (Krueger, 1994). As pre-constituted FG’s were constituted, with existing levels of comfort with each other, participants felt at ease to discuss their experiences. From the data, opinions generally did not vary within groups regarding their opinion of the HIV and SRH services accessed at health care clinics. However, by limiting the FDs to only AGYW, the findings are representative of and specific to the AGYW accessing HIV and SRH services in clinics in Vulindlela and not the surrounding communities.

In-depth interviews

An in-depth interview can be described as face-to-face conversation between an interviewer and an informant, and which seek(s) to build the kind of intimacy that is common for mutual self-disclosure (Gubrium, Holstein *et al.* 2012). In-depth interviews

were conducted with nurses that provide sexual reproductive health (SRH) services to adolescent girls and young women (AGYW). The researcher seeks to gain understanding from the nurses who provide HIV and SRH services on what strategies are currently employed to make the clinic youth-friendly for AGYW. The researcher was able to establish patterns of use by interrogating how the nurses use dialogue to communicate about SRH with AGYW within the clinic.

This was a platform for nurses to articulate their experiences on facilitating the AYFS programme in the clinic, and their overall experiences and challenges of working with AGYW who access the clinic for services like antenatal care, family planning, HIV testing and counseling. This type of interview calls for the establishment of trust between the two parties involved, an element that is not easy to achieve, often taking time to obtain (Johnson, 2002). Therefore, the researcher was able to build trust with nurses by having pre-visits to the clinics; the first pre-visit to the clinics was an introductory meeting with OP's, where the researcher was introducing the aims and broader objectives that the study seeks to investigate. The second pre-visit was with OP's introducing the nurses who facilitate the AYFS programme in each clinic. The researcher was able to introduce the purpose of the study directly to the clinic nurses who facilitate the AYFS programme. This interaction secured trust between the researcher and the nurses, prior the interview.

The interviews took a semi-structured format; semi-structured interviews consist of several key questions that help to define the areas to be explored, but also allow the interviewer or interviewee to diverge in order to pursue an idea or response in more detail (Stewart, Treasure & Chadwick, and 2008:291). This interview format is used most frequently in health care, as it provides participants with some guidance on what to talk about (Stewart, Treasure & Chadwick, and 2008:291). The nurse participants were purposively sampled based on the purpose of the study, which investigates how HIV and SRH services are youth-friendly for AGYW in local clinics in Vulindlela. The nurses were purposively sampled on the foundation that each nurse was in charge of facilitating the AYFS programme in each of the three clinics in which this study was conducted. The researcher purposively sought to interview the nurses that work with AGYW in the AYFS programme in each clinic, Table 4.6 illustrates this further.

Table 4.6: Table representing the number of interviews conducted in this study.

Name of the clinic	Data Collection Method	Number of interviews	Number of nurses participated
Mafakatini	In-depth interview	1	1
Caluza	In-depth interview	1	1
Mphophomeni	In-depth interview	1	1
		3	3

These interviews provided valuable insight into the perspectives of each nurse concerning the youth friendliness of HIV and SRH services provided at the clinic. The importance of these perspectives lies in their confluence, but also in their divergence. This distinction was be explicated through extracts from the interviews in the data presentation chapter of this study. This brought to fore the existing challenges and opportunities, which prevent or encourage youth friendliness in primary health care clinics for AGYW who access the clinic for SRH and HIV services. The nurses were invited into this study to offer a comparative perspective on the youth friendliness of HIV and SRH services towards AGYW. Since the primary data in this stud is from the PhotoVoice workshops and the FG's, which were mutually gathered data from the perspectives of AGYW. The in-depth interviews were a data collection tool administered by the researcher to understand youth-friendly HIV and SRH services from the nurses that administer these services to AGYW.

Data analysis procedure

SHOWED as a 'sifting' method

Firstly, the photographs from the photovoice workshops as the first data collection tool, in this study employed the SHOWED strategy as the initial strategy for analysis. Qualitative data is mainly about interpreting and getting a good understanding of the words, stories, accounts and explanations of our research respondents (Barton, Matthews et al. 2010). In order to arrive at understanding the meanings attached to the photographs captured by AGYW during the PhotoVoice workshop, the researcher applied SHOWED as an initial strategy to sift and make sense of the images. The meaning of **SHOWED** can be explained in context by the following statements:

1. What do you **See** or how do we name the problem?
2. What is really **H**appening?
3. How does the story relate to **O**ur lives?
4. **W**hy does this problem exist?
5. How might we become **E**mpowered now that we have a better understanding of the problem?
6. What can we **D**o about it?

[Adapted from: (Wang 1999, De Lange, Mitchell et al. 2007, Lewis and Lewis 2014)

This was the first point of analysis done by the participants within the PhotoVoice workshops. This is where each participant in the group reflected more critically on each photograph that they have taken in the community. Using photovoice as a tool to action reflects PAR's commitment to social change (Wang 2006). The purpose of root-cause questioning using the acronym SHOWED, described earlier, is to identify the problem or the asset, critically discuss the roots of the situation and develop strategies for improving the situation. This encourages a deeper understanding of the issue under scrutiny (Wang 1999). It not only encourages recording, reflecting and critiquing but also proposing action driven solutions to address the problem. Working on the materiality of the photographs in this way usually evokes rich and animated discussion, which is recorded and the transcribed.

Thereafter, the researcher begins to work with these multiple data sources generated by participants through participation. The transcribed data, for example, along with the captions placed on each photo can be analysed by breaking up the data into manageable themes, patterns, trends, and relationships and the synthesising the data into larger coherent themes (Babbie and Mouton 2001). Hence, SHOWED was the first level of analysis in this study, where AGYW were given the platform to describe the photographs, and the meanings they attach to youth friendliness when accessing the clinic for HIV and SRH services.

Thematic analysis

Secondly, the focus groups and in-depth interviews were analysed thematically. As it has been stated, a qualitative approach to research allows for the collection of rich, descriptive data. It is for this reason a thematic data analysis was chosen as the most appropriate method of data analysis for this study. Thematic analysis is a “process of segmentation, categorisation and relinking of aspects of the data prior to final interpretation” (Grbich, 2007: 16). Braun and Clarke (2006) propose a six-step process of thematic analysis to be followed in order to analyse data. Through this process, the researcher is able to classify data into “patterns and subthemes to form collective experiences, comments and stories” of adolescent females (Govender, 2013: 67). This study is interested in understanding the collective experiences of adolescent females towards sexual and reproductive health services. Thus, through categorising data into common themes and patterns, the researcher gains a better understanding of the general experiences of adolescent females. Data collected through the focus group discussions and in-depth interviews was analysed through thematic analysis.

Table 4.7: Representing the process of thematic analysis

Phase	Description of the process
Familiarising yourself with your data	Transcribing data (if necessary); reading and re-reading the data; noting down initial ideas.

Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set; collating data relevant to each code.
Searching for themes	Collating codes into potential themes; gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2); generating a thematic 'map' of the analysis.
Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names of each theme.
Producing the report	The final opportunity for analysis: selection of vivid, compelling extract examples; final analysis of selected extracts; relating back to the analysis of the research question and literature; producing a scholarly report of analysis.

Source: (Govender, 2013: 69; adapted from Braun and Clarke, 2006: 87)

Thematic Analysis “is a method for identifying, analysing and reporting patterns (Themes) within data” (Braun & Clarke, 2006:79). Thematic analysis is selected as a preferred method as it moves beyond merely describing the data but identifies both the unspoken and obvious ideas within data (Guest, MacQueen *et al.* 2011). Thematic analysis becomes a flexible method of analysing data when it permits an integrated analysis of data collected using different qualitative methods (Braun and Clarke 2006). To analyse the FG’s, the in-depth interviews, and the photovoice workshop feedback debriefs, the inductive approach was employed to identify themes that were strongly linked to the data.

Themes were developed in line with the variables of the study. Transcripts from the focus group discussion and workshop were categorised separately from accordingly. Similarly, in depth interviews with health care workers who provide services to AGYW who attend the clinic for ANC/FP and HCT were categorised distinctly. The researcher then be able to pinpoint and examine patterns within the data to form themes and conduct a thematic analysis. When viewed in isolation, these experiences are often meaningless, but when brought together they form a comprehensive image of their collective encounter (Spencer, Ritchie *et al.* 2003).

Research Trustworthiness

There is no method that is perfect in social science research. Therefore, it is fundamental that the researcher evaluates the measures and methodology in order to safeguard validity and rigour in the research. The researcher can ensure certain standards in the way data is collected, analysed and presented in order to ensure the study is valid (Barton, Matthews *et al.* 2010). The quality of the research study is also known as the objectivity of the study, where “it pertains to the correspondence between the social scientist’s findings, i.e. the descriptions and explanations of a social phenomenon, and the phenomenon as it is experienced by the people in the field” (Boeije, 2009: 168). There are three central dimensions that need to be apparent in a study in order to give it rigour: validity/credibility, generalisability/transferability and reliability/dependability (Glaser, Strauss *et al.* 1967, Boeije 2009). This section will explain how rigour was ensured in this study.

Neuman (2011), defines reliability in two words; 'dependability' or 'consistency', and validity, 'truthfulness and trustworthiness'. According to Durrheim and Wassenaar; "dependability refers to the degree to which the reader can be convinced that findings did indeed occur as the researcher says they did" (1999: 64). It is therefore vital that the researcher evaluate the measures and methodology in order to ensure validity and rigour in the research. The researcher can ensure certain standards in the way data is collected, analysed and presented in order to ensure the study is valid (Barton, Matthews *et al.* 2010). The quality of the research is also referred to the objectivity of the study, where "it pertains to the correspondence between the social scientist's findings, i.e. the descriptions and explanations of a social phenomenon, and the phenomenon as it is experienced by the people in the field" (Boeije, 2009: 168). There are three essential scopes that need to be apparent in a study in order to give it rigour: validity/credibility, generalisability/transferability and reliability/dependability (Glaser, Strauss *et al.* 1967). This section will explain how rigour was ensured in this study.

Validity/Credibility

According to (Golafshani 2003) "while the credibility of quantitative studies depends on instrument scores, in qualitative studies the researcher is the instrument. Therefore, the credibility of qualitative research depends on the efforts of the researcher" (Golafshani, 2003: 600). The challenge with qualitative research is to safeguard that the interpretation is not prejudiced (Creswell and Miller 2000). This is difficult since qualitative paradigms assume that reality is socially constructed (Creswell and Miller, 2000: 125). In the general sense, validity refers to the degree to which the research findings are sound (Blanche, Blanche *et al.* 2006). In this study, validity and credibility were ensured through the cyclical process of PAR (Govender 2013). In "action research the rigour is demonstrated through the cyclical process of revisiting the social problem through various phases" (Govender, 2013:70). As data collection was a three-fold process, where participants were able to reflect on their understanding, it ensured that data collected was valid and credible. Participants were able to reflect on their photographs from the photovoice workshop, by explaining what they understood by youth-friendly HIV and SRH services. Thus, this cyclical process reiterated the validity of the data collected. Furthermore, the researcher reached saturation in the data collected, safeguarding the validity of the research.

Reliability/Dependability

The aim of this study is not to be repeatable, thus being reliable, it is rather focused on being dependable. Influenced by the researchers' worldview, this study does not believe there is an unchanging, stable reality that can be comprehended, it does not expect to find the same results as in other studies (Coetzee 2017). Rather, for a study to be dependable, it is interested in the "degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did" (Van der Riet and Durrheim 2006). The way that dependability was ensured in this study was through the rich and comprehensive descriptions "that showed actions and opinions [were] rooted in contextual interactions" (Van der Riet and Durrheim, 2006: 94). As the words of data were systematically recorded and analysed, the study represents the actions and opinions of the participants in a thorough and dependable way.

Ethical considerations

Ethical considerations in research are imperative, as research participants' rights may be violated by the researcher, either knowingly or unknowingly. It is vital that the rights of participants are placed at the centre of the researcher's decision-making process, so as to minimise the risk of infringing on the participants' rights (Coetzee 2017). As this study was conducted with a vulnerable population (including adolescent girl's younger than 18years old), it was even more crucial that ethical considerations were placed at the forefront. Autonomy and dialogue was essential to this study, allowing participants the freedom of choice as to whether they wish to be involved in the study or not (Coetzee 2017). Therefore, the researcher could not coerce or deceive participants in order to force participation, "authentic participation means that the participants share "in the way research is conceptualized, practiced, and brought to bear on the life-world" (McTaggart 1997). Fidelity and justice are also very important. All participants' rights and dignity should be respected, and the participants should be treated equally and fairly (Bless, Higson-Smith *et al.* 2006)

Ethical guidelines for research seek to minimize risks, burdens and harms; to increase the benefits of research for individual participants(Leadbeater, Bannister *et al.* 2006); to ensure that the consent given by the participants or their guardians is freely offered and informed by knowledge of what the

participants are being asked to do; and to maintain participants' privacy and confidentiality (Leadbeater, Riecken, Benoit *et al.* 2006: 4).

In this study, autonomy was protected through confidentiality and anonymity. The researcher describes three phases that were implemented to ensure ethical considerations:

Ethical accommodations made to the ethical procedure: Negotiating initial Access, Consent, and Gatekeepers

Phase 1:

The researcher began the process of negotiating initial consent for this study by contacting the clinic managers of the three clinics selected as the site of the study and subsequently arranged consultation meetings with them. During the meetings, the researcher outlined the broad aims and scope of the study, including the recruitment plan for the selection of adolescent girls and young women (AGYW) as participants. That is, AGYW had to be between the ages of 15-24 years and have used the clinic for either family planning, HIV testing and counselling, and antenatal care services. The purposive random sampling technique was employed. In purposive random sampling, participants are selected based on certain characteristic(s) of interest to the researchers and arbitrary culling a smaller sample size from the larger population (Struwig and Stead 2013). The managers responded by considering the implication and gatekeeper privileges when working with AGYW. They gave thoughtful consideration to the circumstances of individual young women and the stability of their lives and possible harm of being included in this study. This resulted to three recommendations: (1) A gatekeeper letter from the uMgungundlovu district managers' offices; (2) A gatekeeper letter from the Provincial Health Research Committee in KwaZulu-Natal Department of Health and (3) To notify the region counsellor for permission to conduct this study.

Phase 2:

Commencing with the recruitment process with AGYW was subsequent to us gaining approval from the district manager, who oversees the clinic managers and all the external activities permitted at the clinic. Furthermore, Provincial approval from the Research Committee was to ensure the authenticity of the study and verify protocol approval from the University. Both gatekeeper letters were obtained successfully and immediately. The researcher instigated the recruitment process. Aside from that, the overall objective of creating adolescent youth -friendly services at the clinic and its benefit to HIV and SRH services now and in the future, was pivotal. The more the researcher explained the background of the study, AGYW at the clinic had a clearer perspective of its purpose. Understanding, therefore, translated to their willingness to participate. A list of thirty young women in each clinic was generated over a period of four weeks. The researcher recorded their names, surname, contact numbers and alternative contact numbers and further explained that registering their names on the register during recruitment did not mean automatic participation.

Phase 3:

Once the list was generated, the researcher began the process of inviting adolescent girls and young women to participate in the study. It was convenient that the researcher does this telephonically, and emphasise what the study was about again and what it would entail if they agreed to participate. During the conversation, AGYW were given the opportunity to confirm their participation without coercion. Participants below the age of 18 directed the researcher to their parents telephonically. The researcher sought parental consent through telephone calls because some of the parents and grandparents prohibited the AGYW to participate in the workshop without understanding what it was about. The parents enquired about who the researcher was and which university the researcher came from and also why the researcher thought it was important to speak to AGYW about HIV and SRH youth-friendly services.

Due to the engagement with parents and guardians, it was compulsory for the researcher to plan and prepare for each workshop a week ahead. With some family structure, authority was not with the parents but with the grandparents. For example,

one of the participants was 15 years old and her mother was 29 years of age. The 29-year-old mother had to seek permission from her own mother to release the participant for participation. Ethical considerations are not conventional, but they are dynamic in different individuals and contexts. With this particular family, the hierarchy of authority in the household determined who the consent giver would be. Consent was not premised on biological relationship with the participant but rather on the cultural value that elders direct the home and everyone living in it. The assent form was written clearly in order for participants to easily understand the writing and the conditions for participation. Thereafter, participants were given the specifications of venues central in the community, they were given times to arrive.

Study limitations

As with all qualitative research, where the sample size is relatively small, one cannot assume the findings are general to all adolescent girls and young women (AGYW). However, the findings do give an understanding of what AGYW view as youth-friendly and not youth-friendly and what they want HIV and sexual and reproductive health (SRH) services to look like. Furthermore, this study does not allow for the assessment of perceptions, knowledge and attitudes over an extended period of time, but rather captures these at that specific time. Due to logistical and financial constraints, the sample size for this study was fairly small and limited to clinics where the AYFS programme was beginning to be operational and functional to a certain degree. The data collected was specific to one population, making transferability limited. Govender states that this “highlights the complexity in terms of time and resources to conduct participatory research, suggesting that there is no quick fix to addressing issues of participation” (2013: 71). As this study was conducted with AGYW, where participation was voluntary, participation was not guaranteed. Participants were informed of their right to exit the study at any point. For example, in the Mafakatini clinic, out of eight participants who participated in the photovoice workshop, only seven participated in the focus group discussion. The photovoice exhibition chart of the participants who were not part of the focus group discussion was still used as data.

However, the interpretation was limited to the researcher’s interpretation, rather than being explained by the participant herself. This limit the analysis of this photovoice chart (more discussion about the evaluation of the methodology will take place in the

“Discussion” chapter). In addition, the use of art methodologies, such as photovoice and collage, runs the risk of participants not feeling comfortable to express themselves because it requires them to draw and write. It may pose a constraint to communication, rather than creating openness. Furthermore, the conventional method of interviews may pose a further constraint to communication. Rather than being a group activity, participants may feel shy and intimidated by the one-on-one environment with the researcher.

Conclusion

This chapter has positioned the research within the participatory paradigm, explained and explored the data collection process and outlined how data analysis was conducted. As this study was conducted with some participants under the age of 18 years old, the ethical implications were pertinent to acknowledge and consider. The following chapter will present the data collected and analysed. The chapter will explore the data, in order to answer the research questions and gain an understanding of the perceptions of AGYW towards HIV and SRH youth-friendly services.

Chapter Five: Data Presentation

Introduction

The main objectives of this study have been discussed in previous chapters of this study. Is to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW. Ultimately, adolescent youth-friendly services (AYFS) in primary health care clinics is designed for primary health care clinics as a programme that offers tailored and focused services for AGYW. The aim of the programme is to improve the adherence of AGYW accessing the primary health care clinics for HIV and SRH services.

This chapter presents data collected in this study. The data was collected in this study was a threefold process including: data from the PhotoVoice workshop, focus groups and the in-depth interviews. The PhotoVoice workshop and the focus groups were conducted with AGYW. While the in-depth interviews were conducted with nurses that facilitate the AYFS programme in each of the three primary health care clinics where this study was conducted. The researcher has categorized the data into two data sets for a logical flow of presentation, which enhances understanding. The two data sets are *visual data* set and *verbal data* set.

The visual data is from the PhotoVoice workshop and entails a 'reality' clinic experience and the 'dream' clinic vision of AGYW. In the reality experience, participants, used cameras to produce photographs that represent their current experiences of HIV and SRH services at the clinic. The dream clinic, is a collage exercise that was completed within the photovoice workshop for participants to design and express their vision of the desired dream clinic. The purpose of the collage exercise within the photovoice workshops is explained in the methodology chapter of this study.

The verbal data includes the verbal presentations of the reality and dream clinic, followed by focus groups with AGYW who access the primary health care clinic for HIV and SRH services. Lastly, the researcher presents the nurses responses with regards to providing HIV and SRH services to AGYW in primary health care clinics.

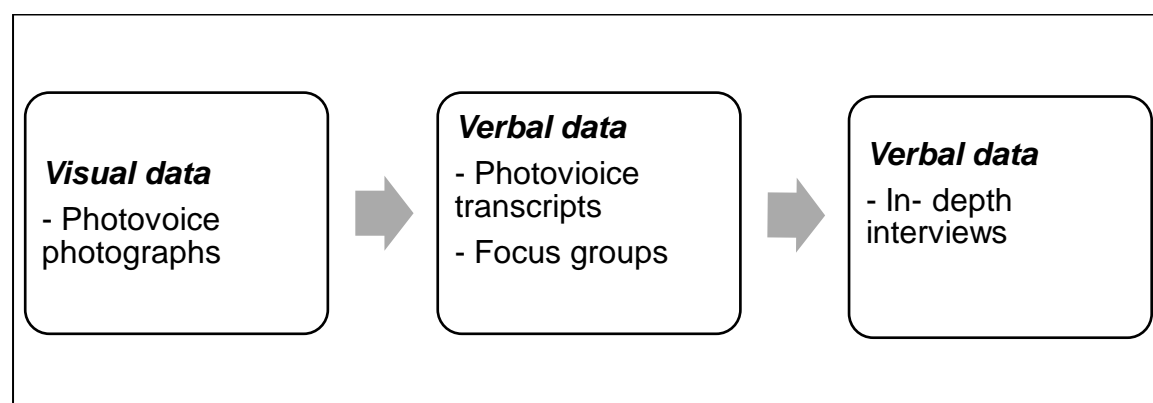
These three data sets are systematically presented in three sections of the chapter following a logical flow.

Therefore, the first section of the chapter is AGYW's visual data from the photovoice workshop. The purpose of the photovoice workshop was to explore AGYW's meaning of youth-friendliness when receiving HIV and SRH related services in primary health care clinics. The AGYW were given chart paper to design and present two charts: (a) the first chart was a representation of AGYW's experiences when they access the primary health care clinic for HIV and SRH services, this chart is labelled the "*reality clinic*." (b) The second chart was a representation of what AGYW desired the clinic to be and how their experience of receiving HIV and SRH services should be like. This chart is labelled "*dream clinic*." All the visual data that is tabulated below, describes according to each AGYW's 'dream and reality' clinic. In the photovoice workshops, the AGYW had to further present both the "reality" and "dream" clinic, explaining and describing what each photograph means. The presentations were recorded as each AGYW described both the charts, drawing out meaning. Therefore, the AGYW depicted their individual photographs and also interpreted the photographs. All the images and signifiers presented in the visual data section were explained by the participants.

The second section of the chapter presents focus group discussions and the verbal transcripts of the reality and dream clinic from the photovoice workshops. Focus group discussions involves organised discussions with a selected group of individuals to gain information about their views and experiences. It is particularly suited for obtaining several perspectives about the same topic, and the benefits of focus group discussions include gaining insights into people's shared understandings (Gibbs 1997). Therefore, focus group discussions were used to expand on the key findings from the photovoice workshop.

The third section of the chapter presents nurses feedback from the in-depth interviews. Nurses who facilitate the AYFS programme in the three clinics in which this study was conducted were interviewed. The researcher was interested in their perspectives as primary health care givers allocated to facilitating HIV and SRH focused care for AGYW within the primary health care setting.

Figure 5.1: diagram representing the logical flow of data presentation



Source: Author

Visual data presentation: PhotoVoice workshop

This first section begins with a presentation of participant biographical information. The three tables below presents biographical information of AGYW participants from all three clinics where data was collected. This information provides insight about the participants, their age, status and the dates when the workshops were conducted. Followed by the biographical information, is the visual reality and dream clinic of AGYW from each clinic.

Table 5.1: Biographical information of AGYW from Mafakatini clinic

Name of the clinic	Participant Pseudo name	Age	Employment status	Workshop date
Mafakatini	Murphy	<18	School learner	July 2018
Mafakatini	Nokcy	<18	School learner	July 2018
Mafakatini	Veeh	>18	Unemployed	July 2018
Mafakatini	Nomalanga	>18	Unemployed	July 2018
Mafakatini	First Lady	>18	University Student	August 2018
Mafakatini	Luleka	>18	Unemployed	August 2018

Table 5.2. Biographical information of AGYW from Mphophomeni clinic

Name of the clinic	Participant Pseudo name	Age	Employment status	Workshop date
Mphophomeni	Fantasy	<18	School learner	September 2018
Mphophomeni	Mzamo	>18	Employed	September 2018
Mphophomeni	Zisanda	>18	Unemployed	September 2018
Mphophomeni	Leti	>18	Unemployed	September 2018
Mphophomeni	Zoleka	>18	Unemployed	September 2018
Mphophomeni	Lufuno	>18	Unemployed	September 2018
Mphophomeni	Anita	>18	Unemployed	September 2018

Table 5.3: Biographical information of AGYW from Caluza clinic

Name of the clinic	Participant Pseudo name	Age	Employment status	Workshop date
Caluza	Q	>18	University student	November 2019
Caluza	Naomi	>18	Unemployed	November 2019
Caluza	Lihle	<18	School going	November 2019
Caluza	Sinethemba	<18	School going	November 2019
Caluza	Sne	>18	Unemployed	November 2019
Caluza	Maneli	>18	Unemployed	November 2019
Caluza	Lulama	<18	School learner	November 2018

Mphophomeni Clinic

Mphophomeni (P1)

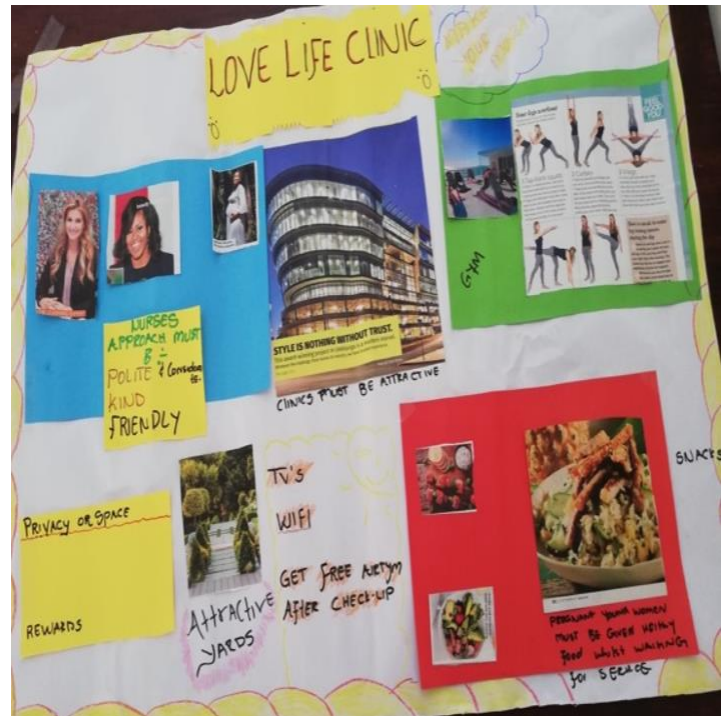
Notable description of collage chart:

1. P1 highlighted the availability of food as an important attribute of a youth-friendly clinic.
2. Furthermore, P1 describes the desired approach that nurses should have at the clinic. The nurse must be kind, friendly and polite when they speak.
3. Improvement in infrastructure and the building of the clinic was highlighted by P1 as critical, so that the clinic has more space. For her, privacy was a priority, therefore the clinic must be spacious to be youth-friendly.
5. The waiting room must be entertaining, if not, the time waiting for a consultation should be an engaging time.

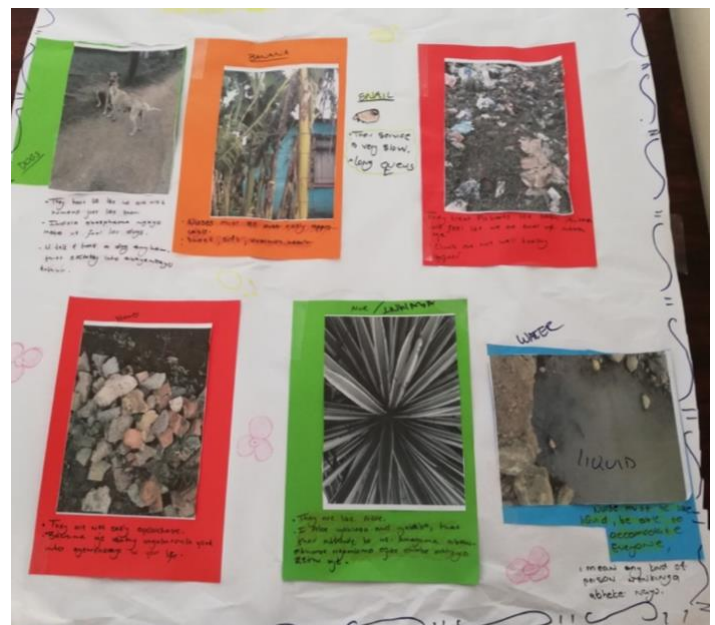
Notable description of photovoice chart

1. P1 presents a 'stray puppy' image. Depicting that nurses are always moving around the clinic without giving them direction (where to sit, what to do, where to go). The stray puppy also depicts the feeling of being 'unwanted' and 'unaccepted' by nurses at the clinic.
2. An image of a 'snail' represents slow service at the clinic. This also describes how P1 felt time was being misused at the clinic before she receives service.
3. An image of 'water' suggests that the clinic should function fluidly, services flowing without wasting time.

Dream Clinic



Reality Clinic



Mphophomeni (P2)

Notable description of collage chart:

1. Firstly, P2 labels her dream clinic “*Love filled clinic*”. This is what the clinic should be like for AGYW who come for HIV and SRH services.
2. The clinic should have a children’s area for those who come for SRH services with younger children. Some nurses are less friendly when you come for antenatal care, with a young baby and there is no one to look after them at home, so they are forced to go with them.
3. The waiting area should be entertaining, comfortable and separate from other people who are not young.
4. The clinic staff must be friendly and available.

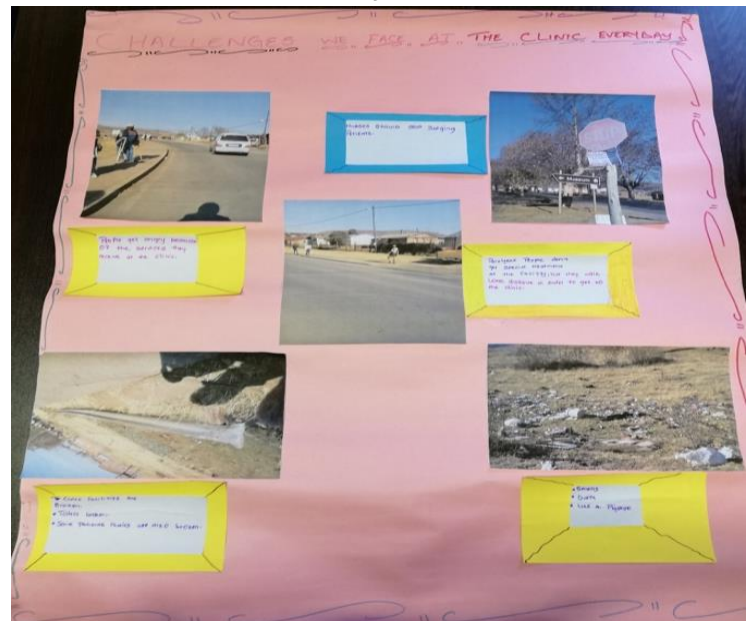
Dream Clinic



Notable description of photovoice chart:

1. A ‘unclean community playground’ is an image representing the facilities inside the clinic, depicting the clinic as an unhygienic environment, especially for a pregnant woman to use.
2. The image of a ‘moving car’ in a certain direction depicts that the clinic must be more user friendly, patients knowing where to stand in line.
3. The nurses need to stop judging AGYW for coming to the clinic SRH services. The ‘road stop sign’ represents the urgency and desire for this to stop in order for services to be friendlier.

Reality Clinic



Mphophomeni (P3)

Notable description of collage chart:

1. P3 labels her dream clinic “*we are one*”. The emphasis here is that the clinic staff and patients should relate as friends, and not as oppositions. The nurses need to be supportive in how they render services, and patients must receive services respectfully.
2. The image of a ‘book shelf’ reveals that disorganisation of the clinic. P3 suggests that the clinic files should always be in order.
3. The clinic should be spacious, offering a separate space for young children to play while waiting.

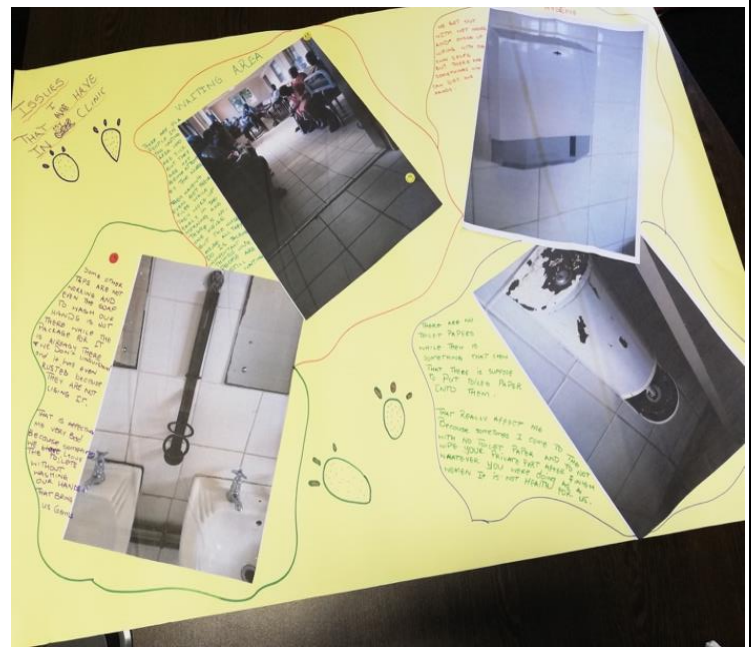
Dream Clinic



Notable description of photovoice chart:

1. P4 noted took an image of a ‘rusty’ toilet paper holder inside the clinic. This represents the entire structure of the clinic, that the clinic needs to be renovated. This is linked to the image of ‘bathroom sinks’ not working, causing toilets not be hygienic.
2. Disorder in the waiting room is represented by an image of people ‘sitting in line’. Often, patients are not sure if they are in the correct line or not.

Reality Clinic

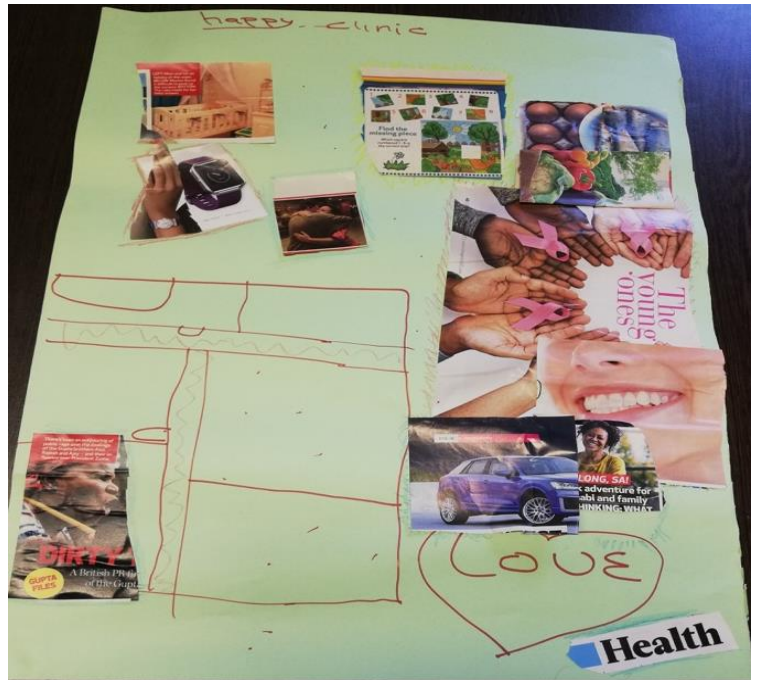


Mphophomeni (P4)

Notable description of collage chart:

1. P4 noted that food must be available in the clinic. She labelled her clinic 'happy clinic' because of how she desires the clinic to feel like.
2. The clinic must be a happy space, where the nurses are friendly and easy to approach.
3. P4 drew a clinic that is 'partitioned', showing that the clinic must be divided according to spaces. So that patients have sufficient privacy in consulting rooms.
4. Time must be considered as patients have different responsibilities outside of the clinic.

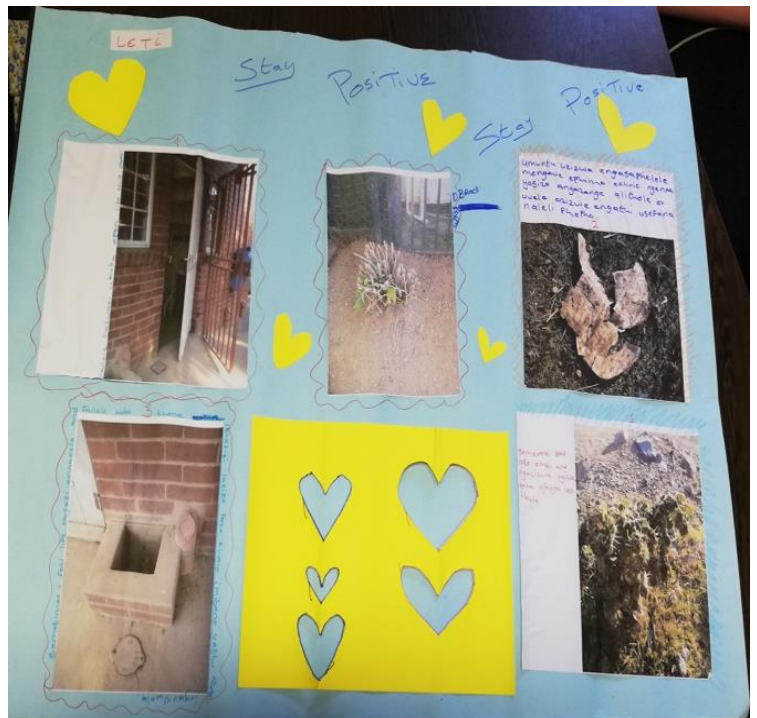
Dream Clinic



Notable description of photovoice chart:

1. P4 presents a picture of a 'door', what is significant is that it is slightly open. This represents the treatment and communication of nurses in the clinic. Nurses will say what they have to say and walk away. Their level of openness often does not allow AGYW to ask questions beyond the service they come to receive. Nurses should be more open to AGYW.
2. The nurses should not cut off the views and questions.
3. Nurses should not throw the ideas of people down the drain.
4. Nurses words are harsh at the thorns in a tree.

Reality Clinic

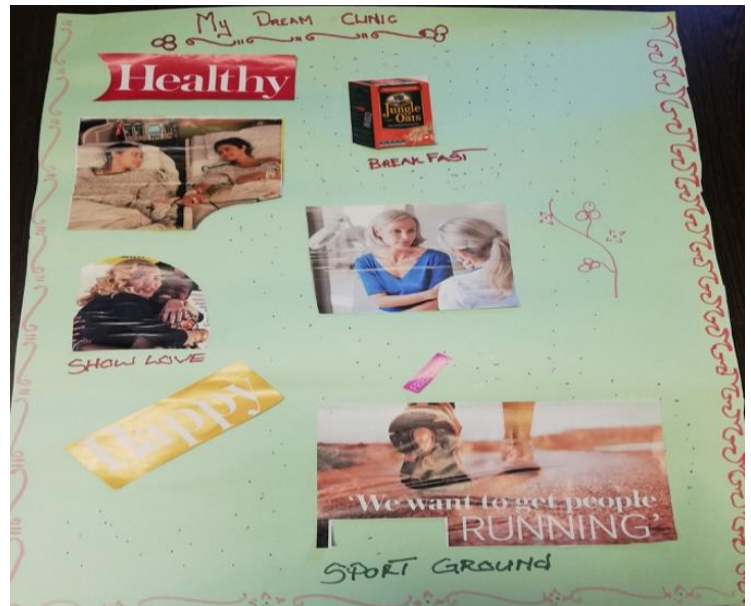


Mphophomeni (P5)

Notable description of collage chart:

1. P5 highlights the importance of health, and demonstrates that for her, a youth friendly clinic should be prepared to make food available.
2. In P5's dream clinic, she expresses that love and compassion from nurses is important. This is what will make her happy to be in the clinic. Nurses must be friendly and welcoming. They must be attentive.
3. The dream clinic for P5 must also be a recreational space.

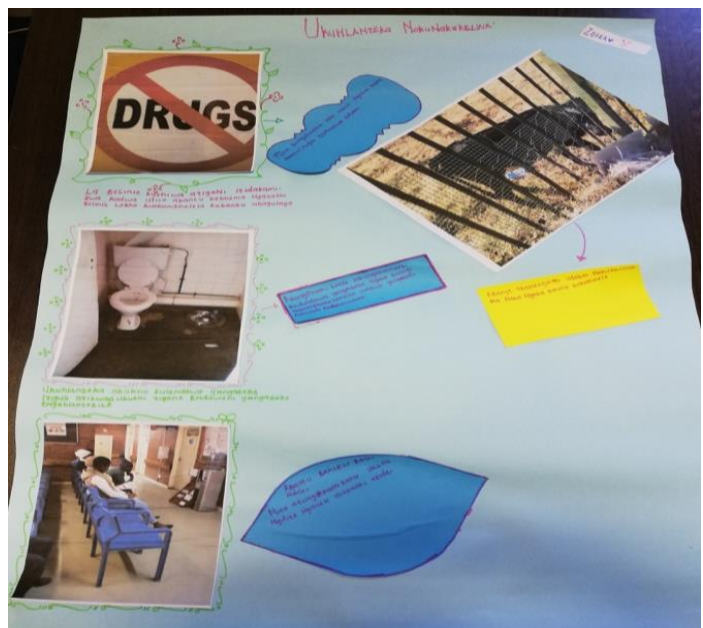
Dream Clinic



Notable description of photovoice chart:

1. The reality of P5 in the clinic is long lines and hours unattended to.
2. The photo of the cow behind the fence depicts the unfriendliness of nurses who just 'look at you' without a sign that they will help you. P5 presents the cow to also mean the nurses are old and don't communicate timeously.
3. The third notable description is that of hygiene issues when they attend the clinic.

Reality Clinic

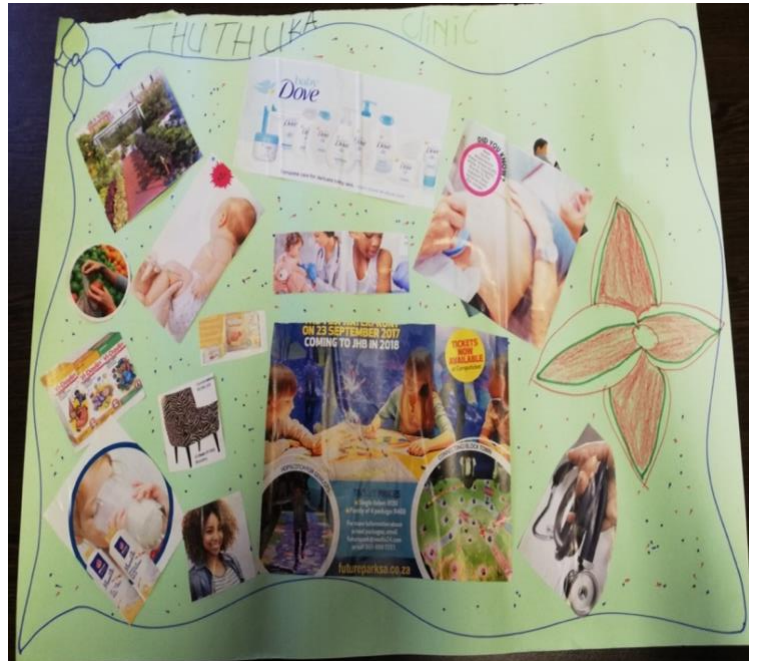


Mphophomeni (P6)

Notable description of collage chart:

1. The first important thing for P6 is the availability of medication, both for her and for her baby. This also includes equipment like ultra-sounds.
2. For P6 the clinic must be space for younger children, since some young women attend the clinic already having children. She also speaks of comfortability of the clinic, that it must be a comfortable space to wait for services.
3. Apart from the nurses, medical doctors must be available more frequently at the clinic.
4. P6 represents healthy food must be an integral part of a youth-friendly clinic.

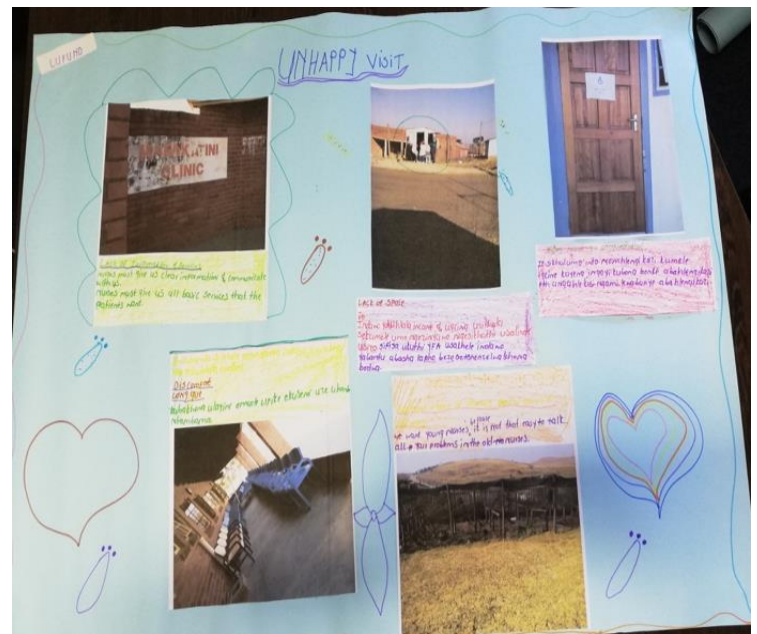
Dream Clinic



Notable description of photovoice chart:

1. P6 uses the door to illustrate that there is lack of communication and information at the clinic. She feels that there is no opportunity to communicate effectively with nurses. The door is also a description of the lack of confidentiality – nurses cannot keep what is shared with them.
2. P6 represents the small 'tuck shop' as a representation of the space in the clinic. The clinic has no space, sometimes they wait outside.
3. The image of the dried landscape of grass, depicts that P6 wants younger nurses, because it is hard to talk to older nurses.

Reality Clinic



Mphophomeni (P7)

Notable description of collage chart:

1. For P7 is the availability of medication is important in youth-friendly clinic.
2. For P6 the clinic must be comfortable, and entertaining with books to read or magazines with information. It must also be a recreational space for young women.
3. P6 represents healthy food must be an integral part of a youth-friendly clinic.
4. The nurses must smile and be warm and welcoming at the clinic. She lists love, friendliness, kindness as attributes that must be in a nurse.

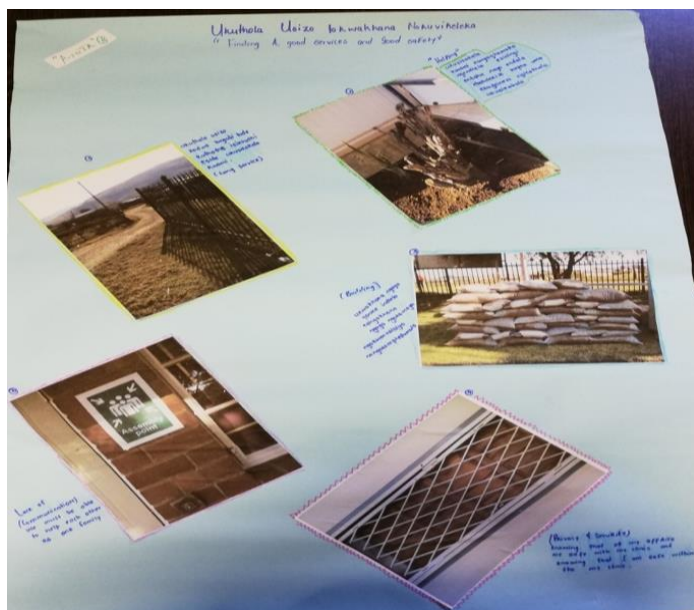
Dream Clinic



Notable description of photovoice chart:

1. P7 represents the pathway as a sign of long lines in the clinic. It takes long to receive services.
2. P7 displays a picture of individuals standing together, meaning the clinic should be a space where clients and nurses work together. This is also displayed by the image of bags of sand stacked one on top of the other. Showing a readiness to 'build' in unity.
3. The concept of a closed door, with a gate represents the lack of confidentiality of private experiences in the clinic.

Reality Clinic



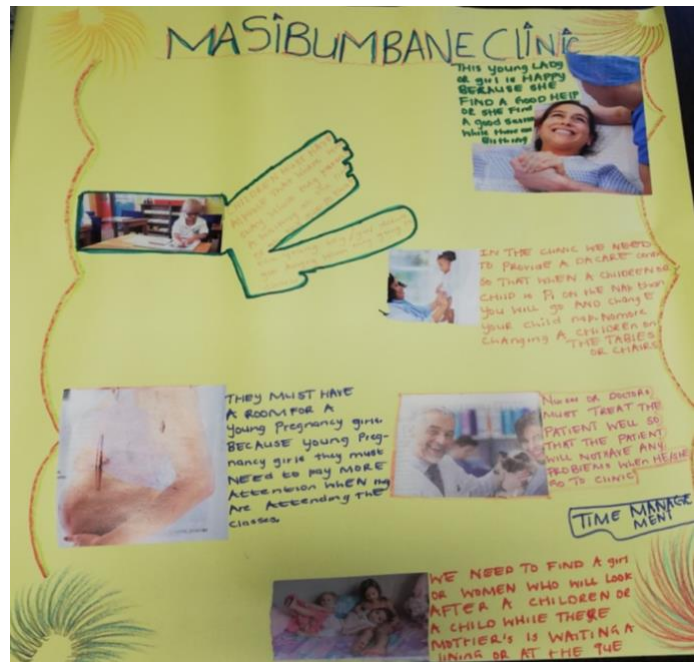
Mafakatini Clinic

Mafakatini (P8)

Notable description of collage chart:

1. P8 introduces the name of her clinic, directly translated as 'let us work together clinic'. This speaks to the client nurse relationship. Furthermore, the clinic must be a friendly space to receive help.
2. The clinic must have day care centers where young women can leave their children while receiving services. P8 adds that nurses must be friendly, present and supportive, particularly for antenatal care. Antenatal care also requires privacy, so the clinic must have special rooms for pregnant girls.

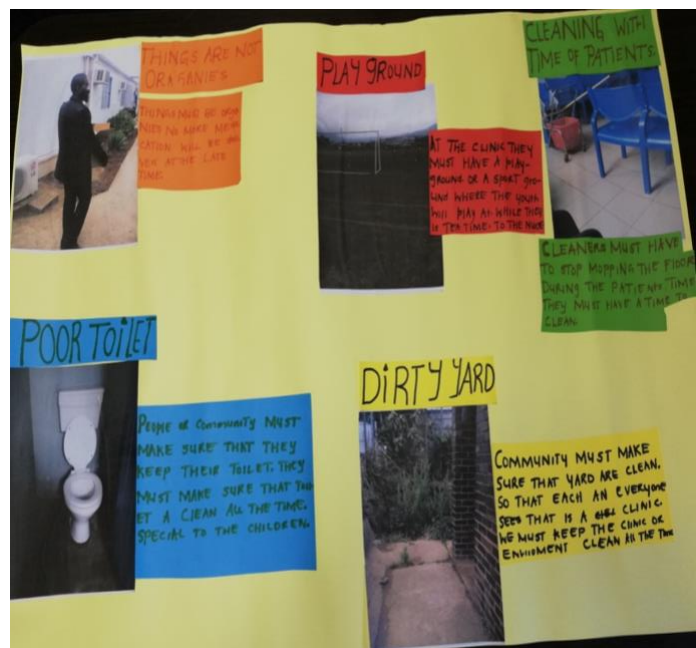
Dream Clinic



Notable description of photovoice chart:

1. P8 notes hygiene in the clinic as the first challenge existing currently in the clinic. This is a problem when visiting for antenatal care can to do blood test because girls need clean toilets and equipment. This is represented by the poor toilet availability.
2. The clinic is not organised, particularly with delivery of medication. P8 suggests that medication is sometimes not available, and they have to wait for it to be delivered late in the day sometimes.

Reality Clinic

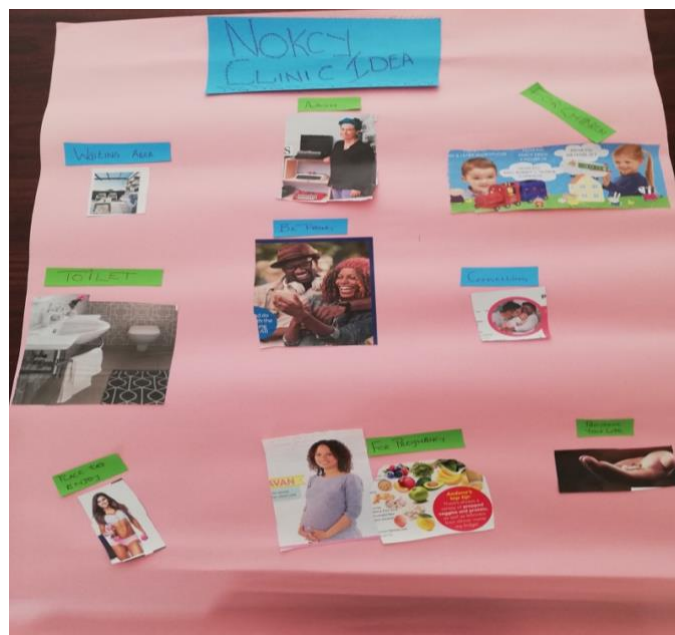


Mafakatini (P9)

Notable description of collage chart:

1. The waiting area, the toilet is first represented as clean space. For P9, a youth friendly clinic is must be one with a clean space.
2. The administration in the clinic but be organised, there must be files for each patient. For P9 the clinic if youth-friendly when the nurses are open and kind to them, able to interact effectively about health.
3. P9 represents that the clinic must have a children's area, for young mothers to leave their kids.

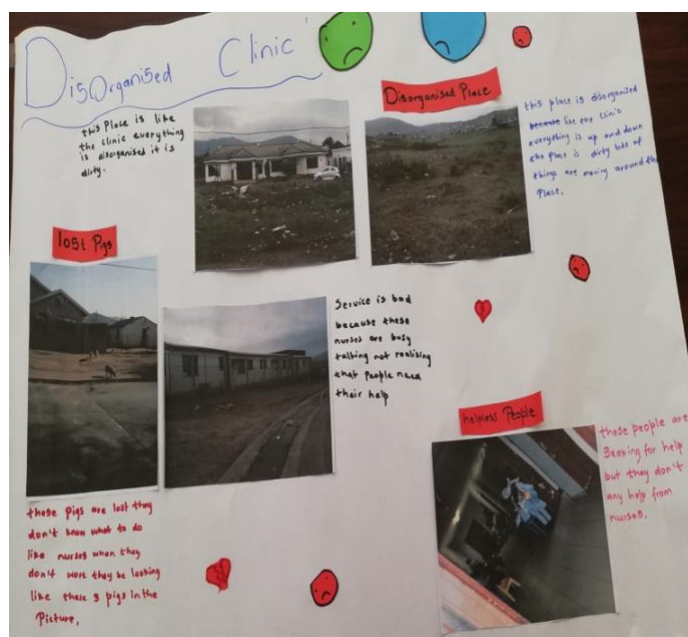
Dream Clinic



Notable description of photovoice chart:

1. P9, on the onset labels her reality clinic as a 'disorganised clinic'. The name already indicates the current experience related to organisation and administration in the clinic. She uses multiple photos in the chart to show this: an open field filled with a variety of things on it. Dirt, stray dogs and chickens. Pigs roaming around. There is a disconnect in the clinic for P9. There is no order.
2. P9 represents a photo of someone standing in the clinic, not knowing where to go.

Reality Clinic

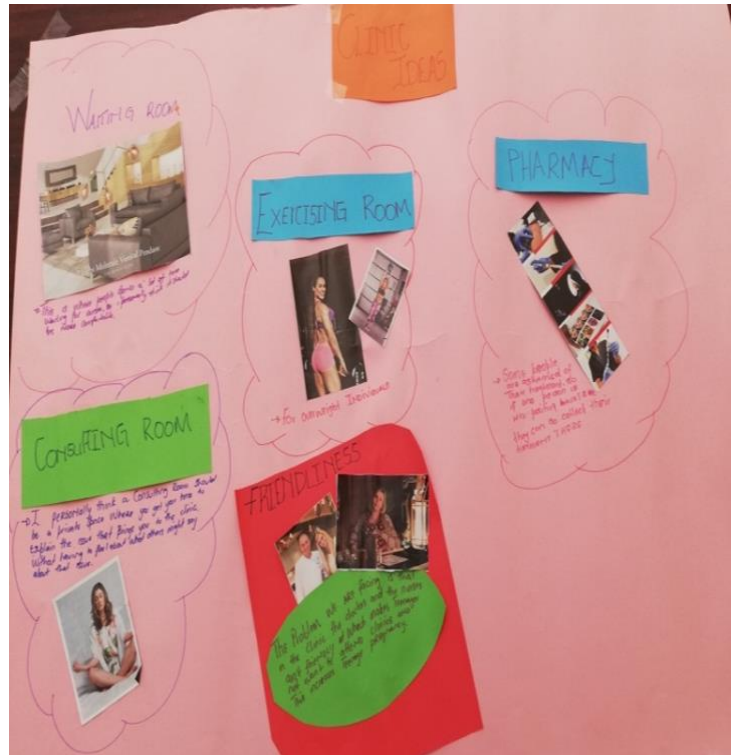


Mafakatini (P10)

Notable description of collage chart:

1. The waiting room must be comfortable and clean space for clients. P10 says this is where they spend the most time in the clinic, it must be comfortable to sit and wait.
2. Nurses must be friendly in the clinic, available to build friendships with young women.
3. For the p10, the clinic must be compartmentalised: having a pharmacy, a waiting area, a recreational centre and specialised counselling rooms. The consulting rooms should be in a secluded area of the clinic, where young women can openly speak without fear of being overheard.

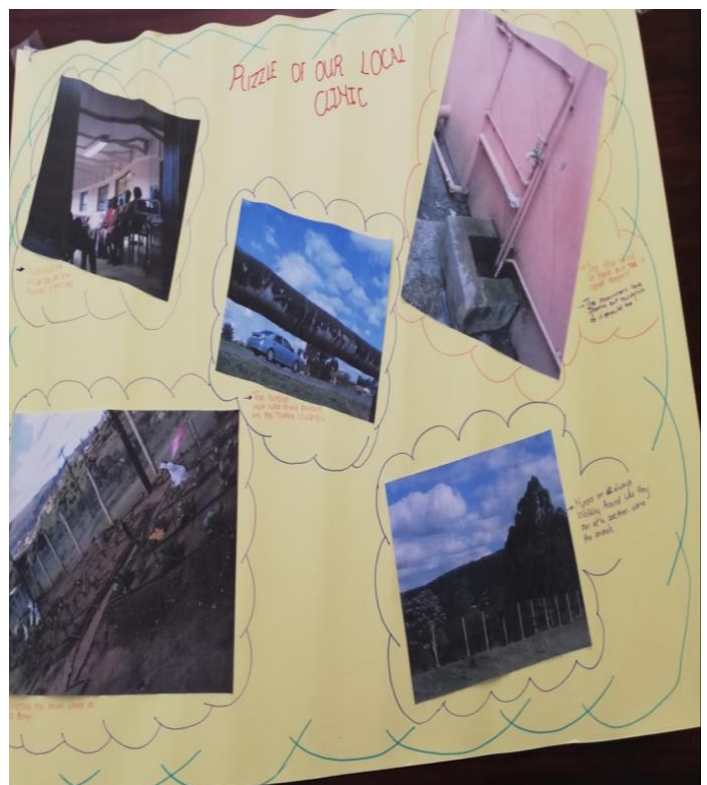
Dream Clinic



Notable description of photovoice chart:

1. P10 labelled her reality clinic as 'puzzle of our local clinic'. A puzzle is something that needs time to figure out and organise. For P10, the current clinic is no easy to understand because of its design and organisation.
2. Nurses are often not unavailable, but are seen walking around the clinic, not showing interest to patients. The long hours of waiting at the clinic are part of the puzzle for P10 because they don't receive updates about services. The tap and the drain for P10 depicts the available rules set to run the clinic, but all seem to go down the drain like water, because they are not visible in how the clinic functions.

Reality Clinic



Mafakatini (P11)

Notable description of collage chart:

1. P11 signifies that nurses need additional staff to help them in the clinic, e.g. counsellors to talk to young women. Some could be facilitators who will deliver seminars for young women on SRH issues. This could improve time management at the clinic.
2. The clinic must have more space and rooms that can function in one building. P11 highlights that a youth-friendly clinic must not have rooms operating outside the clinic where people in the community know it is for ARV's for example.
3. P11 describes that nurses' attitudes contribute a negative impact on pregnant girls coming to the clinic for antenatal care.

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SIMUNYE CLINIC

Everything must be confidential at Clinic. No room must be excluded in the Clinic for HIV room.

Most of the youth have HIV and many are very afraid of their future they arrived in Africa AIDS at a Clinic because they want the protection from their parents.

Time management their Nurses must manage their time to visit the Clinic but have a good service.

In the Clinic Youth advisers are also listed as male and female.

A little communication with Youth for change their lives.

Most of the Youth don't want to go to Clinic to fetch condoms or injection or money that can make them getting pregnant in the future.

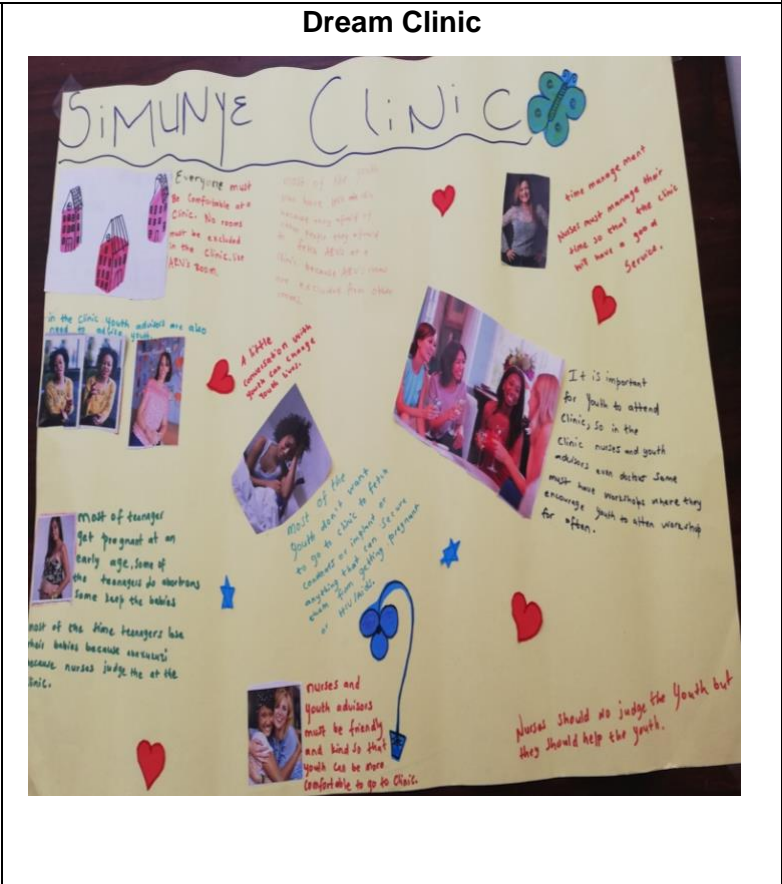
It is important for Youth to attend Clinic so in the Clinic nurses and youth advisers even doctor Jane must have messages where they encourage Youth to often visiting for often.

Most of teenage got pregnant at an early age, some of the teenagers do abortions some keep the babies.

Most of the teenage have their babies because the nurses because nurses judge the at the Clinic.

Nurses and youth advisers must be friendly and kind so that Youth can be more comfortable to go to Clinic.

Nurses should not judge the Youth but they should help the youth.



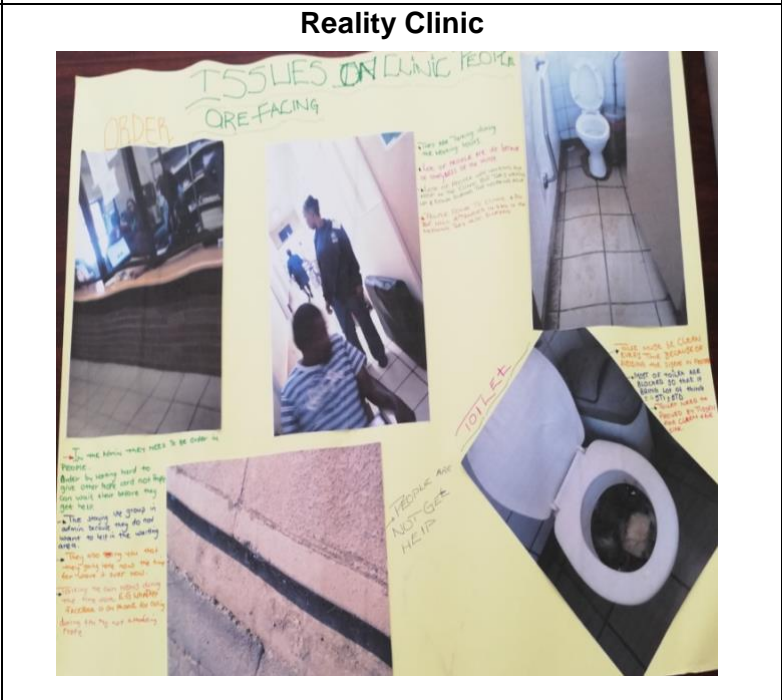
Notable description of photovoice chart:

1. The first notable reality for P11 is the organisation of the clinic. This is what leads to time being wasted. Therefore, the administration and the organisation of the clinic is problematic.
2. The second challenge is the hygiene of the clinic, particularly the toilets that young women use when taking blood and pregnancy tests.

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Reality Clinic

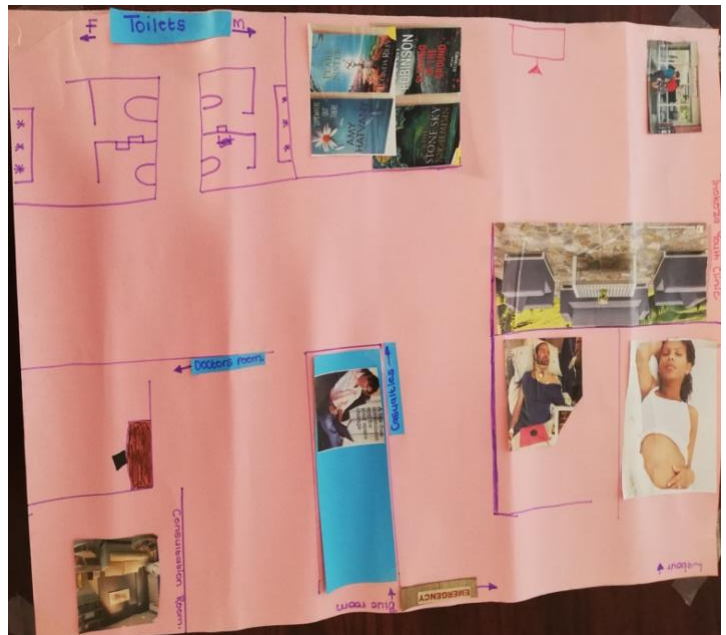


Mafakatini (P12)

Notable description of collage chart:

1. Space at the clinic requires organisation. P12 designed the clinic, clearly showing how the clinic should be structured so that it is youth-friendly. She is specific about where each section should be in the structure of the clinic. Additionally, she lists the rooms that should be made available in youth-friendly clinic: labour room, waiting room, counselling room and doctors' room.
2. P12 deliberately highlights the need to for the waiting area to be an engaging and entertaining area.

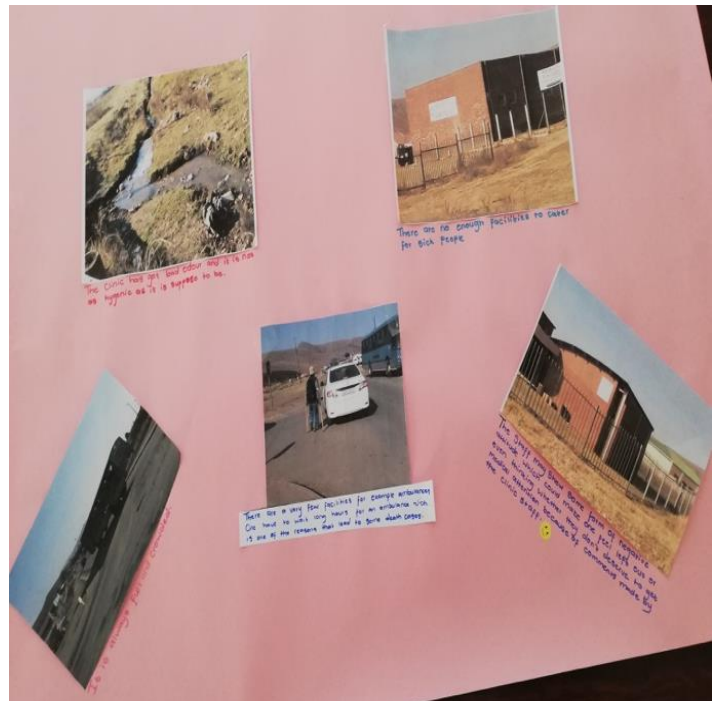
Dream Clinic



Notable description of photovoice chart:

1. P12 reflects her personal experience of the clinic. The first image is that of a field with dirty water flowing on it. The clinic is not a hygienic space.
2. The second image, is of a community bus that has people overflowing in it. Some are standing without seats while going to the local town. P12 uses the bus a representation for the clinic is always being full and crowded.
2. The images of the buildings in effect, further show that for a youth-friendly clinic to function more space is required.

Reality Clinic

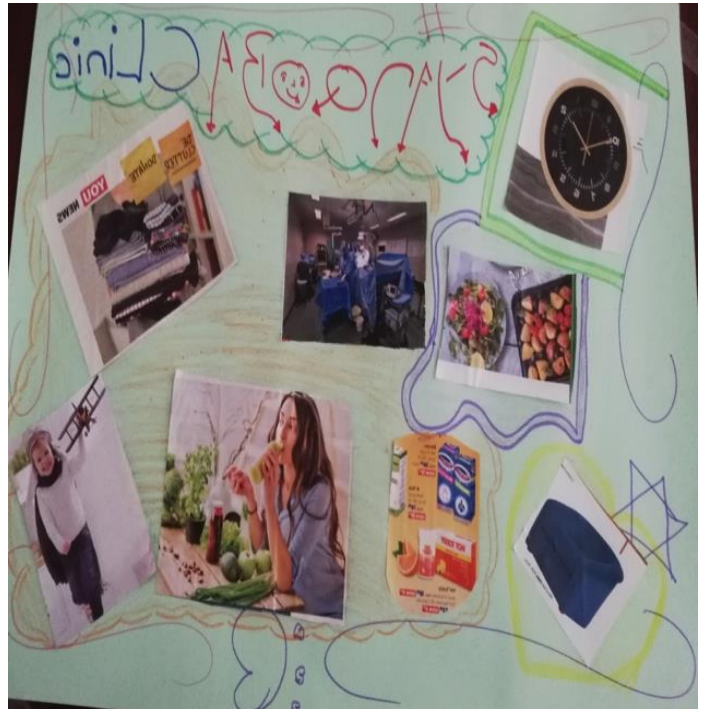


Mafakatini (P13)

Notable description of collage chart:

1. Notable and of importance to P13 is time management in the organisation of the clinic. The clinic name translated is 'we overcome clinic'. She describes the multiple things the clinic needs to overcome in order to be a youth-friendly clinic.
2. P13 represents the issue of time management with a photo of 'folded clothes' in the closet. She highlights that for the clinic to function on time, there needs to be order. The availability of equipment in the clinic, together with medication is critical.
3. Food availability is mentioned as what will make the clinic a youth-friendly space for P13.

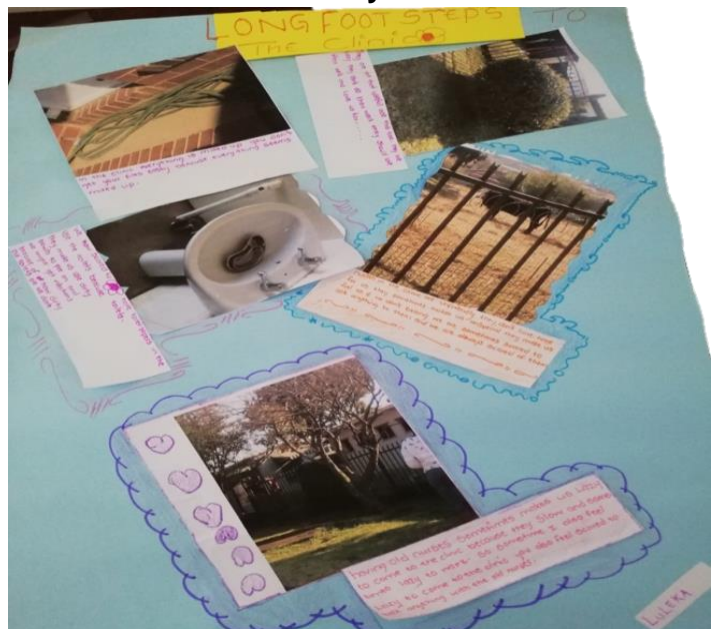
Dream Clinic



Notable description of photovoice chart:

1. Hygiene and the cleanliness of facilities like toilets is the first reality represented by P13. She uses an example of nurses and the old trees around the clinic yard to illustrate that, for her, a youth-friendly clinic is one where nurses are younger and lively towards her as a young woman.
3. P13 directly links the clinic organisation to its administration. That the clinic must be more organised.

Reality Clinic



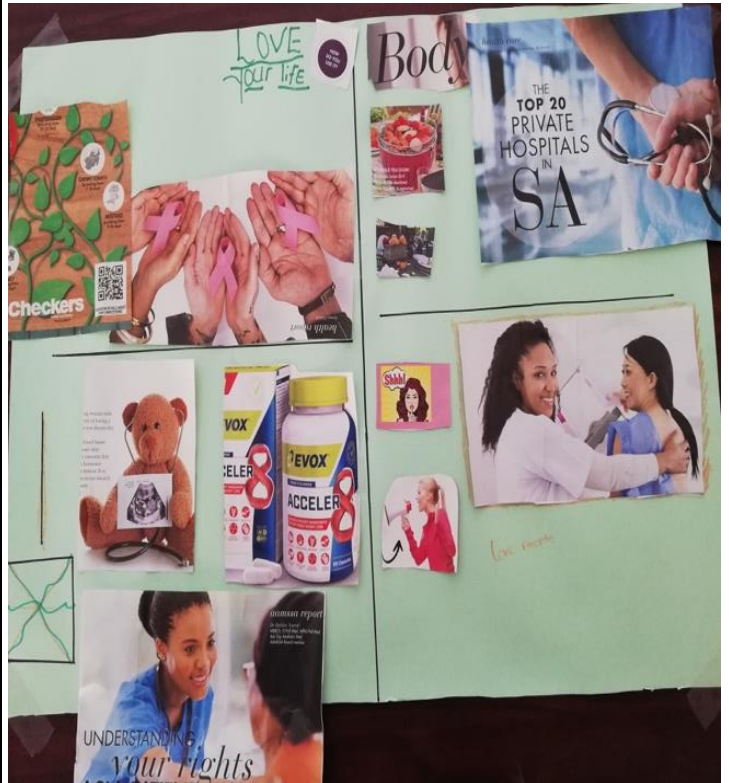
Caluza Clinic

Caluza (P14)

Notable description of collage chart:

1. For P14 is the availability of medication and equipment is more important in youth-friendly clinic.
2. For P14 the clinic should have medical doctors within the health practitioner staff. To be able to assist on cases that nurses cannot reach in understanding and nursing practitioners.
3. The nurses must smile and welcoming at the clinic. They must be a source of information. She highlights love as a critical attribute that must be in a nurse.

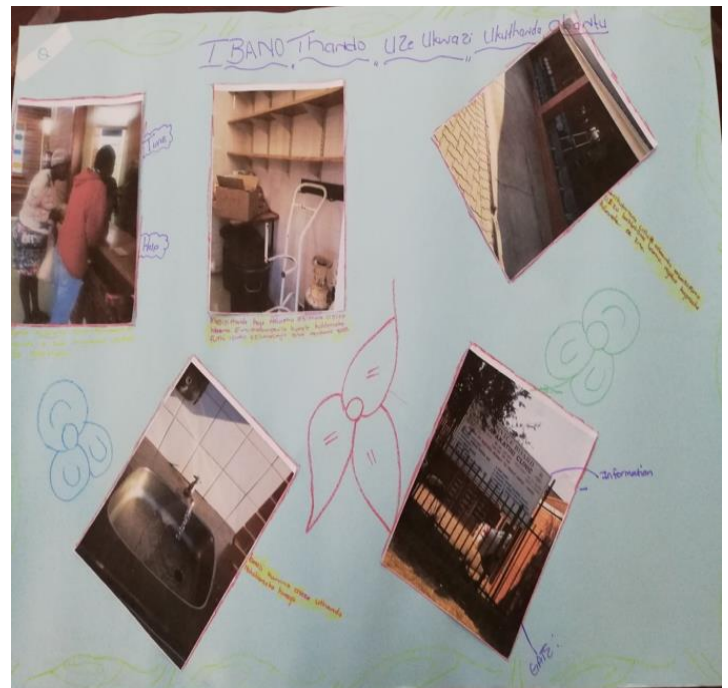
Dream Clinic



Notable description of photovoice chart:

1. The clinic administration needs to improve in order to preserve time. P14 displays the image of shelves, as signifier of order. This depicts a situation where patient files often get lost and takes more time, leading her to be at the clinic for longer. Effective administration is directly linked to time management for P14.
3. Additionally, the lack of information and communication while waiting, makes the waiting feel longer. P14 depicts this using a 'billboard' as a signifier for the importance of information.

Reality Clinic



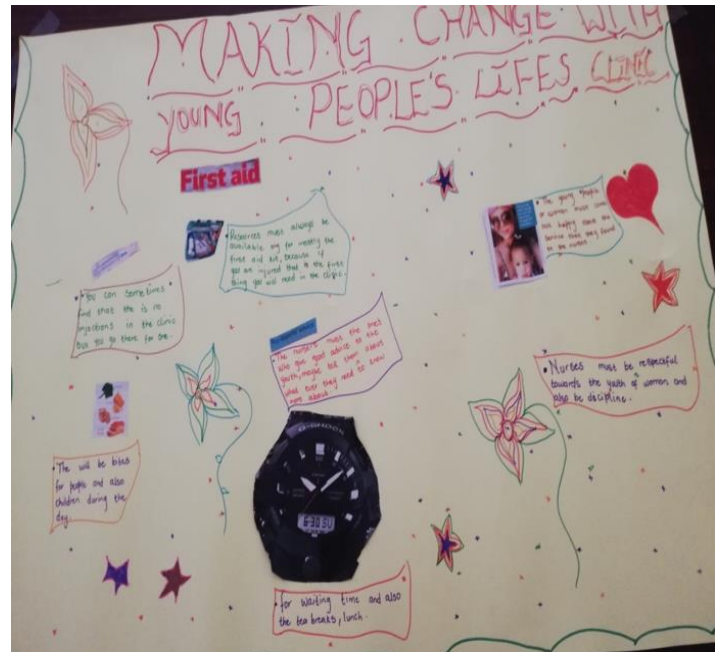
Caluza (P15)

Notable description of collage chart:

1. P15 labels her dream clinic '*making change with young people's lives*'. The clinic must bring about change to young people, by receiving information they need from nurses without judgement. She highlights in writing that nurses should be available and ready to help in any way needed by young women. Additionally, P15 highlights that the nurses must be respectful towards young women.

2. The availability of medication is also a critical point for young women in the clinic. Sometimes, products and tools they need in the clinic are unavailable.

Dream Clinic

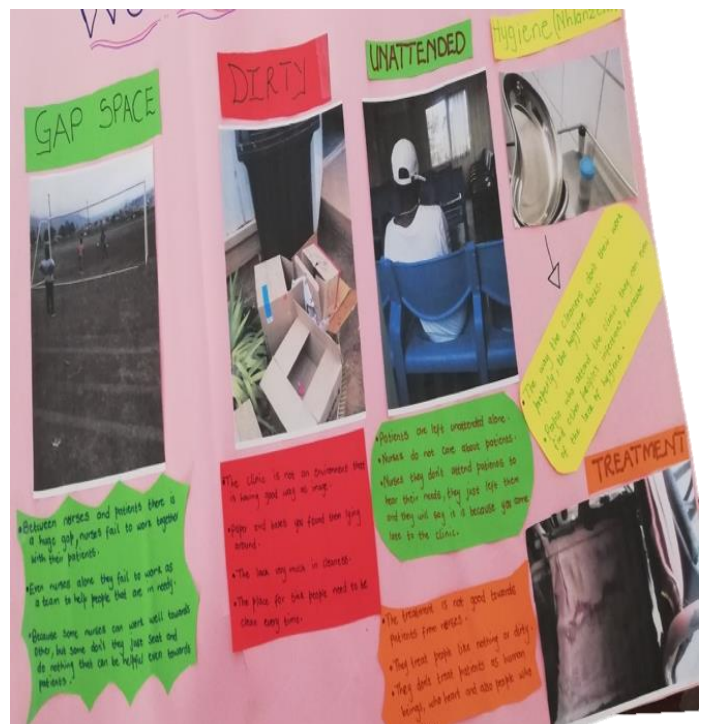


Notable description of photovoice chart:

1. P15 highlights in order some of her challenges currently in the clinic. She highlights that between nurses and patients, there is a huge gap. That there is no relationship between patients and nurses, she uses vacant goal post in the soccer field to illustrate this.

2. The long waiting hours in the clinic are not easy to endure, because the nurses do not communicate timeously with patients. Instead P15 highlights that they are treated like dirt by nurses in the clinic. She illustrates this with a dirty page as the treatment she often receives.

Reality Clinic



Caluza (P16)

Notable description of collage chart:

1. This dream clinic is labelled '*my dream clinic for the community*'. For P16 a youth-friendly clinic must have nurses that are able to communicate, love and respect young women as patients.
2. She highlights that the space for children at the clinic is important for young mother to leave their children.
3. P16 emphasizes the need for food in the clinic. That some patients don't have healthy food at home, therefore young women will find the clinic a youth-friendly space if there is food.

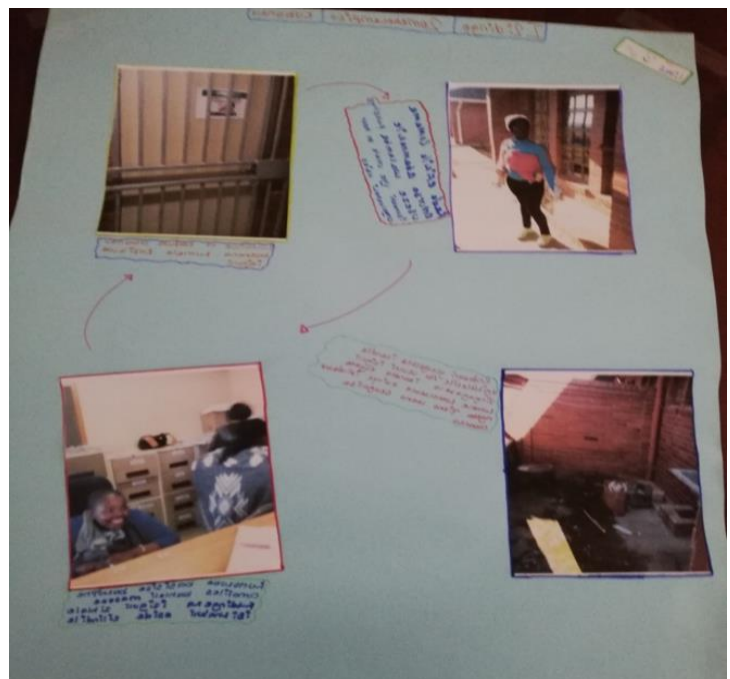
Dream Clinic



Notable description of photovoice chart:

1. P16 highlights the need for hygiene in the clinic, facilities like the toilets need to be improved. The lack of hygiene makes it difficult to want to come to the clinic. The clinic needs to be open at earlier hours of the morning, so that those who are working or going to school can be attended to early. P16 continues to that the clinic must improve its administration and organisation. To avoid long waiting hours

Reality Clinic



Caluza (P17)

Notable description of collage chart:

1. Notable and of importance to P17 is the availability of food items at the clinic. The clinic name is 'we are here to help you'. She describes the multiple things that can facilitate youth-friendliness in the clinic. The clinic needs to have transport for those who are living far away from the clinic.
2. P17 represents the issue of comfortability in the waiting area with a photo of comfortable couches. She also highlights the importance of kind and approachable nurses in the clinic.

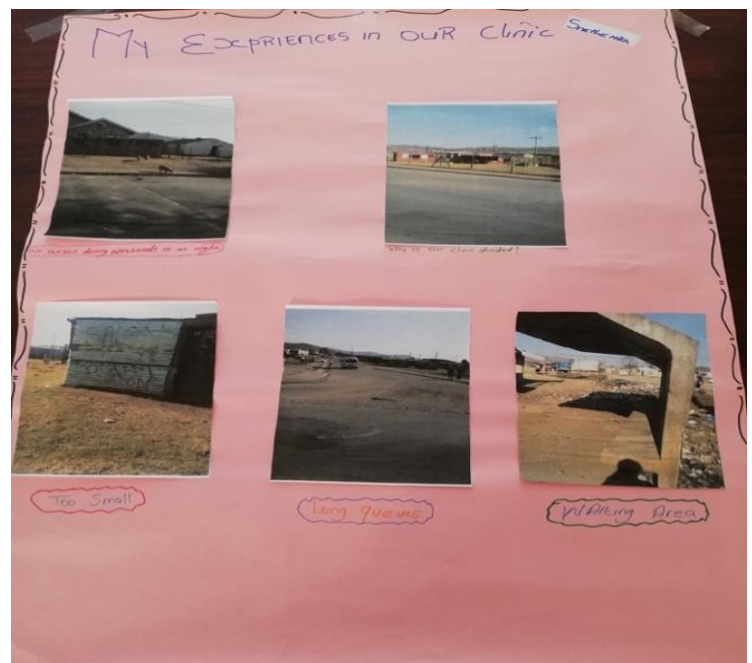
Dream Clinic



Notable description of photovoice chart:

1. The clinic for P17 needs to be more spacious, the current structure of the local clinic is depicted by a 'shack'; referring to its size and capacity. P17 also reveals that the clinic facility in its entirety is not hygienic, the waiting rooms, the toilets too.
2. P17 takes images of local houses, to illustrate that the clinic should not be divided in building, where everyone in the community can see which building you go to, and that in that particular building there are particular services, for example HIV testing.

Reality Clinic



Caluza (P18)

Notable description of collage chart:

1. The dream clinic for P18 includes a waiting room that is comfortable, and has entertainment like TV for patients while waiting. The clinic should be a hygienic space, with clean toilets. P18 also highlights the importance of effective administration, and filling systems so that the time spent at the clinic is less.
2. The clinic for P18 should be a space that has a waiting area for children and special counselling services, by trained counsellors.

Dream Clinic



Notable description of photovoice chart:

1. For P18, the current clinic facility lacks hygiene, which is a hindering barrier for users who are pregnant and attend the clinic for antenatal care services. P18 uses the image of rocks piled up upon each other, forming a mount to represent the long hours where people are not attended to in the clinic. Which ultimately speaks to the need to improve administration in the clinic.
2. The clinic waiting, is sometimes used as a room to service patients, the clinics needs to be spacious.

Reality Clinic



Caluza (P19)

Notable description of collage chart:

1. For the clinic to be a youth-friendly space for P19 they are key important features that should be in the clinic. For example, food must be available, the nurses must be friendly and easy to approach for youth patients. She highlights that it would be preferable for nurses to be young.
2. P19 further states that the waiting room areas should include entertainment. in the waiting area, magazines and books.
4. The clinic should have separate spaces for children to play, while the mothers receive services.

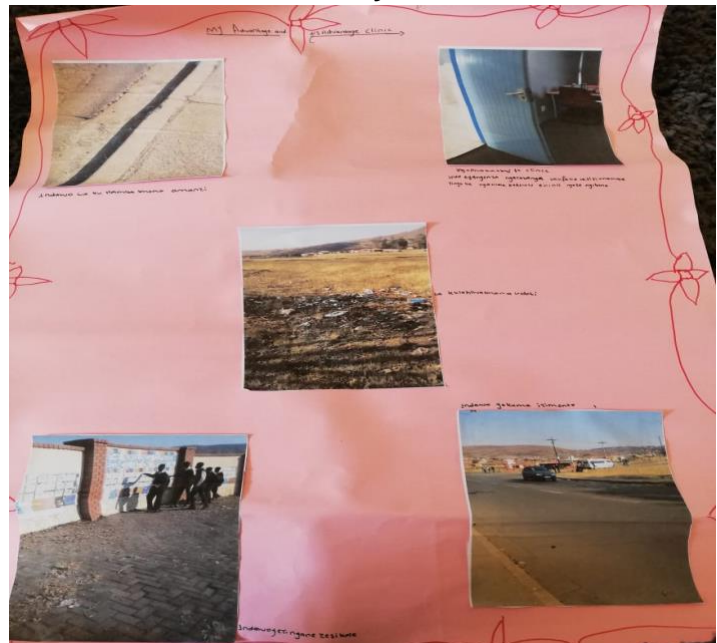
Dream Clinic



Notable description of photovoice chart:

1. P19 represents the lack of communication between nurses and patients by the 'closed door'. This is highlighting the reality of not having a nurse-patient relationship that is functional.

Reality Clinic



Caluza (P20)

Notable description of collage chart:

1. For P 20, the availability of food is essential for the clinic to be a youth-friendly space.
2. The nurses need to be friendly and kind to patients.
3. P20 highlights that in her dream clinic, it will have entertainment in the waiting area, with books and readily available internet and computers.
4. The clinic will have to consider a separate for little children who attend the clinic with their mothers.

Dream Clinic



Notable description of photovoice chart:

1. P20 represents the need for nurses to have better relationship with patients in the clinic. Be able to speak to them and spend time listening. The 'leaking tap of water' in the image represents how P20 feels that the clinic currently has no room for her own opinions. Her needs are not easily heard and met. The long waiting hours make patients to sit in the clinic all day, until it is dark, sometimes without getting holistic help.

Reality Clinic



Verbal data presentation: Photovoice workshops, focus groups and in-depth interviews.

The visual data presentation in this section focused on the experiences of AGYW when accessing the primary health care clinic for HIV and SRH services. Research studies have been explored in chapter two of this study, proving that AGYW (15-24) often access the clinic for HIV and SRH related services. Therefore, there are three overarching themes that were developed thematically from the data in line with the main objectives of this study. The next section thematically presents the verbal data. Thematic analysis is a “process of segmentation, categorisation and relinking of aspects of the data prior to final interpretation” (Grbich, 2007:16).

Braun and Clarke (2006) propose a six-step process of thematic analysis to be followed in order to present and analyse data. Through this process, the researcher is able to classify data into “patterns and subthemes to form collective experiences, comments and stories” of AGYW (Govender, 2013: 67). This study is interested in understanding the collective experiences of youth-friendly services among AGYW when accessing the primary health care clinic for HIV and SRH services. Thus, through categorising data into common themes and patterns, the researcher gains a better understanding of the general experiences of AGYW.

Therefore, three overarching themes are outlined as they guide the data presentation:

1. Structure of the primary health care facility
2. Organisation of the primary health care clinic
3. Health care service delivery in the primary health care clinic.

These themes cannot be viewed in isolation because of their interconnectedness. For example, the structure of the clinic has a direct impact on how the clinic can be organised. The organisation of the clinic also has a critical role in how health care services are delivered. Particularly for key vulnerable populations like AGYW. As the participants expressed their experiences at the clinic, majority of the opinions that were raised by AGYW were related to the clinic structure, the organisation of the clinic and the

services delivered at the clinic. Each of these themes are interrelated and dependent on each other for services to be youth-friendly for AGYW, particularly in rural contexts.

The researcher presents the themes patterns in a significant order following the main research questions in this study and also according to the subthemes that were developed. The arrangement of this section follows the order of the overarching themes presented above. This order is influenced by the interdependence visible in each theme. Meaning, that the structure of the clinic often determines the way it can or cannot be organised to meet the needs of AGYW (James, Pisa *et al.* 2018). The manner in which the clinic is organised also determines the availability of health care service delivery (Saber, Ming *et al.* 2018).

The data presentation begins with a diagram, presenting each theme and the subthemes identified by AGYW in the photovoice workshop and the focus group discussions. Following the diagram is an introduction of the theme and the subtheme and a descriptive discussion of data collected.

Structure of the primary health care facility

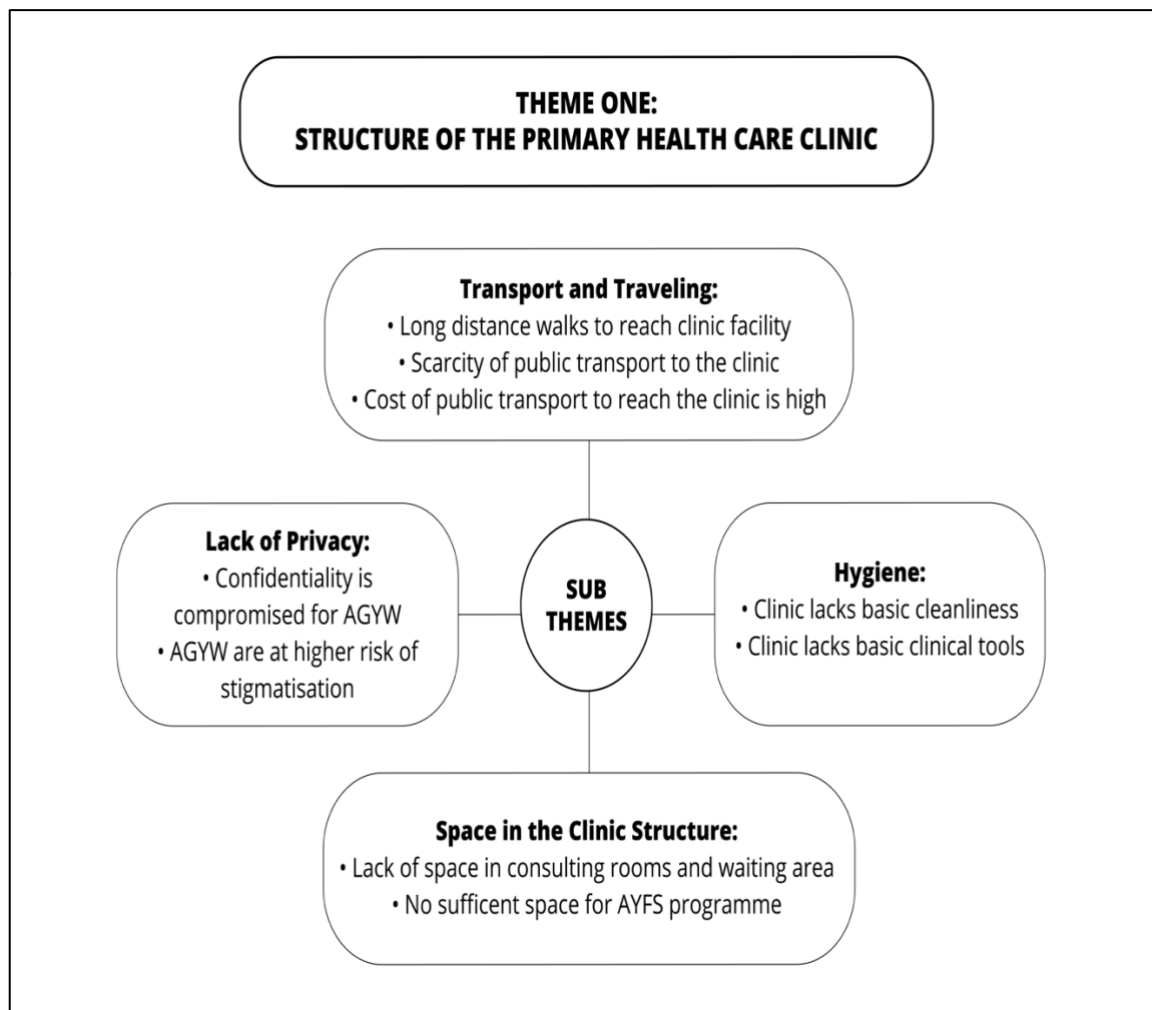


Figure 5.2: Diagram representing theme 1 and the subthemes

The structure of the health care facility in this study, refers to the actual architectural design of the clinic facility. Structure in this study is also related to the location of the clinic and the affordability of transportation for patients to access it (Brittain, Williams *et al.* 2015). The physical environment of where the clinic is located needs to align to the needs of local members who access the clinic for health care services. Furthermore, structural design of the clinic, has not historically considered the impact on the quality of health for patients (Steinwachs and Hughes 2008). Therefore, the structural design must be inclusive of how the building is compartmentalised to meet the required needs of patients in the clinic. One of the standards of the quality assessment tool recommended by WHO is that the clinic must have a physical environment conducive to the provision AYFS. The design of a structure with its fixed

and moveable components, can have a significant impact of the health care programmes like the AYFS programme in the clinic. Fixed components in the context of this study are waiting room areas, toilets consulting and counseling rooms for patients. The moveable components are beds, and clinical utensils required for patient care.

Participants in this study highlighted some of the structural related challenges that hinder them when accessing the clinic for HIV and SRH services. They highlight issues concerning the fixed and movable components of the clinic structure, such as the space in the *clinic structure, lack of privacy, hygiene and transport and distance traveling*.

Space in the clinic structure

The characteristics of a youth-friendly structure is one that is in a convenient location; where local community members can easily gain access. It has adequate space with counselling areas that provide visual and auditory privacy (Desiderio 2014, Müller, Röhrs *et al.* 2016). This requires a reorganisation of the clinic space for AGYW, for example the inclusion of waiting bays, possible communal information rooms and consultation room. It is important for AGYW to have a space that maintains confidentiality, away from the adult clinic space, allowing for private consultations for individual AGYW (Ngambi 2016). The data presented below are excerpts from participant descriptions about their experience of the lack of space in the clinic accessing HIV and SRH services.

Participants demonstrated a heightened need for space in the clinic. One participant clearly stated that for her “*the AYFS to have its own space, with only for us to go and have the service*” (P7, Mphophomeni, September 2018). This participant was highlighting that having sufficient space was a crucial aspect of the clinic being a youth-friendly space for her. Other participants describe the issue of space as directly linked to the services they receive or rather space being a barrier for them not to receive services timeously “*I left my house around 5a.m and only came back around 2p.m... It's was too full; they couldn't even help us quickly. The lady tried to categorize us but there was just too many of us*” (P10, Mafakatini, August 2018). This participant

explains that because of the lack of space at the clinic, patients were overflowing to the outside spaces of the clinic *“Here at the clinic, there is no space...most of the time you sit outside while you wait to go inside...if the nurse says anything you do not hear them because I am outside”* (P14, Caluza, November 2018). This participant said that because she is sitting outside, she does not hear what the nurses are saying, she does not easily hear the instructions because they could not fit inside the clinic structure. This was further articulated through another participant *“I wish that the clinic there would be space for giving birth. So that the clinic has everything”* (P15, Caluza, November 2018).

Lack of privacy

AGYW often described the fear of others finding out they had attended HIV and SRH services. In particular they were afraid of their parents, of being teased or talked about by friends, and being the victim of community 'gossip'. Some were also concerned that their partner would think that they had an STI or had been unfaithful if they knew they had attended HIV and SRH services. The lack of privacy at and government clinics was emphasised, resulting in fear of being seen by friends, relatives or community members. Sensitive health issues such as contraceptive and pregnancy often require privacy, where AGYW will have the liberty to openly discuss their concerns with nurses. The lack of privacy for AGYW directly affects confidentiality between the patients and the nurses. The data presented below are excerpts from participant descriptions about their experience of lack privacy when accessing HIV and SRH services at the clinic.

Participants voiced their experiences of the lack of privacy in the clinic. One participant offered a thick description of her experience of the lack of privacy in the clinic, saying: *“It was my first time going for family planning, what made me reluctant on going to the clinic was that when you come to the clinic for family planning, the toilet is not near by the consulting container. I have to walk outside to go to the toilet and everyone can see me with the urine. Everyone can see what I am doing.”* (P14, Caluza, November 2018). The participant expressed how the lack of privacy when accessing the clinic for family planning was directly related to being seen by other community members. She describes that this experience made her reluctant to go to the clinic again for family

planning. Another participant commented on a similar experience, saying, *“when walking to the nurses room, it is not nice for all the people in the clinic to see that you are coming for family planning or you are pregnant* (P10, Mafakatini, August 2018). The discomfort of being seen by other patients is due to the lack of privacy. Furthermore, the participant indicated that it caused the clinic experience not to be acceptable for her.

Another participants continued to comment on the lack of privacy, saying, *“so, that walking around with urine for a long distance also made me reluctant to continue to come to the nurses at the clinic to check if I am pregnant, they should have had a door leading to a toilet by the cue where sick people sit on the inside. You walk a long distance to the toilet and have to walk all the way back inside again, that draws attention to you from people”* (P20, Caluza, November 2018). This participant highlights that the lack of privacy during a consultation with a nurse, makes her reluctant in going to the clinic for these services. Another participant states that *“there is no space for this one thing, just to be private”* (P4, Mafakatini, September 2018). For participants, privacy had the potential to discourage them from attending the clinic for SRH related services like antenatal care and family planning.

Hygiene

One of the characteristics recommended by the WHO (2012) for making health services youth-friendly for AGYW is that the health services delivery must be in an appealing and clean environment. Some participants described the lack of hygiene in the clinic from a sanitary perspective, others were referring to clinic apparatus. From the sanitary perspective, participants described the fears of acquiring infections during pregnancy, due to the lack of clean toilets in the clinic. Participants expressed how this experience is also contradictory to the information they receive at the clinic concerning the importance of hygiene. Furthermore, the apparatus available at the clinic, both for HIV testing and pregnancy testing is described as not hygienic as well. The data presented below are the excerpts from participant descriptions about the appeal and cleanliness of the clinic.

One of the characteristics of the global youth-friendly standards according to WHO (2012) is that for the clinic structure to be youth-friendly, it must be acceptable for key population like AGYW. The acceptability of a health care clinic includes that the clinic should be the point of health service delivery that is an attractive and a clean environment for AGYW. Participants pointed out that hygiene is an important aspect of the clinic structure that must be taken into consideration if the clinic will be youth-friendly for them. One participant notes how the lack of hygiene in the clinic affects her, she said *“As a pregnant woman you are told that you must sit when using the toilet. You must not bend or squat but sit properly on the toilet seat to avoid infections which may be caused by urine left behind while urinating bending and not sitting. Us as pregnant people, we go to the toilet a lot and imagine you get to the clinic toilet and find that you can’t sit because it’s unhygienic, so you now must bend. You are always nervous of the damage that the urine left behind inside of you may do every time you use the clinic’s toilet”* (P14, Caluza, November 2018).

Another pregnant participant described that *“as a woman we are taught that when you are using the toilet you must sit on the toilet sit and not stand cause there will be urine that won’t come out. The urine causes an infection in the bladder of a woman. Us pregnant people, we are always going to the toilet. Imagine you get here and you can’t sit on the toilet sit. The toilet is appalling. You will always have to squat when urinating and the urine stays in your bladder”* (P5, Mphophomeni, September 2018). Both these participants share their experiences about the lack of hygiene in the clinic and the dangers that accompany it. Although the participants are taught about the various dangers and cautions that they must adhere to during pregnancy. The experiences described by the two participants appear to be a contradiction of what they are taught. Another participant said *“Most of the time you arrive and there is no toilet paper...and the toilet seat is covered by someone else pee...when you are pregnant you need to be careful”* (P3, Mphophomeni September 2019).

There was an understanding that HIV and SRH services require facilities that are hygienic, considering the intimate use AGYW have with toilets at the clinic. Young women who were pregnant and attending the clinic for antenatal care were knowledgeable about the precautions necessary to protect the growing baby. Although they had this knowledge, the facility in the clinic became a barrier. So, even though

the participants came to the clinic, and had the relevant knowledge about antenatal care, the clinic was not a comfortable environment. *“The small bowls that we use or the cups...are always dirty...we use them to pee (urinate) when coming to check on the baby or check HIV status, but it is always dirty and you have to clean it yourself, we can’t accept this”*. (P10, Mafakatini, August 2018). This participant highlighted that hygiene within the clinic as a service that is not acceptable for her as a young woman. *“The clinic is just not clean!”* (P4, Mphophomeni, September 2019). The understanding of the clinic structure, specifically hygiene, was highlighted as important as AGYW move from section of the clinic to the other, in order to make to receive the full package of services.

Transport and Travelling

Distance and the travelling to health care facilities is one of the major barriers to health cares, more especially in rural communities in South Africa, where primary health care clinics are often located further away from a large number of residents. In order to receive adequate health care, rural residents have to travel long distances. The lack of transportation and prohibitive costs is one of the obstacles that AGYW in rural community’s face when accessing HIV and SRH services at the clinic. The location of the clinic structure is sometimes central only to a few residents. In rural communities like Vulindlela, the clinic does not only service immediate local residence, but also the communities surrounding. Therefore, some of the participants in this study expressed the challenge of transportation when accessing the health care clinic. The data presented below are excerpts from participant descriptions about their experience of transportation when traveling to the clinic.

From sharing about the hygiene within the clinic structure, participants continued highlighting that the physical structure of the clinic is not easy to access. *“We walk to the clinic, if we miss the bus then we have to walk. The bus is the only transport that is early to the clinic”* (P17, Mafakatini, August 2018). This participant describes that when she misses the bus in the morning, she is forced to walk to the clinic. There is a lack of transport in some of the surrounding locations where some of the participants live. *“To come to the clinic from home can take me an hour walking, transport moves every hour. And sometimes I do not have the money for transportation”* (P3, Caluza,

November 2018). The equitability of the clinic is underlined by the participants concerning the location of the clinic and the distance they have to travel, noting that the clinic *“must be where a person can take one or two taxis so that money is not wasted”* (P12, Mafakatini, August 2018). This participant describes that having money to go to the clinic is not always available, and the further the clinic is from her location, the more costs she will have to bear.

Theme one summary

The structure of the primary health care clinic is not limited to the above-mentioned subthemes, but the researcher highlights these subthemes on the basis of what participants in this study prioritised within their local and contextual environment. For health care services to be youth-friendly for AGYW in Vulindlela, the structure of the health care facility plays a critical role. Without the physical structure being located in an accessible area where transportation for local members can easily be reached, health care services for AGYW are hindered. Participants indicated that the cost of traveling and the distance to the clinic is too long. What perpetuates dissatisfaction among AGYW in this study is the lack of privacy. Once participants are able to arrive on time, the lack of space within the clinic forms part of what AGYW have highlight as a hindrance to HIV and SRH services. Participants described that the clinic does not have enough space and that the lack of space compromises the acceptability of the services provided for HIV and SRH services to be youth-friendly. Therefore, this theme focused on the key structural issues that were most important for AGYW when accessing the primary health care clinic.

Organisation of the primary health care clinic

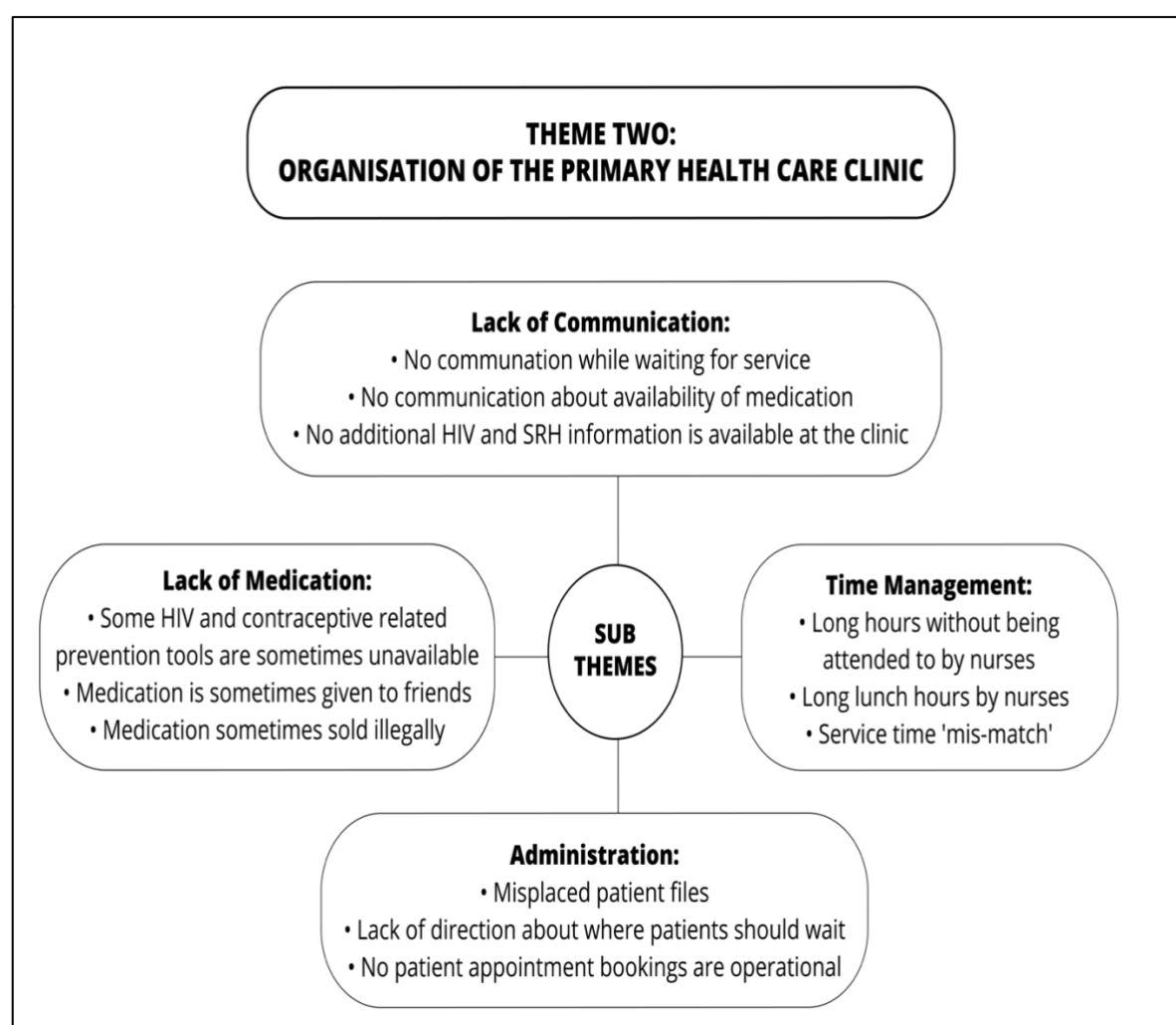


Figure 5.3: Diagram representing theme 2 and the subthemes

Strengthening the organisation of primary health care clinic is critical to improving health outcomes and overall health delivery efficiency for AGYW. There is still limited knowledge on how to make optimally improve the *organisation* of the primary health care clinic. There are large evidence gaps on how the organisation of the clinic should be (re-)organised to integrate AYFS with well-established clinic services such as maternal and child health and the treatment of acute infectious diseases (Dodd, Palagyi *et al.* 2019). However, further efforts are needed to advance the organisation and provision of equitable care in primary health care clinics (Hirschhorn, Langlois *et al.* 2019). Therefore, there remains a need to understand how to ensure the core service delivery functions of clinics, particularly in rural communities, are linked to the desired outcomes of patients. AGYW in this study, raised critical issues related to the

way primary health care clinics should be organised for HIV and SRH related services to be youth-friendly. They reported the current experiences when accessing HIV and SRH services at the clinic. AGYW highlighted administration as a major issue at the clinic, time management, lack of communication and the lack of medication were also as key issues that will be presented below.

Administration

The issue of administration in the current study was a crucial aspect of youth-friendly health care services. AGYW highlighted that the lack of administration at the clinic contributes to their reluctance in attending the clinic for HIV and SRH care services. AGYW discussed that detailed steps should be followed to in order to achieve every element of systematically improving and correcting deficiencies, like administration in primary health care clinics. A study (Hunter, Chandran *et al.* 2017), highlighted that part of the administration at the clinic should include information points that inform the community on the location of the clinic, services, service hours, and contact details of the clinic. (Hunter, Chandran *et al.* 2017).

The functioning of the clinic in terms of its administration was highlighted by participants as an important aspect of youth-friendliness. The genesis is this is usually when participants walk into the clinic: *“People who sit and wait at the waiting area are older people. When you ask them when they got to there, they will tell you that they got there early in the morning. They haven’t even received their files and have not been attended but it almost time for the health workers to leave work. They all have different reasons for visiting the clinic. Other people might have asked for sick leave at work so that they can go to the clinic. They need to see the doctor and get a doctor’s note. That’s the problem that we are facing at Caluza Clinic”* (P16, Caluza, November 2018).

Another participant from another community offers a similar experience, saying, *“In the clinic, everything is mixed up. You don’t get your files easily because everything seems mixed up”* (P 9, Mafakatini, September, 2018). The same participants added, saying that *“sometimes it looks like the nurses are always lazy to work, so sometimes I’m also lazy to come to the clinic.”* Other participants suggest that in *“the clinic there*

needs to be way to schedule times to work...times that everyone will stick to so that things can move faster" (P10, Mafakatini, August, 2018). Other participants say that *"the service at the clinic is slow, they don't attend to patients on time you end up going back home without getting help"* (P 9, Mafakatini, August, 2018).

Participants continue describing their experience of the organization of the clinic. Some say, *"we wait for something that we are not sure of. It would have been better if we are waiting having seen the nurse or just waiting to see the doctor, sometimes we are not sure what we in the waiting room waiting for"* (P 6, Mphophomeni, September, 2018). One participant stated that the use of rooms in the clinic organisation needs to have more order *"The clinic must not keep changing, because of space, it is never the same order as the last visit... but it must have rooms that we all know...because sometimes where we are to take the pill to prevent, the room is use by another person for something...so there is not space for one thing"* (P20, Caluza, November, 2018).

Time management

AGYW in this study shared about their dissatisfaction with the use of time at the clinic, and how they often feel like the clinic nurses are not prepared to deliver services they require. Due to the lack of space at the clinic, sometimes patients are forced to wait outside the clinic building, not knowing for how long they would wait. The lengthy period of time often places AGWY at risk of being see by local community members, within and outside the clinic premises. This intern creates dissatisfaction about the services overall. The dissatisfaction is often aggravated by a perception that their wait was often a result of nurses taking prolonged tea-breaks, leaving early, or dismissing their duties (Schriver, Meagley *et al.* 2014). Young people are generally dissatisfied with current primary health care clinics in their communities.

Convenient hours of operation at the clinic are part of what makes the clinic accessible for AGYW. This is part of the WHO global guidelines for an accessible youth-friendly clinic, and participants expressed that in an ideal clinic they want *"everything in my clinic to be on time... and people get attended on time"* (P11, Mafakatini, August 2018). Participants who shared the reality of their experience shared, saying, *"the service at the clinic is slow, they don't attend to patients on time you end up going back home*

without getting help” (P17, Caluza, November, 2018). The same participant shared that *“people from there arrive around 5a.m to 6a.m some stay far from the clinic.”* This was confirmed by another participant who was located in another area, saying, *“Yes, even for me, one day I have arrived at the clinic at 7am and I left at 3pm. Without getting help”* (P5, Mphophomeni, September 2018).

Another participant said that *“it is common for me, every time I come to the clinic, I arrive at 6am in the morning and I go back home around 4pm”* (P5, Mphophomeni, September 2018). On participant elaborates, saying, *“I went for my pregnancy check-up, I left home early in the morning, my mother woke me up at 5a.m and by half past 6 I was leaving the house. I only came back at 5p.m, I always come back at 5.p.m because when I got there (the clinic) they hadn’t started working, I even finished the food I had in my bag before getting assisted”* (P14, Mafakatini, August 2018). This participant raises the issue of having food to sustain patients who spend long hours waiting to be served at the clinic. Another participant agreed to this and concluded that *“there should be food while people are waiting, especially diabetic ad pregnant people who have to wait for long to be served at the clinic”* (P5, Mphophomeni, September 2018).

Lack of medication

Shortages of essential medicines are a daily occurrence in many of South African public health facilities (Hodes, Price *et al.* 2017). More especially in rural clinics, there are no dispensary’s, the medicines are managed by a nurse who serves as the clinics’ operations manager. The clinics in rural communities have no pharmacy’s with pharmacy assistants, whereas, in some urban clinics there are. The data presented below are excerpts from participant descriptions about their experience of the unavailability of medication at the clinic.

The participants shared that the clinic is not organised in terms of dispensing medication. One participant said *“I once got a paper from the nurse and they said I must go and the pill at the chemist because they did not have...or that I must wait till they have it again at the clinic”* (P3, Mphophomeni, August 2018). The lack of medication at the clinic redirected this participant to the chemist. Another participant

says *“sometimes you get there and they say there is no medication...If I am not feeling well and I don’t know what is wrong... they tell you to drink water with sugar... they tell what to do but it doesn’t help because it not medication from the clinic”* (P6, Mphophomeni, September 2018).

A participant from another community says: *“I had a problem with my cervix, whenever I went there, they would tell me to drink water, always... I thought it would be better to go look for help somewhere else”* (P16, Caluza, September 2018). Another participant says, *“sometimes when I bleed too much and my monthly period lasts for too many days, I come to the clinic and they will say there is not medication to help me. Or that first before they give me any medication, they want to check if I am really bleeding and not lying”* (P14, Mafakatini, August 2018). Due to this, some participants decided not to go to the clinic. As a consequence, one participant said *“I decided not to go to the clinic because they have a problem with handing out medication”* (P18, Mafakatini, August 2018). Similarly, another participant agreed saying: *“They just say that there are no pills, it better to just go to the doctor straight”* (P5, Mafakatini, July 2018).

Lack of communication

The nurse-patient relationship can only be sustained by communication. Patients like AGYW need often need to ask questions and learn about SRH care issues facing them daily. Adolescents, is often described as a critical stage of development and growth, that requires AGYW to receive tailored health care services that will enable them to make informed decisions about their sexual lifestyle. Effective communication requires an understanding of the patient and the experiences they express. It requires skills and simultaneously the sincere intention of the nurse to understand what concerns the patient (Kourkouta and Papathanasiou 2014). To understand the patient only is not sufficient but the nurse must also convey the message that he/she is understandable and acceptable (Kourkouta and Papathanasiou 2014). It is a reflection of the knowledge of the participants, the way they think and feel and their capabilities. Therefore, good communication between nurses and patients is essential for the successful outcome of individualized nursing care of each patient (Kourkouta and Papathanasiou 2014).

The main point raised by participants was that they don't know how to communicate with nurses and nurses do not know how to communicate with them. One participant describes what good communication is like for her, saying: *"...sometimes I was lucky and got a sister whom I was comfortable with, I wasn't even nervous of getting on top of the bed to do the pap smear and everything, because she from the beginning she never blamed me for the pregnancy or said any bad thing. She was able to speak to me and asked me how I knew that I was pregnant, I told her that my menstrual period cycle wasn't the same anymore and she said it's fine. She then checked me and touched and checked my stomach and told me the baby is fine. Then there is thing that is like pipe which is round at the bottom, it looks like an ultra-sound, but it's used for listening to the baby's heart beat only"* (P 17, Mafakatini, August 2018).

This is not a similar account for other participants who says: *"when I told one of the nurses when I went back to Caluza to fetch my file, she told me she doesn't know what the nurses at Edendale told me. She then just left me like that without asking me what the reason for me to maybe move to Edendale. She didn't care"* (P14, Caluza, November 2018). Another participant expressed that *"Since I know that you don't look at an elder in the eyes, I keep my eyes to the wall or I look down. When the nurse comes...you show them the card and tell them that you are here for family planning." "...she takes the injection, cleans it and looks the other way...then she will use the pump...you then leave...they don't tell you about other things or ask you if you want to do something else"* (P14, Caluza, November 2018). The lack of relationship was also described by how nurses look *"without talking first...it's like they are angry"* (P14, Caluza, November, 2018). Participants in this study were discouraged by the lack of communication between nurses and patients at the clinic.

Theme two summary

The organisation of the primary health care clinic is not limited to the above-mentioned subthemes, but for the researcher highlights these subthemes on the basis of what participants in this study prioritised within their local and contextual environment. For health care services to be youth-friendly for AGYW in Vulindlela, the organisation of the health care facility plays a critical role. Nonetheless, for youth-friendly services the organisation of the primary health care clinics cannot be generalised. It is important to

understand the meanings from a localised and contextual perspective of community members. For HIV and SRH services to be organised, AGYW in Vulindlela highlighted the above-mentioned organisational issues.

Health care service delivery in the primary health care clinic.

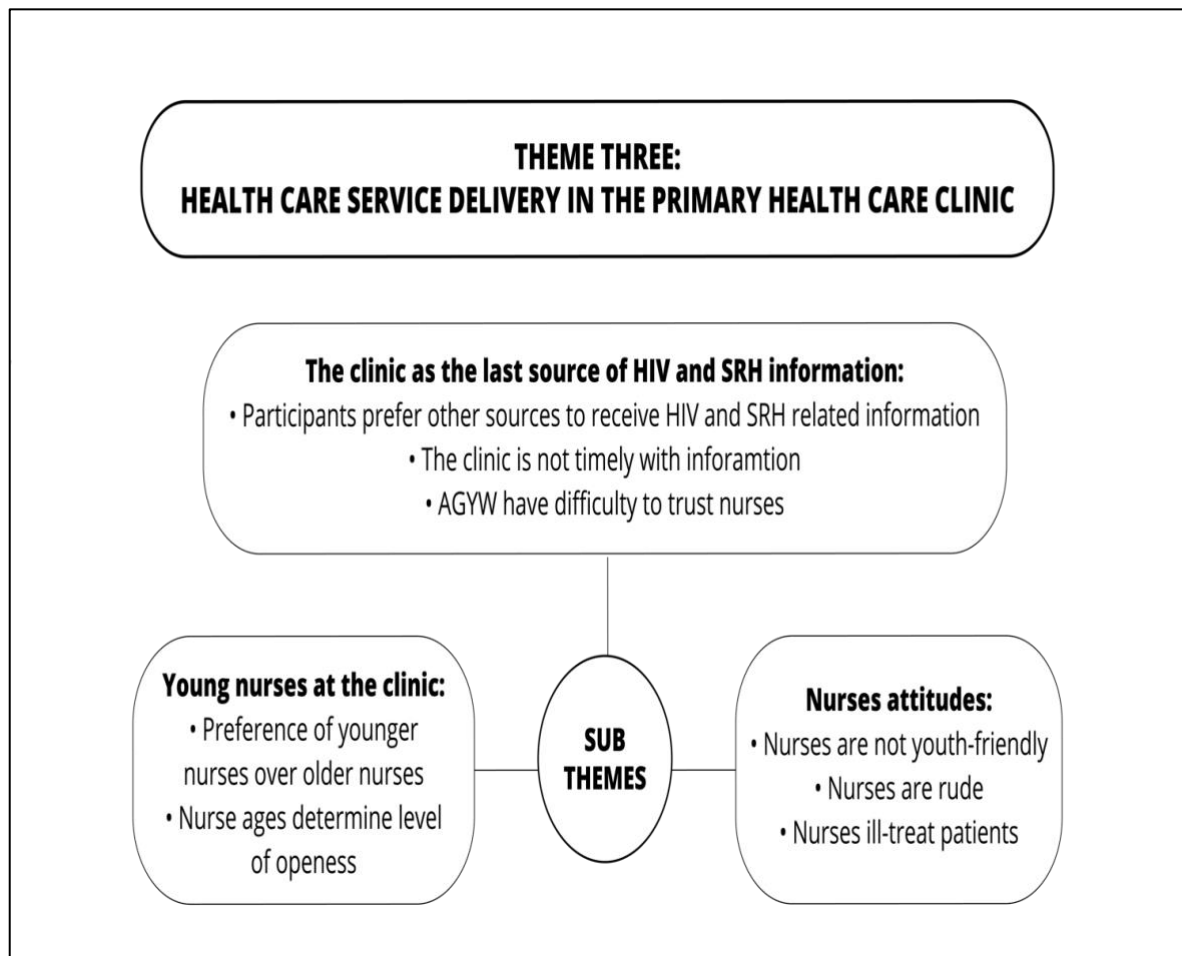


Figure 5.4: Diagram representing theme 3 and the subthemes

The manner in which health care services are delivered for AGYW in the clinic is increasingly recognised as a priority. The AYFS programme has been promoted in South Africa by the National Department of Health (NDoH), as a means of standardising the quality of adolescent health services. However, little is known about how successful they have been, how well facilities have aligned themselves for AYFS. Against this background improving the quality of health services tailored to the needs of AGYW, has the potential to address some of the challenges resulting from the burden of disease associated with AGYW engagement in risk behaviours. AGYW access a range of HIV and SRH services from primary health care clinics, including counselling around healthy sexuality and safe sex. The delivery of these services in clinics is often performed by nurses. Therefore, nurses have a pivotal role in the manner health care services are delivered to AGYW in primary health care clinics.

Participants in this study highlighted some of the challenges related to health care service delivery often includes nurses in the clinic. They highlighted issues concerning the *nurses attitudes, nurses age* and the *clinic being the last source of information*.

Nurses attitudes

High levels of stigma and discrimination in the healthcare clinics are often reported by AGYW. Judgement and moralising views of early sexual debut, pregnancy and HIV testing are frequently expressed within communities, and more specifically by individual nurses delivering services in primary healthcare clinics, warranting specific attention and address. Nurses attitudes are described by AGYW as one of the main reasons they did not access health care services delivery in a youth-friendly manner (Wood and Jewkes 2006). AGYW suggested that, some judgmental nurses who disapproved of their sexual behaviour would deny them services. AGYW's claim to services is ultimately validated by nurses' perspectives which influenced subsequent service delivery. Narratives from participants underscored a misalignment between healthcare nurses' beliefs and the provision of services. The data presented below are excerpts from participant descriptions about their experience of health care service delivery by nurses at the clinic.

Health care nurses have a critical role in the clinic being youth-friendly for AGYW. When participants were asked about health care service delivery that would be youth-friendly, participant expressed that nurses attitudes are a hindrance to youth-friendly service delivery. One participants, explained, saying, *"nurses don't give us their attention, to them it is like we do not exist"* (P14, Mafakatini, August 2018). Furthermore, this participant describes that *"they are not available for us to ask questions"* (P14, Mafakatini, August 2018) because they appear to be *"always angry, without talking to them first...it's like they are angry already"* (P14, Caluza, November 2018). One participant attributed the lack of attention from nurses with that of time, saying, *"nurses at the clinic are unfriendly, they don't have time for us, they sometimes make us un-special, feel as if we don't belong. We are sometimes scared to ask anything from them. We are always scared of them"* (P4, Mphophomeni, September 2018). To this participant, the unavailability of the nurse is described as being

unfriendly. She also highlights being made 'un-special', and not belonging in the clinic as being unfriendly. This is exclaimed by another participant, saying, *"the nurses treat us like dirt"* (P1, Mphophomeni, November 2018)! And *"sometimes they tell you go back home without getting help, and you don't understand why because they don't explain"* (P 12, Mafakatini August 2018). Participants continued to express that because of the treatment and lack of time given to them by nurses *"it is not easy to talk to them"* (P19, Mafakatini, October, 2018). And *"sometimes you walk in and find that the person looks like they are annoyed"* (P11, Mafakatini, October, 2018). One participant signified, saying, *"just like the Aloe plant has thorns and is bitter, that's how their attitude is and even the names (words) they use pierce painfully"* (P8, Mafakatini, November 2018). This is similar to what another participant from another community, described, saying, *"also, the way they talk to us, like when you speaking to a dog you'll speak anyhow, that's how they speak to us"* (P15, Caluza, September 2018).

Participants then expressed what makes a youth-friendly nurse for them, one they could be open and honest with. Participants expressed that *"at the clinic we must find nurses who will sit us down and explain to us how to take care of a baby and what you must do once you find out you are pregnant"* (P,8 Mafakatini, August 2018). Another participant said that for her a nurse who *"knows how to understand people, being relaxed and calm, eager to help people and loving people"* (P7, Mphophomeni, September, 2018) is what defines youth-friendly. Additionally, another participant said: *"I can see that a nurse has a good heart by their constant smiling, someone who knows how to help people, who knows how to speak with people and show them how things are done, who can be able to be around people. Also, someone who can be able to conceal even their bad moods, who always know how to talk to people"* (P2, Mphophomeni, September 2018).

Young nurses at the clinic

There wasn't a clear age gradient recommended by participants concerning the preferred age of nurses to deliver health care services for them. On the basis that participants in this study were between the ages of 15-24 in this study, most of the participants described that they preferred to have health care services delivered to them by nurses that were not far from their age group. AGYW said they were unlikely

to access HIV or SRH services if they feel judged or placed on a moral ' or if older people lectured them and spread rumours about them. They felt that their sexual behaviour was stigmatised and therefore were not fully informed of their options by clinic nurses. Participants preferred that nurses were younger in age so that they could be more open with them.

Health care nurses that are young appeared to be an important aspect for AGYW who access the clinic for HIV and SRH services. Participants were specific, saying: *“even though some of the old nurses are good, but I cannot be open about my sexual life to them and ask the information I need”* (P14, Caluza, November 2018). This participant added that *“sometimes I wish they were younger, even though sometimes it’s nice to talk to someone who is like a mother to me, but because of that it is hard to be open about my sexual life.”* Another participant added that *“sometimes the nurse will look at you as if they are your mother and you will feel like they are your mother...and then I am scared of saying anything to her”* (P7, Mphophomeni, September 2019).

Participants specifically expressed that consulting with older nurses at the clinic was like consulting with their mothers. One participant said *“as much as it is good for others to say they like old nurses, maybe that is because they know how to talk to their mothers at home, but for me, I wish they had young nurses at the clinic”* (P19, Caluza, November 2018). Another participant said: *“It would be easy to be honest and open about what I do to someone who is not that much older than me, they would the sexual life of a young person better”* (P10, Mafakatini, September 2018). The age of nurses contributes to the fear young women have about the possibility of their parents knowing what they doing at the clinic. One participant shared her concern, saying, *“Some of the older nurses know the people in the chronic section, and those people are our neighbours at home. It is easy for my mom to know that I came to the clinic for family planning. It is better is there is younger nurses who can keep my business to herself”* (P7 Mphophomeni, September 2018). It appears as if age appropriate nurses in health care delivery, are also a safety for AGYW being stigmatized about their sexual life because of their age, *“young nurses are sometimes new, and they like to stay in town, so not many people close to me and my family can know them”* (P1, Mphophomeni, September 2018). To summaries the concern of age and how it directly links to the level of openness AGYW have with nurses, one participant said *“We want*

young nurses because it's not easy to tell all your problems to the old nurses" (P10, Mafakatini, September, 2019).

The clinic as the last source of SRH information

According to the WHO (2012) youth-friendly guidelines, health care clinic should provide information and education through a variety of channels. There should be displays of information and health education materials on issues related to HIV and adolescent sexual and reproductive health (Desiderio 2014). A primary objective of comprehensive sexuality education is to increase knowledge and enable young people to make informed decisions related to sexuality and reproductive health, thereby increasing their preproperate utilisation of services (Pillay, Manderson *et al.* 2019).

Two of the five characteristics of youth-friendly services according to WHO (2012) is that they must be acceptable and accessibility. Meaning that the point of health service delivery at the clinic should provide information and education for AGYW for it to be acceptable. It is also accessible when AGYW are well in-formed about the range of available reproductive health services and how to obtain them. With that said, participants shared saying: *"I prefer the internet"* (P15, Caluza, November 2018)! Another participant suggested a similar source of information *"I use google first, then I go to the chemist to buy what I need"* (P20, Caluza November 2018). The internet has replaced the clinic as a better source of information for AGYW because of barriers like long waiting hours. *"You see the internet is easy, because if I go to the clinic, I will have to wait long ques for information to help me...I think the internet is faster"* (P17, Caluza, November 2018). These participants refer to their source of information as being the internet first.

Furthermore, participants continue to describe that the clinic is not their immediate source of information. One participant said *"in the community, there are many NGO's, they go around and give talks and advise, I got all that I know from there"* (P3, Mphophomeni, September 2018). Another one said, *"you'll pick up pamphlets...that is better than going to the clinic to ask...I think this is better"* (P17, Caluza, November 2018). The same participant said her alternative source was her mother: *"I also ask*

my mother; I don't go to the clinic." For another participant, school was the most reliable source of information concerning HIV and SRH related information *"everything about my body and sexual health...I get explanations about these things at school...not at the clinic"* (P7, Mphophomeni, September 2018). Another participant from the same community and clinic said: *"They don't explain anything to us here at the clinic, have you heard them before? I get information from the caravans that come to school to teach about sex decision"* (P6, Mphophomeni September 2018). A participant residing in a different community confirmed that school was also preferred source of information *"I get all my information from my class in life orientation at school"* (P11, Mafakatini, September 2018).

Apart from the internet and school being a source of information for AGYW, there was evidence of a consistent negative perception about the clinic being an acceptable source of providing information. In with this, participants highlighted issues concerning the competency of nurses, saying, *"how I see it is that if you will go to the clinic, you must not go there without a clue of what's happening with you and the cause of it. Because when you get there and tell them your problem and what happened, they'll ask what cause it and you'll say you don't know"* (P19, Caluza, November 2018). Another participant said *"before I go to the clinic, I need to first do a good search of what is wrong with me. I need to go to the clinic knowing and understanding because at the clinic they will not explain to me"* (P17, Caluza, November 2018). It was definite that the clinic was not an acceptable source of information for AGYW: *"No! We do trust it (the clinic)"* (P13, Mafakatini, August 2018).

The clinic was not a trustworthy source of information for AGYW in this study. Some participants shared other preferred sources, saying, *"groups are very good because I'll speak and share my opinion and someone else will also share, then we'll all understand better on whatever we'll be discussing at that time, that's how you would be helped. Because as we are talking maybe there's a problem that I have which I don't understand but by what this lady says I'll be able to fix the problem"* (P4, Mafakatini, September 2018). Another participant said: *"In the community, there are many NGO's, they go around and give talks and advise, I got all that I know from"* (P3, Mphophomeni, September 2018). In addition to this, other participants shared, saying, *"I trust my mother more than the clinic"* (P14, Caluza, November, 2018). Another

participant in the same clinic said *“I also ask my mother; I don’t go to the clinic* (P17, Caluza, November 2018).

Theme three summary

The health care services in primary health care clinics is summarised by AGYW in Vulindlela by the above-mentioned subthemes. The AGYW raise critical service delivery limitations that negatively hinder their uptake of HIV and SRH prevention tools available for them in primary health care clinics. It is important to highlight at this point that the researcher highlights these subthemes on the basis of what participants in this study prioritised within their local and contextual environment. This is important because it is within different contexts and local environments that even health interventions like AYFS will have meaning. It is when local community members draw meaning from their own lived experiences that health care services among AGYW can be sustained. For health care services to be youth-friendly for AGYW in Vulindlela, the health care service delivery at the clinic holds a critical role. AGYW in this study described nurses attitudes and the need for younger nurses in health care clinics as a necessity in order for HIV and SRH services to be youth-friendly for them.

Thematic data presentation of nurse's feedback

Table 5.4: Biographical information of Nurses in this study

Name of the clinic	Qualification/Training	Age	Interview date	Nurse Code
Caluza	Clinical Nurse	>30	June 2019	N1
Mphophomeni	Staff Nurse	>45	September 2018	N2
Mafakatini	Clinical nurse	<50	June 2019	N3

Having presented data collected with AGYW as the key population for effective HIV and SRH services, literature highlights the critical role of health care nurses in ensuring that services are youth-friendly for AGYW (Geary, Gómez-Olivé *et al.* 2014, Tanner, Philbin *et al.* 2014, Brittain, Williams *et al.* 2015, Callie Simon 2015, Geary, Webb *et al.* 2015, Reif, Bertrand *et al.* 2016, Thomée, Malm *et al.* 2016, James, Pisa *et al.* 2018, Mazur, Brindis *et al.* 2018, Saberi, Ming *et al.* 2018). The global WHO guidelines (presented and explained in chapter 2), also states that for the primary health care clinic to be youth-friendly, it must be effective. That means, the clinic must ensure that the health care nurses have the required competences to work with adolescents and to provide them with the required health services. Secondly, that the health care nurses must use evidence-based protocols and guidelines to provide health services. Lastly, according to these global standards, health care nurses must be able to dedicate sufficient time to work effectively with their adolescent clients.

This section of this chapter presents data collected with nurses who were leading the AYFS programme within the clinics where this study was conducted. The health care nurses were relevant to include in this study as they were given the responsibility to facilitate the AYFS programme in each clinic where this study was conducted. The following themes follow the already existing presentation in this study. From three in-depth interviews with three health care nurses, the he same overarching themes presented in the previous sections in this chapter were evident in the interviews:

1. *Structure of the primary health care clinic*

2. *Health care services of the primary health care clinic*
3. *Organisation of the primary health care clinic*

Following the presentation of each theme and the sub-themes, there is a descriptive discussion concerning the opinions of AYFS nurses and their understanding of this study. The discussion will include all the nurses opinions from all three clinics which this study was conducted.

Structure of the primary health care clinic

Insufficient clinic space

The structure of the clinic, referring to the physical facility is critical for youth-friendly services. A nurse from Caluza clinic, who is a clinical nurse trained for the AYFS programme in the clinic, explained elaborately, saying: *“the issue is shortage of space, as you can see, actually So, you can see there is no privacy because adolescents should be alone this side and adults on the other side. But, as it is, they have to wait on the same waiting area which I something we did not want hence we created the AYFS but still so, it’s a bit difficult”* (N1, Caluza, June 2019). She continued to say: *“I think they need their own space I don’t know if it’s possible because the government is the way it is. I’d suggest that we at least get park homes so that we are isolated from here...”* Another nurse also strongly suggested that *“they don’t want their secrets to be exposed...it must not be in public where everyone can see...they like private things and they don’t like to wait so, if it’s their own clinic space they won’t wait long”* (N3, Mafakatini, June 2019). One nurse expressed that *“the clinic does not have enough capacity, because in just this clinic, we do maybe about 50 million people, because it’s only Mpophomeni people who come here, we also do Amashinga, Chief, Nguga, Mafakati, Lime’s river, so you can see it’s a lot.”* (N2, Mpophomeni, September 2019).

Staff shortage

The nurses described that there is a shortage of staff in the clinic which directly impacts how services are delivered. One nurse said: *“I think we need to have enough staff and place to work in, right now I don’t have a place they can check their urine when they do pregnancy test...”* (N2, Mpophomeni, September 2019). Another nurse

said that AGYW need *“one sister dedicated to them, they are very secretive also”* (N3, Mafakatini, June 2019). However, *“there is shortage of staff”* (N1, Caluza, June 2019). Another nurse explained that if there were more staff available at the clinic, *“I should only be attending to AYFS and then the other sister next door should be doing ACUTE which are adults”* (N1, Caluza, June 2019).

To further highlight the need for more nursing staff in primary health care clinics, the nurses across the three clinics reported the HIV and SRH services that were available for AGYW at the clinic. The purpose was to expound the multiple services they have to provide as individual to a large number of AGYW as patients. The nurse said: *“We offer family planning services, HIV testing and counselling. We also now offer Oral PrEP. Beyond this, we offer life coaching talks, about safe sex, careers and decision-making skills for the youth”* (N1, Caluza, June 2019). This was the only clinic that was offering Oral PrEP. Other nurses said: *“It’s orals, injectables like IUCD and, implanons”* (N3, Mafakatini, June 2019).

Apart from the biomedical services provided, another nurse continued to say *“We offer talks, during the happy hour. The ones from school come the most. We have to teach them about life and making decisions. Some don’t know and they do not have mothers at home “* (N2, Mphophomeni, September 2019). This nurse extends the explanation of what services the clinic offers, exposing that as a nurse they are also responsible for talking to and teaching AGYW, particularly those without mothers. *“When a person has come for family planning, the first thing you do is test them if they are not pregnant, then you show them the chart on the wall with the various available methods, then tell them to choose which method they would like... IUS, IUCD, male condoms, female condoms, ovarian, oral coil, implanons...”* (N2, Mphophomeni, June 2019). Therefore, it is a challenge for most nurses to attend to AGYW on time.

Organisation of the primary health care clinic

Inconsistent service delivery

The functioning of the clinic sometimes calls for nurses to rotate in rendering different services. One nurse explained that *“the nurses rotate...we go where it is most busy. I can’t just take a PN (professional nurse) to go stay there (at AYFS for the whole day*

without doing a thing” (N3, Mafakatini, June 2019). This is another challenge the nurses have in delivering timely services to AGYW. Another confirmed this by saying: *“I cannot be in one place, even if I want to focus on AYFS, because I am a clinical nurse. I am forced to move to serve in other programmes of the clinic...So, in one day I can be serving in more than one programme”* (N1, Caluza, June 2019). The demand to service in multiple programmes within the clinic demands that nurses rotate. The workload increases and nurses are not available to work on weekends, where most school going young girls are available. One nurse brought this out, saying, *“this clinic does not open during the weekend. It doesn’t, that’s the problem... The clinic closing on weekends is affecting them. Because they are in school. But there are no nurses to work on weekends, this would need more staff”* (N3, Mafakatini, June 2019).

Staff training for competence

The nurses described their need for more training. One nurse exclaimed, saying, *“No, I need training! I want them to train me in every possible way that they know I should use in teaching the youth”* (N2, Mphophomeni, September 2019). This was alluded to the need to become competent in working with AGYW. Another nurse said: *“There is a need for more training for nurses, especially with new things coming for HIV prevention like PrEP.” More nurses need to know how to work with youth*” (N3, Mafakatini, June 2019). Another nurse concluded that: *“The AYFS training was only three days. The skills that I’ve gained through it was that uhm we were taught how to talk to the youth, that we should be on their level and be welcoming, being non-judgmental and listening to their concerns.” “But there is a need for more nurses to be trained”* (N1, Caluza, June 2019). *They have to trained as well on how to treat young people, how to talk to them and being able to be in their shoes, because you can’t just ask them why they are dating, why are you on family planning, that child...* (N2, Mphophomeni, September 2019)

Health care services of the primary health care clinic

Youth-friendliness in the clinic

The nurses have a personal understanding of why youth-friendly services are important and why they need to be friendly. One participant describes that *“some*

nurses are like mothers and can say- you are so young, but you are sleeping with boys”, meanwhile she’s... shutting the door and they won’t confess anything after that. It is important to be able to be open and listen” (N3, Mafakatini, June 2019). Another participant describes that “as nurses we have to motivate them while they are young, we must talk to them about HIV and the consequences of engaging in sexual intercourse at a young age. We must implement family planning so that they don’t get pregnant at an early age because that destroys their future which is what we are trying to build. The future of South Africa starts with them. We need to care when doing this job...” (N1, Caluza, June 2019).

The nurse must also have skills to motivate AGYW. The CC follows that if nurses are to develop cultural competence, the knowledge, skills and attitudes forming the core components of cultural competence should be relevant to practising nurses (Purnell 2002, Harris 2003). The CC merges the importance of skills and the ability to understand the cultural needs of people that nurses serve. The nurses in this study acknowledged the importance of this merge in providing HIV and SRH services for AGYW. One nurse in this study said: *“I can have the skills, but my behaviour can say something else. Someone who works with the youth is said to be one that is on their age range so that when they talk to them, they understand each other. Secondly, they must be friendly, must be able to laugh with them...” (N3 Mafakatini, June 2019).* AGYW have stated above, that younger nurses would be more comfortable for them when accessing HIV and SRH services in clinics. The assumption is that younger nurses can easily be inclined to their needs than older nurses. This nurse acknowledges and relates the behaviour of being youth-friendly to young nurses. Research shows that, it is younger nurses that have the capacity to understand AGYW (Maru, Rajeev *et al.* 2016, Pilgrim, Mathur *et al.* 2016).

The nurses continues to say that a nurse providing HIV and SRH services to AGYW cannot be *“someone they can see and be afraid of, like their mother, let me say maybe a 15-year-old must have a 25-year-old care giver” (N2, Mphophomeni, September 2019).* The nurses describe that youth-friendliness can also be enhance by the space being *“beautiful; they like beautiful things and it should be a bit brighter and should have writings that favour them. What else ...uhm. ...it should also be comfortable. There must be something to watch like a T.V while they are still waiting at the waiting area,*

there should also be food” (N3, Mafakatini, June 2019). Another nurse confirmed that “...the first thing I would do is get a T.V, computers, games, a toilet and then someone who will provide food” (N2, Mphophomeni, September 2019). Entertainment and food came up as one the necessary commodities to make a youth-friendly clinic from the observation nurses have made with the AGYW they work with.

Youth defaulting

The nurses raised that one of the challenges in providing HIV and SRH services for AGYW was that they often default. One nurse said: *“They default... They don’t condomise, you see these condoms here... I often must always tell them to take them some do but throw them outside” (N1, Caluza, June 2019). She continued to saying: They say it hurts them then some who came to do a pregnancy test and came out negative, when you tell them about family planning, they just say they’ll see some other time. Ut’s their right, we can’t force them, but we keep pushing until eventually they agree.”* Another nurse from a different clinic in Vulindlela raised a similar challenge: *“They do have an awareness but, I don’t know if I don’t know how to put this, it’s just carelessness I don’t know how else to put this or ignorance” (N3, Mafakatini, June 2019).*

The AGYW that they work with do know of all the options for HIV prevention and other SRH related issues, but they do not adhere. Another participant felt that this was because *“the nurses that work here are from the local community and we see patients from the local community as well so, if maybe a teenager’s mom’s friend works at the clinic and the teen has come for family planning, they will eventually run from the clinic because of that” (N1, Caluza, June 2019). The challenge expressed by this participant is that: “we do programs that are part of AYFS like family planning, ante natal, HIV testing but the problem is that the youth only comes when there are issues.”* The AGYW do not easily adhere to the services offered at the clinic in the AFYFS programme.

Summary of nurse’s feedback

This section of the chapter highlighted nurses’ positions on the structural, organisational and health care services at the clinic. This section produces a comparative position, where nurses respond to the issues raised by the patients. Table

5.4 presents significant statements that were raised by AGYW concerning structural, organisational and health care service issues within the health care clinic. Multiple studies have highlighted AGYW's concerns about HIV and SRH services delivered to them and the clinic (Brittain, Williams *et al.* 2015), other studies focused on understanding nurses perspectives about health care delivery for AGYW (Jonas, Roman *et al.* 2019). Nonetheless, this study offers the perspective of both AGYW and nurses.

Table 5.5 : Table representing voices of AGYW and the nurses responses

Participant issues	Nurses position
<i>"Time management"</i>	<i>"Staff shortage"</i>
<i>"Nurses ages"</i>	<i>"Younger staff needed"</i>
<i>"Clinic as a last source of information"</i>	<i>"Lack of staff specialization"</i>
<i>"Capacity of clinic structure"</i>	<i>"Lack of space in clinic buildings"</i>
<i>"Clinic organisation"</i>	<i>"Staff shortage"</i>

Conclusion

Part of understanding HIV and SRH services that are youth-friendly, is investigating youth-friendly services among AGYW who come from different localized communities and contexts. In order to establish the key influences of accessibility to health care services among AGYW, it is vital to establish what AGYW understand about AYFS. Although the WHO and other global organisations define AYFS as services that are equitable, accessible, acceptable, appropriate and effective for AGYW, it is important to understand from a localized and community-based perspective what AGYW understand AYFS to be. It is important to understand these as global guidelines that may not be applicable in different contexts and local communities. In South Africa for example, the health care needs in local communities differs from other countries.

The AGYW in this study spoke about issues related to three overarching themes: structure of the health care clinic, the organisation of the clinic and also the health care services at the clinic. Within the structure of the clinic, they specifically spoke about the importance of having separate spaces for AGYW to receive SRH care services.

The lack of space in the clinic led to multiple issues like stigma and discrimination for AGYW in this study. They expressed the discomfort of being seen by community members while consulting at the clinic. The issue of space, was directly linked to the lack of privacy experienced by AGYW at the health care clinic. The AGYW expressed that they felt that the health care clinic could not protect their confidentiality, due to the lack of privacy.

One of the critical factors expressed by AGYW concerning the organisation of the clinic was administration and time management at the clinic. The long waiting hours and the delayed receipt of the client files upon arriving at the clinic contributed negatively to the overall clinic experience for AGYW. Across all three clinics that this study was conducted, the AGYW believed the long waiting are discouraging and sometimes made them reluctant to access the clinic for HIV and SRH services. Nevertheless, the nurses in this study attributed the long waiting hours to several other factors, like the shortage of staff. Nurses expressed that the clinics are overcrowded and that there is a lack of trained staff at the clinic. Because of the deficiency in staff training, patients are often forced to wait for nurses as they serve in multiple programmes at the clinic.

The health care services at the clinic were attributed to the attitudes of nurses. AGYW expressed that they access the clinic for family planning, HIV testing and antenatal care and that nurses' attitudes had a direct effect on the young women's experiences of going to the clinic for SRH care services like family planning. The AGYW in this study felt that nurses were not approving of their sexual behaviours, making other SRH services like family planning uncomfortable for them because of their age. AGYW felt judged by nurses and the clinic was not a space where they felt comfortable to seek help. The AGYW attributed the nurse's judgmental behaviour to their age. The AGYW in this study confidently said that younger nurses would be more suitable to render health care services like family planning and antenatal care for them.

This chapter presented the data collected in this study across three clinics in Vulindlela that offer the AYFS programme. The first section of the chapter presented visual data, and then the transcribed data from the photovoice workshops, focus group

discussions and in-depth interviews with the nurses. The next chapter is the analysis of data presented in this chapter.

Chapter Six: Data Analysis

Introduction

Data analysis transforms the data collected in a study into findings by bringing order, structure and meaning to the mass of collected data (Patton 2002). The analytical process “does not proceed tidily or in a linear fashion but is more of a spiral process; it entails reducing the volume of the information, sorting out significant from irrelevant facts, identifying patterns and trends, and constructing a framework for communicating the essence of what was revealed by the data” (de Vos *et al.*, 2005:333).

The current chapter functions as the ‘melting-pot’ for the ‘bricoleur’, allowing for the synthesis of theory and observations to form the analysis of the data. The data in this study established that AGYW vulnerability to HIV infection, unplanned pregnancy and other SRH related health concerns is enhanced by issues of access to HIV and SRH services that are youth-friendly in primary health care clinics. The structure of primary health care clinics, the organisation and the manner in which services are delivered at the health care clinic was a major barrier for AGYW seeking HIV and SRH services that were youth-friendly. According to the World Health Organization (WHO), adolescent youth-friendly services are those that are acceptable, accessible, appropriate, equitable and effective (WHO, 2012).

Reflexivity forms part of this analysis, but will not be employed in the traditional linear or sequential manner. Rather, it will simultaneously be weaved into the analysis resulting in a bricolage that connects the parts (data) to the whole (bricolage) (Denzin and Lincoln, 2013b). This accounts for the complexity of knowledge production and the interrelated complexity of both the bricoleur’s position and phenomena occurring in the research field (Kincheloe, 2001; 2005; Kincheloe and Berry, 2004; Kincheloe *et al.* 2013). Additionally, reflexivity is vital to the study of social change communication, “as it engages with questions of truth and participates collaboratively with subaltern sectors” in the co-construction of knowledge (Dutta, 2011: 288).

This chapter is arranged according to the emerging themes created following the main objectives in this study. The layout of this chapter follows the sequences the three main data presentation themes

1. Structure of the primary health care facility
2. Organisation of the primary health care clinic
3. Health care service delivery in the primary health care clinic.

These three themes are interrelated, they cannot be viewed in isolation because of their interconnectedness. As the participants expressed their experiences at the clinic, majority of the points that were raised were related to the clinic structure, the organisation of the clinic and the services delivered at the clinic. Each of these themes are interrelated and dependent on each other for services to be youth-friendly for AGYW, particularly in rural contexts. Under each theme, are sub-themes that are discussed below to elaborate on each theme.

A summary of these findings is then discussed in relation to the culture-centered approach (CCA) which attends to subaltern agency by addressing the capacity of communicative processes to transform social structures and in doing so give voice to communities at the margins (Dutta, 2011; Acharya and Dutta, 2013). Thus, an examination of culture, structure, agency and their intersections with power, exposes the processes that facilitate and/or hinder subaltern agency among AGYW accessing the primary health care clinic for HIV and SRH care services. An amalgamation of these practices results in an intricate bricolage of the research findings that will be analysed in the framework of Purnell's (2002) Cultural Competence (CC) model with particular emphasis on the CCA (Dutta 2011).

CCA and CC as frames for analysis

The CCA is fundamentally premised on three pillars; structure, culture and agency (Dutta 2008). Data is analysed through the CCA, highlighting the influence of culture on the sexual reproductive health for AGYW. The CCA gives a framework in analysing the influence of culture on the understanding of AYFS among AGYW. Furthermore, Purnell's CC model, was deemed relevant in this study as it endeavours to enhance

patient care and well-being through culturally competent nursing. Purnell's CC is premised on the importance of transcultural nursing. Which describes nurses who understand that delivering culturally competent health care, requires them to immerse themselves within the diverse cultural systems, beliefs and values of the patients they serve (Leininger, McFarland *et al.* 1987, Betancourt, Green *et al.* 2002). The CCA and Purnell's (2002) CC value the role of culture if health services will be rendered by nurses and received by patients appropriately.

AGYW are often disadvantaged and seen as 'passive victims' of the social structures that undermine their agency. In fact, social structures and AGYW's agency are intertwined and are mutually constituted (Giddens 1984). Neither the agency nor the social structures are independent of one another (Giddens 1984; Jones & Karsten 2008). Individuals and community members depend on social structures for their action and their actions in turn serve to create and recreate the social structures (Jones & Karsten 2008). The CCA seeks to address health disparities by fostering opportunities for listening to the voices of those at the margins through a variety of participatory communication methods such as PhotoVoice exhibits (Dutta, 2008). Photovoice is a participatory methodology that seeks to include participants in the research process and not further alienate them but rather provide a space for them to be co-creators of knowledge. It enables us to gain "*the possibility of perceiving the world from the viewpoint of the people who lead lives that are different from those traditionally in control of the means for imaging the world (Catalani and Minkler 2010).*" As such, this approach to participatory research values the knowledge put forth by people as a vital source of expertise (De Lange, Mitchell *et al.* 2007). It confronts a fundamental problem of community assessment: what professionals, researchers, specialists, and outsiders think is important may completely fail to match what the community thinks is important.

The participatory paradigm, in which this study is premised assumes that the inquirer will proceed collaboratively so to not further marginalise the participants as a result of the inquiry (Creswell 2009). Participation provides a voice for participants, raising their consciousness or advancing an agenda for change for change to improve their lives (Creswell 2009). The voice between researchers and the 'researched' become a united voice for reform and change.

This emphasis on participation is central to the CCA which focuses on structural change with an emphasis on the agency of the subaltern (Acharya and Dutta, 2013; Dutta 2011). The CC emulates the principles of the CCA by revealing the communicative processes in its key tenants which explain that culture is the unconscious ways learned within our families, in which we develop our behavior, values, customs, and thought characteristics that guide our decision making and the way we view the world around us (Purnell 2002, Harris 2003). CC interrelates characteristics of culture to promote congruence and facilitate the delivery of consciously sensitive and competent health care (Purnell 2002). Once a primary health care clinic is culturally competent, it is able to devise strategies to identify and address cultural barriers community members face when accessing HIV and SRH care. Ultimately, it provides a platform for agency in contending with health care structures that direct the lives of community members. Hence, the subaltern make their voices heard within their contexts and local environments and are presented with possibilities to enact their agency. Therefore the “intersections of culture, structure, and agency [which] create openings for listening to the voices rendered silent through mainstream platforms of society, thus creating discursive spaces that interrogate the erasures and offer opportunities for co-constructing culture-centered narratives by engaging marginalised communities in dialogue” (Acharya and Dutta, 2013: 225).

Theme One:

Structure of the primary health care clinic

The structure of the health care facility in this study, refers to the actual architectural design of the clinic facility. Structure in this study also refers to the location of the clinic and the affordability of transportation for patients to access it (Brittain, Williams *et al.* 2015). The physical environment of where the clinic is located needs to align to the needs of local members who access the clinic for health care services. Furthermore, structural design of the clinic, has not historically considered the impact on the quality of health for patients (Steinwachs and Hughes 2008). Therefore, the structural design must be inclusive of how the building is compartmentalised to meet the needs of patients in the clinic. One of the standards of the quality assessment tool

recommended by WHO is that the clinic must have a physical environment conducive to the provision AYFS (Senderowitz 1999, Dickson-Tetteh, Ashton *et al.* 2000).

According to the CCA, structure refers to those aspects of social organisation “that both constrain and enable the capacity of cultural participants to participate in communicative platforms and in utilizing the fundamental resources of mainstream societies” (Acharya and Dutta, 2013: 226; see also Dutta-Bergman 2004). As such a discussion of structure in the South African health context is embedded in colonial discourse and the apartheid regime.

The design of a structure with its fixed and moveable components, can have a significant impact of the health care programmes like the AYFS programme in the clinic. Fixed components in the context of this study are waiting room areas, toilets consulting and counseling rooms for patients. The moveable components are beds, and clinical utensils required for patient care.

Participants in this study highlighted some of the structural related challenges that hinder them when accessing the clinic for HIV and SRH services. They highlight issues concerning the fixed and movable components of the clinic structure, such as the space in the *clinic structure, lack of privacy, hygiene and transport and distance traveling*.

Space in the clinic structure

Health and risk are said to be organised worldwide amid structures of unequal flow of labour, capital, commodities, and communication, shaped by the material inequalities in the distribution of resources (Graham 2004). In light of that, increasing attention has been placed on studying health communication within the cultural context in which it is placed, in order to create the climate for multicultural health communication structures (Airhihenbuwa 1995, Dutta and Basu 2007, Dutta 2008, Dutta and Basu 2011). Therefore, CCA highlights structure as one of the critical influencers of individual behaviour (Dutta 2008). The characteristics of a youth-friendly structure re embedded within the cultural context in which it is placed, meaning that AGYW must be at the center of such interventions. AGYW in this study highlighted that, firstly, a

youth-friendly structure, is one that is in a convenient location; where local community members can easily gain access. It is one that must have adequate space with counselling areas that provide visual and auditory privacy. This is similar to characteristics in (Desiderio 2014, Müller, Röhrs *et al.* 2016). In another study, AGYW were specific to say that the structure must have in it examination areas that provide visual and auditory privacy and comfortable surroundings (Mathews, Guttmacher *et al.* 2009, Desiderio 2014). Access to youth-friendly health services provided in a clinic structure described above is vital for ensuring the HIV and SRH well-being of AGYW (Denno, Hoopes *et al.* 2015). The environment including both the geographical location and service structure (e.g., clinic waiting room or other individuals present in the waiting room) is important for AGYW HIV and SRH care.

This current study established that the clinic structure lacks space that is able to accommodate the health needs of AGYW. Some of the participants in this study highlighted that due to the lack of space in the clinic, the AYFS programme was not yet effective for them in their local clinic.

“I left my house around 5a.m and only came back around 2p.m... It’s was too full; they couldn’t even help us quickly. The lady tried to categorize us but there was just too many of us” (P10, Mafakatini, August 2018)

Since the AYFS programme did not have space allocated to them at the clinic, participants in this study felt that they were un-able to receive tailored services suitable to their needs. The nurses during interviews one of the nurses also confirmed that space was an impeding factor to AGYW receiving HIV and SRH services that were suitable.

“The issue is shortage of space, as you can see, actually So, you can see there is no privacy because adolescents should be alone this side and adults on the other side. But, as it is, they have to wait on the same waiting area which I something we did not want hence we created the AYFS but still so, it’s a bit difficult. I think they need their own space I don’t know if it’s possible because the government is the way it is. I’d suggest that we at least get park homes so that we are isolated from the rest of the clinic...” (N3, Caluza, June 2019).

Therefore, both AGYW and the nurses in the current study are confronted with the issue of space at the clinic. For nurses, it is to deliver tailored and suitable health care services, and for AGYW space meant receiving timely, private and confidential services. These findings ratify findings from another study, where young adolescent girls emphasised the need for a separate AYFS space in the clinic. A space that will have sufficient waiting rooms areas and other facilities (Ngambi 2016). This study identified the importance of a space that maintained confidentiality for adolescents away from the adult clinic space, and allowed private consultations for individual adolescents. Similarly, (Nkosi, Seeley *et al.* 2019) state that adolescents raised concerns about the organisation of health service delivery and pointed out that the lack of adequate space in health clinics compromised their privacy and confidentiality. Adolescents noted that they were sometimes made to wait outside the building while waiting for consultation because of overcrowding.

Participants in this current study shared similar sentiments about confidentiality and access to private consulting rooms that are not shared or used as storage rooms. A possible justification for why AGYW seek the AYFS programme to have its own stand-alone structure in order to receive HIV and SRH related services may be gleaned from findings from two studies; one conducted in rural South Africa (Tsawe and Susuman 2014) and another in rural Zambia (Ngambi 2016). In both these studies adolescents were reported saying that for the AYFS programme to be effective for them in their local clinics, designated space that would promote privacy and confidentiality would be more suitable.

This finding of lack of privacy was similar for AGYW across all the clinics where this study was conducted. All the AGYW, from different ages noted the need for space in the clinic structure.

Lack of privacy

The AGYW in this study reported being fearful of meeting local community members at the clinic, who would possibly alert their parents that they were attending the clinic for HIV and SRH related needs, like family planning. They were also afraid of being teased or talked about by friends, and being the victim of community 'gossip'. Some

were also concerned that their partner would think that they had an STI or had been unfaithful if they knew they had attended HIV and SRH services. The lack of privacy in primary health care clinics was emphasised, resulting in fear of being seen by friends, relatives or community members. Additionally, the lack of privacy for AGYW in this study was directly linked to the possibility that sensitive experiences at the clinic would not remain confidential. A study conducted across three cities in South Africa; Gauteng, Cape Town and Durban aimed at understanding what South African adolescents want in SRH services (Smith, Marcus *et al.* 2018). Adolescents in the current research study found that trust in staff and health facilities is an important factor for services to be youth-friendly (Smith, Marcus *et al.* 2018). Similar to this AGYW in this study reported, saying:

“It was my first time going for family planning, what made me reluctant on going to the clinic was that when you come to the clinic for family planning, the toilet is not near by the consulting container. I have to walk outside to go to the toilet and everyone can see me with the urine. Everyone can see what I am doing. (P14, Caluza, November 2018).

The participant expressed how the lack of privacy when accessing the clinic for family planning was directly related to being seen by other community members. She describes that this experience made her reluctant to go to the clinic again for family planning because of the fear of being seen community members. Fear about lack of confidentiality is a major reason for young people’s reluctance to seek help (Tylee, Haller *et al.* 2007). For example, fears about being recognised in a clinic waiting room with the possible stigma attached deters young women from visiting health services (Tylee, Haller *et al.* 2007). Young women also fear that health workers will not maintain confidentiality, especially from parents.

Adolescents reported similar findings from (Smith, Marcus *et al.* 2018); that health care clinics are a daunting place where they may see people they know, leading to actual or perceived loss of confidentiality (Smith, Marcus *et al.* 2018). “If adolescents felt judged or if older people lectured them and spread rumours about them, they would not go to the clinic anymore” (Smith, Marcus *et al.* 2018). The stigma often came from community members who felt that AGYW should not be engaging in sexual behaviour.

The fear of parents knowing about their clinic visits, consequently discouraged attendance of HIV and SRH services. The fear of parents or guardians finding out about a visit to a health service can be profound (Tylee, Haller *et al.* 2007). This is also confounded by the inability of parents to communicate with AGYW about their sexuality (Mbugua 2007, Ballard and Gross 2009, Kamangu, John *et al.* 2017). The inability of parents to communicate with AGYW about sexuality has been consistent in studies from Western and African contexts. However, parents from the African cultural context report socio-cultural and religious inhibitions from providing meaningful sex-education to the pre-adolescent and adolescent daughters (Mbugua 2007, Gumede 2017).

For example, in cultures where social norms forbid premarital sex (Mkhwanazi 2010, Mkhwanazi 2014), unmarried young women with a sexual problem such as a sexually transmitted infections (STI's) or unplanned pregnancy are likely to deal with the issue themselves, turn to trusted friends or siblings, or to service-delivery points, such as pharmacies or clinics far from home (Tylee, Haller *et al.* 2007).

As applied to public health, social psychological perspectives suggest that stigma is an umbrella concept with various interrelated components: labelling, stereotyping, separation, status loss, discrimination, and the exertion of power (Link and Phelan 2001, Airhihenbuwa, Ford *et al.* 2014). The focus tends to be on how stigma affects individual sufferers, paying close attention to cues that highlight their unique appraisal of undesirable characteristics that lead to the devaluing of their identities, their range of coping responses, and the negative impact of stigma on their psychological well-being (Yang and Seto 2007). This is a highly individualistic approach to stigma that is neither practical nor adequate in societies where individuals are not isolated entities (Smith and Mbakwem 2010). The individual "self" belongs to or is part of a family or community and cannot be changed in isolation from the larger entity (Muula and Mfutso-Bengo 2005).

In these contexts, it is important to understand not only the social psychological constructs, but also the cultural processes by which stigma is manifested in the lived experience of stigmatized people (Kleinman and Hall-Clifford 2009). Accounting for

familial and community contexts in which individuals have little or no control must be the first step toward reducing HIV/AIDS stigma in non-Western and other contexts

Further to this, in rural communities, surrounding environments and the beliefs systems in the community often influences how sexuality and sexually active AGYW are viewed (Mkhwanazi 2010, Mkhwanazi 2014). AGYW in this study felt that the lack of privacy at the place placed them at risk of being identified at the clinic and talked about by friends, and being the victim of community 'gossip'. Some AGYW were also concerned that their partners would think that they had an STI or had been unfaithful if they knew they had attended HIV and SRH services.

The lack of privacy in clinics was emphasised by AGYW in this study as it directly affects confidentiality and mistrust between them and the nurses. A study conducted in Tanzania, participants cited lack of privacy as a key factor hindering pregnant adolescent girls from seeking reproductive health services (Hokororo, Kihunrwa *et al.* 2015). They perceived the antenatal clinic as their only healthcare option, but that due to lack of privacy many felt that they could not seek help for their sexually related problems (Hokororo, Kihunrwa *et al.* 2015).

In the current study, AGYW shared that they are often infringed by the structures of the clinic. Yet, structures are cultural settings that have been constructed through the communication of shared meanings local members who share their beliefs and values. (Dutta 2008) asserts that meanings of health occur within collective values, beliefs and ideas of individuals that circulate within spaces. The idea of spaces in and of itself is connected to structures, in the sense that spaces are organised, spaces are shaped by boundary conditions that determine what gets included in these spaces and what gets excluded (Dutta 2014). Within these spaces, groups of people come together, they develop a set of shared symbols through which they participate in relationship to each other and build joint meanings. These joint meanings then form continuous joint communication which becomes a culture within spaces. Therefore, it is through communication that we come to create culture. In this notion of culture being constituted through communication, we also need to understand the role of structure (Dutta 2008).

There are instances where they end up changing the story and telling the nurse incorrect information about their sexual lifestyle. The findings in this study are similar to the findings from (Smith, Marcus *et al.* 2018) where adolescents shared that they change the conversation because when the nurse you talk with leaves you, she is telling another nurse in front of other patients sitting in the waiting area that “children of today are like this... and she will point at where you are” (Smith, Marcus *et al.* 2018).

It has been argued that health communication scholars and practitioners need to consider the structural constraints that might exist in a community’s environment when planning for interventions (Dutta-Bergman 2004). In the rural context of Vulindlela, the structural context limits access to HIV and SRH services that are youth-friendly for AGYW. Any intervention, therefore, that overlooks this constraint is bound to be fraught with challenges. Research has shown that structural vulnerabilities that are a result of social, legal, power, or political inequalities often prevent people from effectively engaging in solving community health problems (Malik, 2014).

Interventions like the AYFS programme in primary health care clinics need to engage cultural and local members in continued dialogue to identify solutions to structural challenges like the lack of privacy at the clinic. Cultural factors constitute an important aspect when it comes to the use of health programmes like AYFS. “Cultural factors affect the uptake health care” (Simkhada, Teijlingen *et al.* 2008), and in South Africa particularly, culture is an important concept that influences the way people live, as well as their belief systems (Tsawe and Susuman 2014).

Consequently, this gives rise to the quandary that if the AYFS is seen to be a necessary strategy to curb the challenge of adolescent pregnancy and high HIV rates, how can it be promoted within contexts where such cultural complexities exist? The CCA to health communication refutes the culture-as-barrier approach, where local cultures are seen as barriers to be overcome through the imposition of Western values (Dutta 2008). Instead, the CCA proposes that the voices of AGYW should be central in achieving meaningful change. A cultural understanding of this phenomenon of AGYW avoiding health care facilities and communication on sexuality with nurses may be pointing to a limitation of the dominant cultural system where AGYW are expected to be open when communicating with nurses on SRH issues

Hygiene

The characteristics of a youth-friendly clinic include a health facility, where health service delivery has an appealing and clean environment (World 2012, Desiderio 2014). Adequate water, sanitation and hygiene (WASH) are essential components of providing basic health services (WHO and Unicef 2015). The provision of WASH in health care facilities serves to prevent infections and spread of disease, protect staff and patients, and uphold the dignity of vulnerable populations including young pregnant women. This joint WHO/UNICEF report shows that globally, provision of WASH services in health care facilities is low, and the current levels of service are far less than the required 100% coverage by 2030. The report also notes that large disparities in WASH services in health care facilities exist between and within countries including South Africa. There is a paucity of information on the WASH at health care facilities in South Africa. AGYW in this study highlighted the importance of sanitation and hygiene in health care clinics where they access HIV and SRH health care. One participant noted how the lack of hygiene in the clinic affects her, she said:

“As a woman we are taught that when you are using the toilet you must sit on the toilet sit and not stand cause there will be urine that won’t come out. The urine causes an infection in the bladder of a woman. Us pregnant people, we are always going to the toilet. Imagine you get here and you can’t sit on the toilet sit. The toilet is appalling. You will always have to squat when urinating and the urine stays in your bladder” (P5, Mphophomeni, September 2018).

Although the participants were able to follow what they were taught by nurses at the clinic, concerning hygiene, especially during a pregnancy. The lack clean toilets was a barrier for them in exercising good health practice. “Unsafe water and sanitation and poor hygiene practices in health care facilities lead to health-care-acquired infections” (Mulogo, Matte *et al.* 2018). Previous studies also show that compliance with hand washing standards in health care facilities like clinics is often low. As a result, health care facilities are a source of infection and patients seeking treatment fall ill, and potentially die, for the lack of basic elements of a safe and clean environment (Mulogo, Matte *et al.* 2018).

A study conducted in rural Uganda, with the aim of evaluating the sanitation and hygiene in public health care facilities, including public hospitals found that only 38% of the health care facilities visited by local community members had the floor of the toilets clean (absence of litter, urine, or fecal matter) (Mulogo, Matte *et al.* 2018). The majority of health facilities (98%) lacked cleaning materials in the toilets (Mulogo, Matte *et al.* 2018). The frequency with which the toilets are cleaned at most of the health care facilities (66%) was every other day (Mulogo, Matte *et al.* 2018). The toilets at the majority of health facilities (74%) were cleaned by hired cleaners. However, at 6% of the health care facilities, the toilets are cleaned by patient caregivers (Mulogo, Matte *et al.* 2018). At the majority of the care health care facilities (86%), the toilets could close and lock. The capability to close and lock the toilets was significantly associated with cleanliness of the toilet floor (Mulogo, Matte *et al.* 2018). The findings from this Ugandan study demonstrate critical gaps in the provision of hygiene in health care facilities that need to be addressed to ensure full realization of health care programmes like AYFS.

As stated in CCA, the health beliefs, values and meanings are in continuous flux with the broader macro structures surrounding them (Dutta, 2008). HIV and SRH health care among AGYW in rural communities like Vulindlela goes beyond their knowledge, attitudes and sexual risky behaviors, but it is being further influenced by their ability to negotiate the structures within which they find themselves. The basic universal health care requisite of prevention of risk, whether preventing HIV or unplanned or unwanted pregnancies. Health care requisites needs to be met, before sustainable uptake of health care services can be met.

The content, medium, and style of the messaging must suit different societal contexts because audiences differ as to their assumptions, attitudes, self-efficacy, and receptivity to messages from health practitioners (Vermund, Van Lith *et al.* 2014). Similarly, the design of health care programmes like AYFS must also differ as to suit different societal contexts and groups of people. Therefore, culture, language, religion, education, gender, age group, socioeconomic status, level of trust, degree of social isolation or integration, social norms, and other elements in a person's background and social context shape a person's behavior and their response to key health issues (Vermund, Van Lith *et al.* 2014). Therefore, members of stigmatised or marginalized

subpopulations may respond differently to messages and programmes than would persons from the majority subpopulation (Vermund, Van Lith *et al.* 2014). This accounts for the importance of hearing the voices of AGYW from rural contexts, to understand their own perceptions about youth-friendly HIV and SRH services in primary health care clinics and how they want to receive these services.

In order to minimise the risk of health-care-acquired infections among AGYW who are already a vulnerable key population group, efforts to improve hygiene in primary health care facilities should give prominence. Priority should be given to the sustainable provision of hygiene amenities such as soap for hand washing particularly in the high patient volume health care facilities like the local clinics in Vulindlela. These efforts should be complemented by ensuring the availability of toilet facilities that are clean on a regular basis. Overall, availability of AYFS can be improved by institutionalisation of maintenance plans that would assist AGYW to adhere to HIV and SRH health care provided for them.

Transport and Traveling

The characteristics of a youth-friendly structure is one that is in a convenient location; where local community members can easily gain access. Distance and the travelling to health care facilities is one of the major barriers to health cares, more especially in rural communities in South Africa, where primary health care clinics are often located further away from a large number of residents. In order to receive adequate health care, rural residents have to travel long distances. The lack of transportation and prohibitive costs is one of the obstacles that AGYW in rural community's face when accessing HIV and SRH services at the clinic. The location of the clinic structure is sometimes central only to a few residents. In rural communities like Vulindlela, the clinic does not only service immediate local residence, but also the communities surrounding. Therefore, some of the participants in this study expressed the financial challenge of transportation attached to her accessing the health care clinic for HIV and SRH related issues.

To come to the clinic from home can take me an hour walking, transport moves every hour. And sometimes I do not have the money for transportation” (P3, Caluza, November 2018).

We walk to the clinic, if we miss the bus then we have to walk. The bus is the only transport that is early to the clinic” (P17, Mafakatini, August 2018).

Both these participants expressed that the lack of transportation to transport them from where they live, to the clinic was a hinderance for the. This is similar to a study conducted in a rural community in the Eastern Cape province in South Africa, reported inadequate use of maternal health care services among adolescents due to the accessibility of the health care clinic (Tsawe and Susuman 2014). This study found that the distance and the time adolescents use to get to the clinic is one of the major barriers to health care use (Tsawe and Susuman 2014). It is common for health care clinics in rural communities to be located further away from a large number of residents (Mosala, Shisana *et al.* 2005). The negative result of this is also expressed by health care nurses in the current stud. Nurses acknowledged that due to the distance, travelling costs and the lack of financial support for AGYW, it was not easy for the clinic to maintain the appointment scheduling system. The appointment system was a strategy designed to improve the long waiting hours, the lack of privacy and confidentiality between nurses and AGYW. The young women were mean to come in at set times, without having to wait where they could be seen. But the nurses in the current study revealed that:

“With the youth attending AYFS, there is transport issues in this area... when we were doing appointment system which is where we book clients for that day and we allocate time for each of them. We couldn’t allocate time because they had transport problems, they could not arrive on time while I am still at AYFS area. The youth will come when I am somewhere else already and they are forced to wait” (N1, Mafakatini, June 2019)

In a study conducted in urban Johannesburg, South Africa, nurses complained that young women did not turn up for ante-natal care appointments because these times conflicted with school attendance (Pillay, Manderson *et al.* 2019). Another study with

similar findings was conducted in rural Australia reporting that an added barrier to health service that limited young people's willingness to seek help was the location of the clinic (Johnston, Harvey *et al.* 2015). In Australia, these access issues are magnified for young people from low socioeconomic backgrounds and those living in non-urban areas (Johnson, Bukachi *et al.* 2007). Transport barriers included infrequent bus services, expenses related to public transport.

Theme Two:

Services at the primary health care clinic

In multicultural societies, it is becoming essential for healthcare professionals to be able to provide culturally competent care due to the results of enhanced personal health (Suh 2004) as well as the health of the overall population. The greater the overall knowledge a health practitioner has about cultures, the better their ability is to conduct evaluations and in turn provide culturally competent suggestions to patients. Purnell's model of cultural competence (Purnell 2002) requires the healthcare worker or health caregiver to contemplate the distinct identities of each patient and their views towards their treatment and care (Albougami, Pounds *et al.* 2016). For example, adolescent youth-friendly services (AYFS) that are effective in primary health care clinics for AGYW, require health care nurses that are able to provide culturally competent HIV and SRH services. The ability to provide these services requires an understanding of the diverse identities of AGYW within each cultural context.

The manner in which health care services are delivered for AGYW in primary health care clinics is increasingly recognised as a priority. The AYFS programme has been promoted in South Africa by the National Department of Health (NDoH), as a means of standardising the quality of adolescent health services (Dickson-Tetteh, Ashton *et al.* 2000, Dickson-Tetteh, Pettifor *et al.* 2001). However, little is known about how successful they have been and how much primary health care clinics have aligned themselves for AYFS. Improving the quality of health services tailored to the needs of AGYW, has the potential to address some of the challenges resulting from the burden of disease associated with AGYW engagement in risk sexual behaviours. Nevertheless, this requires transcultural nursing practice in primary health care clinics.

These are nurses who are able to focus on promoting and maintaining the cultural care needs of individual patients. “Nurses who are prepared in transcultural nursing know how to identify and provide for diverse cultures. They learn ways to discover and provide safe and meaningful care to people of diverse cultures” (Leininger, McFarland *et al.* 1987).

Since nurses remain the largest health care providers in South Africa, they have a unique opportunity to learn about individual cultures of patients and providing health care within their environmental contexts. Cultural competency in healthcare systems can be manifest in three distinct ways: *organizational*, focusing on the hiring and promotion of culturally diverse staff; *systemic*, focusing on eliminating institutional barriers to care and improving the healthcare systems ability to monitor and improve the quality of care; and lastly, *clinical*, focusing on enhancing health professionals’ awareness of cultural issues, beliefs, and to introduce methods to elicit, negotiate, and manage this information (Betancourt, Green *et al.* 2002). Although organizational and systemic cultural competencies are important, there is an emphasis on the need to train practitioners as they interact directly with patients (Betancourt, Green *et al.* 2002).

AGYW access a range of HIV and SRH services from primary health care clinics, including counselling around healthy sexuality and safe sex. The delivery of these services in clinics is often performed by nurses. Therefore, nurses have a pivotal role in the manner health care services are delivered to AGYW in primary health care clinics. Participants in this study highlighted some of the challenges related to health care service delivery, which often includes nurses in the clinic. The AGYW highlighted the most pertinent issues, like the *nurses attitudes*, *nurses age* and the *clinic being the last source of information*.

Clinic last source of information

A primary objective of comprehensive sexuality education is to increase knowledge and enable young people to make informed decisions related to sexuality and reproductive health, thereby increasing their preproperate utilisation of services (Pillay, Manderson *et al.* 2019). According to the WHO (2012) youth-friendly guidelines, health care clinic should provide information and education through a

variety of channels. The health care clinic should display information and health education materials on issues related to HIV and adolescent sexual and reproductive health (Desiderio 2014). AGYW in the current study indicated that the health care clinic was not the first and trusted source for HIV and SRH health information.

Before I go to the clinic, I need to first do a good Google search of what is wrong with me. I need to go to the clinic knowing and understanding because at the clinic they will not explain to me” (P17, Caluza, November 2018).

Considering the attributes of cheapness, availability, ease of use and confidentiality of online resources, adolescent information needs may better be served by the internet, which allows them to explore sensitive topics online which they may not want to reveal to parents, physicians, school officials, or acquaintances (Nwagwu 2007). However, where health care services are provided within their environmental contexts, AGYW in Vulindlela may not require the internet as the first source of information. The option of doing research before accessing the health care clinic for HIV and SRH services among AGYW, does not depict a lack of information available at the clinic, because nurses confirmed that the clinic has an array of information packages and staff that can explain.

“We offer family planning services, HIV testing and counselling. We also now offer Oral PrEP. Beyond this, we offer life coaching talks, about safe sex, careers and decision-making skills for the youth” (N3, Caluza, June 2019).

“We offer talks, during the happy hour. The ones from school come the most. We have to teach them about life and making decisions. Some don’t know and they do not have mothers at home” (N2, Mphophomeni, September 2018).

There’s a visible variance between what AGYW report lacking concerning information at the clinic and what nurses are reporting. Perhaps, this is an interplay rooted on what (Koenig, Dutta *et al.* 2012) mean when explaining that voices are important. In the South African context, AGYW are becoming more complex to understand due to the changes they experience, causing this population to become more diverse and more challenging to understand. Health care nurses need to understand the culture of

AGYW and how their culture informs their meaning making process. Essentially, transcultural nursing provides nurses a new way to learn about and provide culturally congruent and meaningful care to people in various communities.

It is a new and different pathway for most health care nurses from their traditional nursing orientations and modes of helping people. At the present time, health care nurses must learn about and respect different cultures and their care needs in different life contexts to be transcultural nurses (Leininger, McFarland *et al.* 1987). Therefore, health care nurses as the direct care providers in primary health care clinics that offer HIV and SRH services to AGYW must be prepared to function with transcultural nursing knowledge and competencies to ensure beneficial outcomes to people of different cultures. For without such preparation in transcultural nursing, nurses will be greatly handicapped, disadvantaged, and culturally ignorant to help people of different lifeways, beliefs, and values. Cultural competence will not be reached.

Nurses attitudes

There is extensive literature on discord in the relationship between nurses and patients, particularly young women, and the barriers to HIV and SRH services this presents (Wood and Jewkes 2006, Holt, Lince *et al.* 2012, Alli, Maharaj *et al.* 2013, Geary, Webb *et al.* 2015). Young women often anticipate sanctions from nurses, reflecting community attitudes towards early, unintended pregnancy (Pillay, Manderson *et al.* 2019). Stigma and discrimination, personal beliefs and health system challenges, including overcrowding and limited space capacity at the clinic, provided fertile ground for these attitudes to flourish and become deeply entrenched (Pillay, Manderson *et al.* 2019).

In the current study however, AGYW and nurses both acknowledge nurses attitudes as an impeding factor for AGYW when accessing the clinic for HIV and SRH services. This study discovered from both the AGYW perspective and the nurses perspective that nurses attitudes is a combination of experiences and challenges. AGYW felt that nurses don't talk to them, some felt nurses did not make efforts to make them feel important and special, while others described the body movement and facial expressions of nurses as an 'attitude'. Nurses also reflected their complex position by

the often contradictory ways in which they described their opinions about experiences working with young women.

A similar narrative concerning the unfriendliness of nurses (Jonas, Roman *et al.* 2019) was reported by AGYW in the current study.

“Nurses in the clinic are unfriendly, they don’t have time for us, they sometimes make us un-special, feel as if we don’t belong. We are sometimes scared to ask anything from them. We are always scared of them” (P4, Mphophomeni, September 2018).

“At the clinic they must find nurses who will sit them down and explain to them how to take care of a baby and what you must do once you find out you are pregnant” (P8, Mafakatini, August 2018).

The nurses in this study, then, raised factors that AGYW are usually not aware of them when accessing the clinic. It was evident that nurses were aware of their role towards the AGYW and the AYFS programme at the clinic. However, the issue of services was hindered by macro level structural issues like shortage of staff members, the lack of qualified clinical nurses who can be available to meet all the needs of AGYW. Nurses reported, saying,

“I cannot be in one place, even if I want to focus on AYFS, because I am a clinical nurse. I am forced to move to serve in other programmes of the clinic...So, in one day I can be serving in more than one programme. “...you know young people don’t like waiting.” (N1, Caluza, June 2019).

Although the shortage of trained staff was a critical factor that contributed to their attitude towards AGYW. Some nurses were able to recognise that their attitude is not always accommodating AGYW who are seeking SRH services. Nurses felt that their attitude, is an important factor affecting AGYW’s access to and utilisation of SRH services.

“Some nurses are like mothers and can say- “you are so young, but you are sleeping with boys”, meanwhile she’s... Shutting the door and they won’t confess anything after that. It is important to be able to be open and listen as a nurse working in the AYFS programme ” (N3 Mafakatini, June 2019).

Purnell’s model of cultural competency (Purnell 2002) recognises that in multicultural societies like South Africa, it is becoming essential for healthcare nurses to be able to provide culturally competent care (Suh 2004). The greater the overall knowledge a health care nurse has about cultures and identities of patients, the better their ability will be to conduct evaluations and in turn provide culturally competent suggestions to patients like AGYW (Purnell and Paulanka 2003).

Since nurses remain the largest health care providers in South Africa, they have a unique opportunity to learn about AGYW’s individual cultures and providing health care within their environmental contexts. It is imperative that health care nurses understand the youth culture that informs AGYW’s understandings and conceptualisation of services delivery. All cultures have their own set of rules, values and morals by which those who are part of that culture are expected to live (Selikow, Zulu *et al.* 2002). Understanding the dynamics and nuances of any culture requires individuals to become deliberately competent (through learning about others’ cultures) so that they are able to apply personalised interventions (Whitman 2006).

Thus, it becomes vital for nurses to explore how cultural context impacts how “health meanings are constructed and employed in practice” (Dutta, 2008:1). With this culture-centered contextualization of AGYW in mind, this study situates AGYW as cultural bodies who transport their personal identities, social identities, and cultural experiences into the healthcare environment (Allen, (Allen 2011). Nurses need to understand these complexities in order to deliver services culturally competent for AGYW. It is the acceptance of the nurses role of understanding the persona identities of AGYW within their cultural and structural environments, that can contribute to youth-friendly HIV and SRH services in primary health care clinics.

Nonetheless, another study found that nurses perceive certain behaviours of adolescent girls as irresponsible and warrant their negative attitudes and reactions

toward them (Jonas, Roman *et al.* 2019). In this study, nurses expressed that there is a level of carelessness among adolescents they sometimes have to confront and risk being labelled as unfriendly and judgemental. Nurses reported that adolescent girls' non-compliance with proposed services, like family planning regimen is one of the most frustrating irresponsible behaviours in SRH health care services (Jonas, Roman *et al.* 2019). The nurses explained how they often dwell on the importance of compliance when AGYW come to initiate family planning use (Jonas, Roman *et al.* 2019). This non-compliance behaviour also has an influence on how the nurses treat adolescent girls who continue to miss their follow up appointment, as they reported to use harsh and unfriendly attitude towards the young woman who continues to miss their follow up appointment (Jonas, Roman *et al.* 2019).

Given the complexity of adolescent sexuality and the barriers highlighted between AGYW and health care nurses, this study has established the importance continuous upskilling of nurses in providing AYFS (Mulaudzi, Dlamini *et al.* 2018). Nurses in the current study stated that they had received limited or no training in counselling and delivering AYFS to AGYW (Mulaudzi, Dlamini *et al.* 2018). Therefore, nurses attitudes in primary health care clinics are confounded by the structural barriers within government and policy level limitations.

Nurses Ages

The issue of nurses age was raised by AGYW in this study after discussing nurses' attitudes towards them when accessing the primary health care clinic for HIV and SRH related issues. The AGYW expressed that it was often difficult to be open about their sexual lives to nurses that were older, likening them to their mothers at home. This is similar to the subtheme *lack of communication*, categorised within this chapter, where AGYW expressed that it was challenging for them to forge effective communication with health care nurses due to cultural beliefs and seeing them as elders rather than health care nurses. Here, AGYW liken nurses to their mothers because of the age gap between them. Mothers from the African cultural context report socio-cultural and sometimes religious limitations from providing meaningful sex-education to the pre-adolescent and adolescent daughters at home (Gumede 2017).

AGYW in a study by (Smith, Marcus *et al.* 2018), expressed that they wanted tailored information and for services to be directed at their specific developmental stage. Young women felt that the staff would be more encouraging if they were open to listening to young people, if they had the ability to connect with common issues faced by adolescents (Smith, Marcus *et al.* 2018). “Didactic and punitive commands issued by clinic staff were specifically noted as being unhelpful” (Smith, Marcus *et al.* 2018). The young women in this study suggested younger staff and possibly peers to act as guides to help navigate the services was also made (Smith, Marcus *et al.* 2018).

The AGYW in this current study also noted the need for younger nurses who would disseminate information in an appropriate manner for their age and tailored needs. Dutta, (2008) states that agency is achieved when adolescent females have the ability to enact their choices and participate actively in negotiating the structures which surround them (Dutta 2008). Although nurses ages in primary health care clinics is a cultural hindrance to AGYW accessing HIV and SRH related services, it has also handed over agency for AGYW to discuss the impact of having older nurses at the clinic. Through the use of dialogue, this study hopes to give agency to AGYW, as they have the capacity to be actively involved in identifying health-related challenges experienced in their community, and consequently also have the opportunity to actively confront the structures within their community.

This finally produces a cosmos where communicating for social change has an opportunity to be carried out. “From the standpoint of praxis, the culture centred approach stresses the need to develop respect for the capabilities of members of marginalised communities to define their health needs and to seek out solutions that fulfil their needs” (Dutta and Basu, 2011: 331). The core of CCA in this study is understanding that AGYW have the ability to identify their HIV prevention and SRH needs and the ability to be catalysts in providing their own health-related solutions to problems they face. This is also at the center of AYFS. This study advocates for AYFS within primary health care clinics to be to a discursive space where AGYW can facilitate the process of solving their own challenges and describe and prescribe their own solutions. Concerning the need for younger nurses, AGYW in this study had similar views to the young women in the (Smith, Marcus *et al.* 2018) study:

“Even though some of the old nurses are good, but I cannot be open about my sexual life to them and ask the information I need” (P14, Caluza, November 2018).

“Sometimes the nurse will look at you as if they are your mother and you will feel like they are your mother...and then I am scared of saying anything to her” (P7, Mphophomeni, September 2019).

The AGYW quoted above highlight the barrier of having older nurses to deliver SRH services. Nonetheless, the nurse from Caluza clinic was within the age range recommended by adolescent girls

Theme Three:

Organisation of the primary health care clinic

There are large evidence gaps on how the organisation of the clinic should be organised to integrate AYFS with well-established clinic services such as maternal and child health and the treatment of acute infectious diseases (Dodd, Palagyi *et al.* 2019). Further efforts are needed to advance the organisation and provision of equitable care in primary health care clinics (Hirschhorn, Langlois *et al.* 2019). According to the CCA, structure encompasses a wide spectrum of services critical to the healthcare of cultural participants such as medical and transport services, diet and shelter among others. Structures that impact on the lives of subaltern communities operate at several levels; these are micro, meso, and macro levels (Dutta 2011). Agency on the other hand, refers to the capacity of people to interact with structures in order to create meanings (Dutta, 2008:61). Such meanings provide scripts for the marginalised, not only to interact with the structures but also to sustain and transform them. The concept of agency reveals the dynamic processes individuals, groups, and communities engage in as they interact with the structures whose impact is either to constrain or enhance the lives and health of cultural members. The organisation of the primary health care clinic is context driven and deferrers in each local community. AGYW in this current study have highlighted key issues that hinder their ability to interact within the clinic structure.

Therefore, there is also a need to understand better how to ensure the core service delivery functions of clinics, particularly in local communities, are linked to desired outcomes of patients. Meaning that structures must respond to the, handing over agency in defining how the primary health care clinic should be organised. AGYW in this study, raised critical issues related to the way primary health care clinics should be organised for HIV and SRH related services to be youth-friendly. They highlight issues concerning the organisation of the primary health care clinic is *administration, time management, lack of communication, and lack of medication*.

Administration

The issue of administration in the current study was a crucial aspect of youth-friendly health care services. AGYW highlighted that the lack of administration at the clinic contributes to their reluctance in attending the clinic for HIV and SRH care services. AGYW discussed that detailed steps should be followed to in order to achieve every element of systematically improving and correcting deficiencies, like administration in primary health care clinics. A study (Hunter, Chandran *et al.* 2017), highlighted that part of the administration at the clinic should include information points that inform the community on the location of the clinic, services, service hours, and contact details of the clinic (Hunter, Chandran *et al.* 2017).

What the study emphasised, is the importance of administrative changes within the primary health care clinic that have the potential to improve health care services delivery. Administrative changes such as sign posting services areas including reception and toilets within the facility. Moreover, the clinic should have a single patient record; a single location for storage of all patient records; patient records should be filed in close proximity to patient registration desk (Hunter, Chandran *et al.* 2017). The administration of the clinic among AGYW in the current was imperative.

“People who sit and wait at the waiting area are older people. When you ask them when they got to there, they will tell you that they got there early in the morning. They haven’t even received their files and have not been attended but

it almost time for the health workers to leave work” (P16, Caluza, November 2018).

“The clinic there needs to be way to schedule times to work...times that everyone will stick to so that things can move faster. If things were moving fast, maybe no one would see that you have been in the clinic” (P10, Mafakatini, August, 2018).

The administration and order at the clinic have a direct impact on the acceptability of health services provided. The AGYW in this study expressed that the lack of order at the administration level impedes them from accessing the clinic and being able to exit early, without being seen by community members. AGYW suggested that there should be standardised patient record filing system in place so that when they arrive, they do not need to wait at the clinic for hours to receive a file and instructions of where to go and where to wait. “To reassure teenagers of competence, providers should keep diplomas and certificates displayed; and to alleviate perceptions of racism, sites should post signs that clearly explain why patients are sometimes seen out of order” (Ginsburg, Menapace *et al.* 1997).

Lack of Communication

The CCA examines the communicative processes by which marginalization takes place in contexts and the ways in which health risks and vulnerabilities are constituted amid material inequalities in distributions of resources (Dutta 2008). The main point raised by AGYW was that they don't know how to communicate with nurses and nurses also highlighted that there are points where there is a disconnect in how they communicate with AGYW. One participant describes what her communication is like when she visits the health care clinic for SRH.

Since I know that you don't look at an elder in the eyes, I keep my eyes to the wall or I look down. When the nurse come, you show them the card and tell them that you are here for family planning, she takes the injection, cleans it and looks the other way...then she will use the pump...you then leave...they don't

tell you about other things or ask you if you want to do something else” (P14, Caluza, November 2018).

The above finding highlights a common cultural practice of not looking at elders in the eyes, even if they are health care nurses and not parents. Although the clinic is a health facility, and organised by professional services, the cultural beliefs of AGYW were influential in how they perceived communication with nurses. This is a common norm and belief among black South Africans Nguni cultures, particularly the IsiZulu culture, that when you are young, you cannot look at your elders in the eyes. This cultural act inhibits the necessary communication between nurses and AGYW, creating a barrier in a platform where they should receive tailored HIV and SRH services. According to the CCA, structure refers to those aspects of social organisation “that both constrain and enable the capacity of cultural participants to participate in communicative platforms and in utilizing the fundamental resources of mainstream societies (Acharya and Dutta, 2013: 226; see also Dutta-Bergman 2004).

The lack of communication between nurses and AGYW at the clinic proves that structural barriers still play a critical role in shaping the context of vulnerability that either contributes to increased individual risk of exposure to HIV or compromises the ability for AGYW to protect themselves from infection (Gupta, Parkhurst *et al.* 2008). Where (Kourkouta and Papathanasiou 2014) states that effective communication requires an understanding of the patient and the experiences they express. It requires skills and simultaneously the sincere intention of the nurse to understand what concerns the patient (Kourkouta and Papathanasiou 2014). He continues to state that to understand the patient only is not sufficient but the nurse must also convey the message that he/she is understandable and acceptable (Kourkouta and Papathanasiou 2014). Purnell’s model of cultural competence offers a basis for nurses providing care to be ensure that they are understood and accepted by patients. The model assists nurses to gain knowledge around concepts and features that relate to various cultures in anticipation of providing and performing culturally competent care in clinical settings (Purnell 2002). The model explains that culture is the unconscious ways learned within our families, in which we develop our behavior, values, customs, and thought characteristics that guide our decision making and the way we view the world around us (Purnell 2002, Harris 2003).

In some cases, the cultural norms and beliefs have perpetuated the stigmatising of AGYW's sexuality and sexual behaviours by nurses. The authority gained from such cultural perspectives leads nurses to the unwillingness to acknowledge adolescents' experiences, which ultimately undermined the effectiveness of contraception (Wood and Jewkes 2006) and HIV prevention methods available for them (Bogart, Chetty *et al.* 2013). From a health care nurses perspective, and in the context of communicating with AGYW at the clinic, Purnell's model of cultural competence provides a framework for all nurses, to define circumstances that effect a person's cultural worldview. It interrelates characteristics of culture to promote of consciously sensitive and competent health care. Therefore, good communication between nurses and patients is essential for the successful outcome of individualized nursing care of each patient (Kourkouta and Papathanasiou 2014). Structural challenges that inhibit AGYW should also be considered in line with how health care nurses understand and accept the need for culturally competent health care provision.

Studies conducted with rural AGYW showed that rural young women were equally discreet to discuss HIV and SRH related issues with nurses at the clinic, but this lack of communication was related to restrictive gender and cultural norms in general (Izugbara and Undie 2008, Wamoyi, Wight *et al.* 2010), and not to specific cultural practices as found in the current study. In this study, AGYW explained their experiences of communicating with nurses in the context of cultural meanings and values that they have grown up with, which challenged how they translate their HIV and SRH related needs to nurses.

Studies in other contexts have revealed that "socio-demographic factors such as sex, age, level of education, religious affiliation and other household characteristics such as family size and marital status of nurses play a role in determining the occurrence of nurse-patient communication on HIV and SRH related issues" (Bastien, Kajula *et al.* 2011). In the same study, issues of lack of communication skills and information on sexuality were cited as barriers that prevented nurses from communicating with AGYW on issues of sexuality (ibid:14).

Health care nurses' cultural beliefs strongly impact on how they treat and communicate with AGYW adolescents – the belief that women shouldn't have sex before marriage,

for example (Holt, Lince *et al.* 2012). Furthermore, a lack of specific youth-friendly training and dedicated space for youth services were reported as a barrier to HIV and SRH services (Dickson- Tetteh *et al.* 2001; Geary *et al.* 2014). The underlying gap in the health care system's ability to deliver age-appropriate services for adolescents became evident with the increasing HIV prevalence in South Africa (Mburu *et al.* 2013). These barriers needed to be addressed in order to improve the nurse-patient relationship.

Lack of Medication

Shortages of essential medicines are a daily occurrence in many of South African public health facilities (Hodes, Price *et al.* 2017). More especially in rural clinics, there are no dispensary's, the medicines are managed by a nurse who serves as the clinics' operations manager. The clinics in rural communities have no pharmacists or pharmacy assistants, whereas, in some urban clinics there are.

The study (Hodes, Price *et al.* 2017), was conducted in the Eastern Cape province, South Africa. The researchers found that the nurses at the clinic would often contact other clinics in the district and borrowed certain medications to avoid turning patients away without their medicines. In another study, the negative perceptions of adolescent girls concerning the lack of medication stemmed primarily from interactions with service staff and the non-availability of resources (Schrivver, Meagley *et al.* 2014). Therefore, the current study found that the lack of medication was both a challenge to health care nurses in primary health care clinics. The study found that because of the frequent drug stock-outs, clinics often only offered basic medications such as antibiotics or generic painkillers like Panado© which are readily available at small shops and supermarkets within the community (Schrivver, Meagley *et al.* 2014). In the current study, participants reported the same issues concerning the lack of medication in health care clinics in Vulindlela.

"The only thing that they gave me are only Panado© " (P14, Caluza, November 2018).

"They just say that there are no pills, it better to just go to the doctor straight" (P5, Mafakatini, July 2018)

Participants in the current study and in (Schriver, Meagley *et al.* 2014) felt that going to a clinic was an unnecessary step that did not always result in better outcomes. At times, patients are advised by nurses or community healthcare workers at the clinic to travel to other facilities presumed to have better stocks (Hodes, Price *et al.* 2017). Through trial and error, in both studies (Hodes, Price *et al.* 2017) and (Schriver, Meagley *et al.* 2014), patients had themselves ascertained which facilities reliably stocked the medicines they needed, and sought healthcare there despite greater travel and time costs. Since there a wide range of factors that can be defined as structural, including governance, policy and legal aspects. Health care nurses in this study responded to the lack of medication by highlighting it as a provincial and governmental challenge, a challenge that is beyond their control.

“The medication will sometime be delivered late to the clinic, even if the order was requested on time. In that case, there is nothing we can do, there is nothing we can prescribe the clients at the clinic. The only way is to refer them to clinics we know have medication (N3, Mafakatini, June 2019).

With an emphasis on the processes of erasure of diverse voices, the CCA asks the question: What are the processes, strategies, and tactics through which the voices of subaltern communities are erased? The access to communicative spaces, platforms, strategies, and tools is shaped within material structures, thus shaping messages, processes, and discourses within the agendas of powerful political, social, and economic actors with economic access to resources (Dutta 2019). The disenfranchised, with limited access to the communicative spaces and to the spheres of voicing, are often absent from the discursive spaces where health policies and programs are discussed, the sites where interventions are planned, and the processes where communicative strategies targeting them are carried out (Dutta and Pal 2011, Dutta 2019). The agency of the subaltern is erased from the sites of recognition and representation where policies are debated, decided upon, implemented, and evaluated (Dutta 2008). In line with this study, AGYW are frequently the target of public health policies and programs, yet policies and programmes often do not reflect their voice (Penazzato, Lee *et al.* 2015). The lack of medication is a structural constrain that limits AGYW from taking control of their own health.

Although literature globally and in South Africa highlights the crucial role of the AYFS programme (Mmari and Magnani 2003, Erulkar, Onoka *et al.* 2005, Tylee, Haller *et al.* 2007, Brittain, Williams *et al.* 2015, Callie Simon 2015, Geary, Webb *et al.* 2015, Thomée, Malm *et al.* 2016, Saberi, Ming *et al.* 2018). It is equally important to engage and listen to the young people whom the intervention is designed for.

Conclusion

There is a critical need for more research exploring the tailoring of health care delivery to the unique and complex needs of AGYW. In this study, youth-friendliness in primary health care clinics for HIV and SRH services is the point of enquiry. This study set out to discuss the findings of what ‘youth-friendliness’ means to the AGYW in Vulindlela and what constitutes an AYFS clinic based on their own experiences. AGYW in this study were all users of the local primary health care clinics in Vulindlela for HIV and SRH services. The AYFS programme had been initiated in all three clinics where this study was conducted. Together with the health care nurses, AGYW referred to a youth-friendly clinic as one that able to meet basic structural, organisational and service related health care needs like medication, privacy, confidentiality and hygiene.

Most AGYW in this study spoke strongly about structural, organisational and service related health care needs that had a direct impact on the AGYW’s experiences of going to the clinic for HIV and SRH services that are youth-friendly. Although the nurses highlighted the services and the prevention packages available at the clinic, the accessibility, acceptability, equitability, appropriateness and effectiveness of these services were hindered by local and community based issues related to the structure at the clinic, the organisation and the services delivered at the clinic.

The nurse-patient relationship, which is connected to nurse’s attitudes, nurse’s ages, and other factors became evident as the main factor that was most important for AGYW in the clinic. AGYW felt that nurses in the clinic are responsible for communicating with them, delivering timely services, preserving their privacy and confidentiality. This was the general expectation of AGYW in this study. However, nurses did not always understand that it is within the contextual and localised environments that you can be able to understand them.

The AYFS programme in South Africa is one of the few to have been scaled up to a national level with the aim of providing HIV and SRH services to a key population like AGYW. Nonetheless, there is often no evidence that clinics providing the AYFS programme provide a more positive experience to clients, or were more likely to be recommended by clients to their peers, than those not providing this programme. Therefore, it is important to explore the youth-friendliness of AYFS from young people's context and local experiences of how these services influence HIV and SRH care for them.

Chapter Seven: Local voices speak out: a localised approach to youth-friendly services.

Introduction

The previous chapters in this study presented and analysed data concerning primary health care clinics that offer youth-friendly HIV and SRH services for adolescent girls and young women (AGYW). The findings revealed many aspects of youth-friendliness that are important for AGYW in rural KwaZulu-Natal (KZN), Vulindlela. This study aimed to investigate whether primary health care clinics offer youth-friendly HIV and SRH services to AGYW. Data revealed that AGYW in Vulindlela had specific challenges when accessing the primary health care clinic for HIV and SRH services. Multiple studies have been conducted in KZN, presenting the province and some of the districts to be the epicentre of HIV. But a few studies of those studies have evaluated youth-friendly services from a user's perspective. Furthermore, there are even fewer published studies describing conceptual models for designing and sustaining uptake of health care services in primary health care clinics. This chapter offers a contribution towards filling this gap, by describing the development of a generic model that places communities at the center of interventions designed for them.

Contextualising AGYW in South Africa

There are various accounts in literature why the HIV rates and the SRH of AGYW should be considered. The context of the high prevalence rates among AGYW in South Africa, KwaZulu-Natal is linked to multiple vulnerabilities faced by AGYW. Physiological vulnerability (Stoebenau, Nixon *et al.* 2011, Mavedzenge, Luecke *et al.* 2014); peer pressure; engaging in risk-taking behaviour; less ability to negotiate safer sex practices (Ranganathan, Heise *et al.* 2016); and challenges in accessing HIV and SRH related services that are context specific (Baloyi 2006, Delany-Moretlwe, Cowan *et al.* 2015, James, Pisa *et al.* 2018). In addition, HIV infection and early, unplanned and unwanted pregnancy threaten the health of AGYW more than any other age group (Bearinger, Sieving *et al.* 2007).

AGYW within the South African context are further disadvantaged and made vulnerable by the differences in gender norms and pressure to engage in transactional

sex for economic reasons (De Oliveira, Kharsany *et al.* 2017, Kilburn, Ranganathan *et al.* 2018, Ranganathan, Heise *et al.* 2018). AGYW who are in intergenerational relationships are also less likely to have negotiating power in the relationship (Bearinger, Sieving *et al.* 2007, Wamoyi, Wight *et al.* 2010). Barriers such as stigma, and negative attitudes of health care nurses in primary health care clinics have all contributed to the high rates of HIV and among AGYW in South Africa.

Therefore, the significance for investing in the HIV and SRH care of AGYW is that changing the behaviour of young people provides the greatest opportunity for intervening against HIV and other SRH related vulnerabilities. Research has shown that the few countries that have successfully decreased national HIV prevalence among AGYW, those that have made progress, have done so mostly by encouraging AGYW to be at the centre of designing and implementing HIV and SRH interventions like AYFS developed for them (Chamie, Eisman *et al.* 1982, Tanner, Philbin *et al.* 2014, Smith, Marcus *et al.* 2018, Nkosi, Seeley *et al.* 2019). Sweden is an example of a developing country that has successfully integrated AYFS within the primary health care clinic, and offers acceptable and accessible AYFS according to the WHO quality framework that states that AYFS should be acceptable, accessible, appropriate, equitable and effective for AGYW in order to sustain AGYW as consistent clients. Research proves that the implementation and the success of the programme was understood within the broader context of the Swedish social and cultural norms concerning the youth (Thomé, Malm *et al.* 2016).

The generic model described in this study, stems from the theoretical foundations of this study, which states that marginalised community members like AGYW must be give the agency over their own health. Since AGYW are often disadvantaged and seen as 'passive victims' of the social structures that undermine their agency. In reality, social structures and AGYW's agency are intertwined and are mutually constituted (Giddens 1984). Neither the agency nor the social structures are independent of one another (Giddens 1984, Jones and Karsten 2008). Therefore, human agents depend on social structures for their action and their actions in turn serve to create and recreate the social structures (Jones and Karsten 2008).

Contextual background of AYFS in South Africa

In South Africa, the National Adolescent-Friendly Clinic Initiative (NAFCI) was developed as a significant investment in the HIV and SRH care for AGYW. The aim was to provide public health service managers and providers with a practical, achievable self-audit and external assessment process to improve the quality of adolescent health services at the primary care level, and to strengthen the public sector's ability to respond appropriately to adolescent health needs (Dickson-Tetteh, Pettifor *et al.* 2001).

The key objectives of the NAFCI was to make health services more accessible and acceptable to adolescents, to establish national standards and criteria for adolescent health care in clinics throughout South Africa and to build the capacity of health care workers to provide quality adolescent health services (Dickson-Tetteh, Pettifor *et al.* 2001, Baloyi 2006). One of the indicators for the success of the NAFCI was the increased utilisation of public sector clinics by adolescents. Additionally, the aim of the NAFCI was to work with primary health care providers in public health care clinics is so that the majority of young South Africans can access clinical services and information close to their homes (Dickson-Tetteh, Pettifor *et al.* 2001). Therefore, the NAFCI was formed out of the recognition that a successful sexual health campaign must be supported by health services that accommodate the needs of young people. NAFCI recognized that the public health sector is the most sustainable way of providing health services that can reach out to most adolescents (Dickson, Ashton *et al.* 2007). As a result, standards (*discussed in chapter Two of this study*) were developed to define “adolescent-friendly” services, tools were designed to measure the quality of the services, and quality improvement methods were introduced to assist in overcoming barriers to providing quality services.

The NAFCI was driven by a quality improvement approach. Quality improvement focuses on client needs as well as relying on data to make improvements in the system (Glynn, Caraël *et al.* 2001). This approach was facilitated by management; it was not management-driven. The driving force was a team, which is inclusive of youth; clinic staff and the community working together to achieve the goal (Dickson-Tetteh, Ashton *et al.* 2000). These quality teams were working towards responding to the needs of South African youth in order to decrease HIV, teenage pregnancy and STIs (Glynn,

Caraël *et al.* 2001). The tools and skills taught in the programme were universal and comprehensive rather than vertical (Geary, Webb *et al.* 2015). At the same time, focusing on youth was necessary to address specific health-care needs and the looming issues of the HIV epidemic (Glynn, Caraël *et al.* 2001, Dellar, Dlamini *et al.* 2015, Hargreaves, Delany-Moretlwe *et al.* 2016).

Nevertheless, recent studies show that almost two decades later since the development of the NAFCI programme for primary health care clinics in South Africa, the call for adolescent youth-friendly services in primary health care clinics remains (Dickson, Ashton *et al.* 2007, Geary, Gómez-Olivé *et al.* 2014, Geary, Webb *et al.* 2015). Policy makers, researchers and scientist in sub-Saharan Africa, have repeatedly emphasised the importance of adolescent youth-friendly health services and that these services must not only be “friendly but also supportive, providing a wide range of services and information (Mmari and Magnani 2003, Erulkar, Onoka *et al.* 2005, Tylee, Haller *et al.* 2007, Reif, Bertrand *et al.* 2016, James, Pisa *et al.* 2018, Mazur, Brindis *et al.* 2018, Saberi, Ming *et al.* 2018).

Dating back to the early 1990’s, when HIV acquired and accumulated the highest rates of infection among young people, studies have discovered that health care facilities that are not youth-friendly are a barrier to HIV prevention (Geary, Gómez-Olivé *et al.* 2014, Schriver, Meagley *et al.* 2014, Tanner, Philbin *et al.* 2014, Lee and Hazra 2015). Recommendations for creating youth-friendly services were made and highlighted as vital to reducing the number of new HIV infections among AGYW (Huntington and Schuler 1993, Bohmer and Kirumira 1997, Hughes and McCauley 1998, Mfono 1998, Speizer, Hotchkiss *et al.* 2000, Tylee, Haller *et al.* 2007). However, there remains a consistent scarcity of research available signifying the success of implementing youth-friendly services in primary health care clinics in South Africa (Geary, Webb *et al.* 2015).

Cultural contributions to AYFS in the South African context

Although the NAFCI relied on a participatory approach, using national and international consultation as well as focus groups with adolescents, to design the programme and develop the standards to determine whether or not a clinic could be defined as adolescent-friendly for adolescent-friendly health services. What was

missing from the inception and implementation of the NAFCI programme was the surveillance of contextual and localised factors within the cultural settings of the young people which the programme was designed for. Although various health services, like HIV testing and other SRH related services are made available for AGYW, cultural and structural factors also constitute an important aspect when it comes to the use of health care services (Tsawe and Susuman 2014). Within the South African context, culture is an important concept that influences the way people live, as well as their belief systems. Therefore:

“Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts” (Airhihenbuwa and Webster 2004).

Ali Mazrui defines culture as ‘a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society’ (Mazrui 1986). Robert Hahn emphasizes the role of culture and context in relation to sickness and healing, and highlights the use of language in the understanding of illness concepts (Hahn 1995). Furthermore, Howard Brody posits that one’s cultural belief system influences one’s social roles and relationships when one is ill (Brody 2002). Finally, Deborah Lupton (1994) postulates that the practice of medicine is a cultural production, particularly with respect to the focus on the body rather than the cultural and structural contexts that define and shape the body (Lupton 2012).

Culture has been identified as factor contributing to the HIV and AIDS epidemic, cultural beliefs around sexual practices have a direct effect on HIV prevalence (Airhihenbuwa and Dutta 2012). HIV and AIDS research recognise the importance of understanding the epidemic within the social and cultural context in which it exists (Auerbach, Parkhurst *et al.* 2011, Kippax and Stephenson 2012, Airhihenbuwa, Ford

et al. 2014, Kaufman, Cornish *et al.* 2014). It is this argument that forms the theoretical foundations of the culture-centred approach (CCA) in this study.

Theoretical consequence for model development

Culture is the main concept that drives the CCA, justifying the participation of community members like AGYW in the construction of meanings concerning their HIV and SRH care. Culture is constituted through the act of participation of local community members. Noted as a form of health disparity because it results in dramatically differential health outcomes in different segments of the population, HIV among AGYW is rooted in lack of participation in designing and constructing health meanings that are relevant to them. HIV and SRH services that are youth-friendly, are tied to structural and cultural inequalities in which AGYW find themselves at community level. (Dutta, 2008). On the basis of the argument that the erasure of the marginalised from decision-making platforms is intrinsically tied to their impoverishment and their lack of access to fundamental resources such as youth-friendly HIV and SRH services.

The CCA seeks to address health disparities by fostering opportunities for listening to the voices of the marginalised through a variety of participatory communication methods such as PhotoVoice exhibits (Dutta, 2008). The marginalised refer to those who are often pushed and involuntarily placed at the margins of the socio-economic, cultural and political mainstream society, preventing them from developing their capabilities, access to resources, opportunities and services (von Braun and Gatzweiler 2014). Marginalised individual are they who have relatively little control over their lives and the resources available to them; they are victims of exclusion, stigma, discrimination and oppression, are mostly ignored and neglected by the dominant social order, and hence are 'at the receiving end of negative public attitudes' (Kagan, Evans *et al.* 2002). Earlier CCA work suggests that when the voices of the marginalised are recognised and represented through dialogue, HIV prevention and SRH care can be articulated by the marginalised as their most pressing health problem (Dutta-Bergman 2004).

Key population groups like AGYWs in South Africa who are more vulnerable to HIV infection, are those who are usually marginalised. These key population groups normally do not have platforms to meaningfully engage in dialogue that informs social

and health-related policies. AGYW are often disadvantaged and seen as 'passive victims' of the social structures that undermine their agency. In fact, social structures and AGYW's agency are intertwined and are mutually constituted (Giddens 1984). Neither the agency nor the social structures are independent of one another (Giddens 1984, Jones and Karsten 2008). Human agents depend on social structures for their action and their actions in turn serve to create and recreate the social structures (Jones and Karsten 2008).

The role of listening to the cultural and local voices of the marginalised was recently acknowledged in the 2019 World AIDS day. Where communities were highlighted for their invaluable contribution to the AIDS response. Community members were acknowledged as the lifeblood of an effective AIDS response and an important pillar of support to HIV related interventions like AYFS (UNAIDS 2019). Communities are delivering incredibly important services and support to contribute to the response to HIV (UNAIDS 2019). Providing access to treatment, ensuring that confidential HIV testing services are available, making sure that people have the prevention services they need, community organisations are often the sole means of support in some of the most hostile environments (UNAIDS 2019). International partners and civil society organisations are urged to support communities by giving them a voice and support through the engagement. This is the position of the CCA highlighted above and also the position of this study based on the key findings. The surveillance of AGYW cultural values and beliefs in the design and adoption of youth-friendly HIV and SRH services is critical.

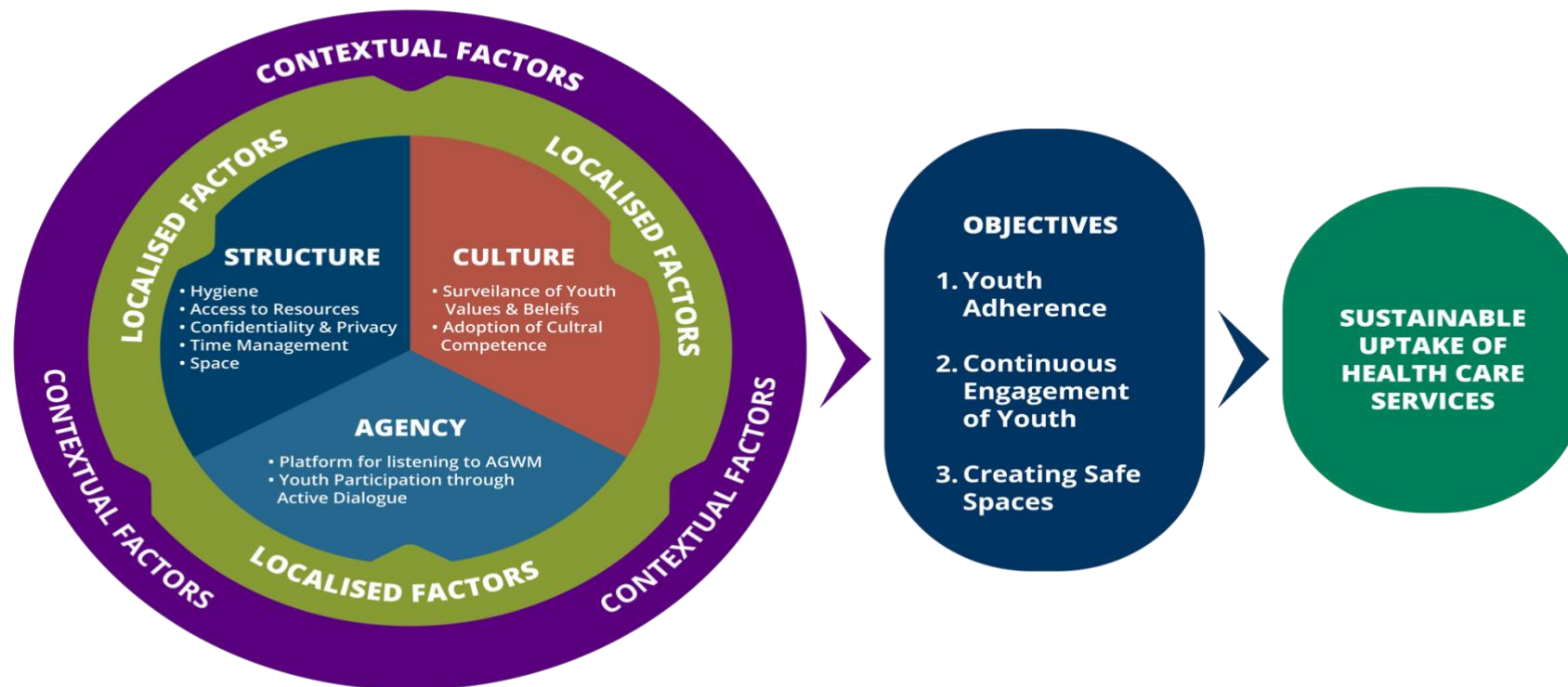
A Model for listening to the voices of AGYW for AYFS.

The proposed model is designed to be used for any health related intervention aimed for a community level response. The WHO quality framework provides standardised working definition of AYFS. The framework suggests that to be considered youth-friendly, health care services in primary health care clinics should be accessible, acceptable, equitable, appropriate and effective, as outlined in chapter two of this study (WHO 2001). Nevertheless, although the framework proves to be effective in multiple contexts globally. This study found that AYFS should not only follow the WHO

quality framework recommendations for AYFS as a tool to curb HIV and other SRH related issues among AGYW, but there is a need to take into cognisance the localised and contextual factors within the communities that interventions are designed for. To reflect this, we propose a generic model based on findings in this study.

The model proposes that the three key domains, structure, culture and agency, must be understood within contextual and localised factors of community members. This model is data driven, meaning that it is the shared meanings of AGYW in Vulindlela that proved that the culture, structure and agency of community members is found within the broader contextual factors and then within local factors experienced daily by community members. Therefore, this model proposed that there must be a surveillance of structural, cultural issues within the community that could in turn hinder their agency (See Figure 8.1). Researchers must go into communities and understand the localised issues and contextual issues that AGYW face, and how within them, structure, culture and agency play a role.

Figure 8.1: Diagram representing Model design for listening to voices of AGYW



The need to survey communities

Globally, studies that have been conducted to evaluate the potential of AYFS prove its potential in altering the HIV epidemic among key populations like AGYW by providing HIV and SRH services to AGYW that tailored to their needs (Mmari and Magnani 2003, Erulkar, Onoka *et al.* 2005, Tylee, Haller *et al.* 2007, Brittain, Williams *et al.* 2015, Callie Simon 2015, Geary, Webb *et al.* 2015, Thomée, Malm *et al.* 2016, Saberi, Ming *et al.* 2018). Nevertheless, AGYW are regularly excluded from health-related processes and interventions concerning them. Patterns of exclusion result in the silencing of AGYW in particular. In contrast, meaningful engagement with AGYW serves as a positive force against this systemic exclusion. The inclusion and engagement of AGYW disrupts those patterns of exclusion by facing them squarely. Therefore, tailoring HIV and SRH services to the needs of AGYW, who subsequently suffer a disproportionate burden of HIV infection in South Africa is an opportunity break down the barriers that prevent them from accessing quality health care.

As noted in the introduction, the CCA is founded on the principles of listening to the voices of the margins that have hitherto been unheard in policy and programming circles (Dutta-Bergman 2004, Dutta 2008). These erasures of the voices from the margins are tied to the continuing disenfranchisement of the margins through top-down programs that are often out of touch with the lived experiences of the marginalized. Therefore, essential to addressing health disparities are the processes of dialogue and listening that foreground community voices at sites of knowledge production and implementation (Dutta-Bergman 2004). “Behaviour cannot be permanent unless it is based upon culture, spirituality and the logical system of thought or philosophy of a people and their surroundings” (Lubombo and Dyll 2018)

The AYFS programme has been promoted in South Africa by the National Department of Health (NDoH) as a means of standardising the quality of adolescent health services in primary health care clinics (James, Pisa *et al.* 2018). Even though the AYFS programme has been scaled up in some countries, a few studies have evaluated it from young people’s perspectives (Geary, Webb *et al.* 2015). This study presented findings from AGYW perspectives, that can be utilized in understanding what young people in rural settings require in primary health care clinics. This study also presented how AGYW desire to receive HIV and SRH services with the AYFS programme. This

was facilitated from a CCA perspective which highlights the need to listen to the voices of community members in marginalised communities.

The AYFS programme in South Africa is one of the few to have been scaled up to a national level with the aim of providing HIV and SRH services to a key population like AGYW. Nonetheless, a study conducted in South Africa, found that there is often no evidence that clinics providing the AYFS programme provided a more positive experience to clients, or were more likely to be recommended by clients to their peers, than those not providing this programme (Geary, Webb *et al.* 2015). These results are consistent with those of an earlier study conducted in South Africa, where clinics providing AYFS were no more likely than facilities not providing AYFS to provide a more positive experience to young clients seeking HIV tests (Mathews, Guttmacher *et al.* 2009). Therefore, it is important to explore from the youth-friendliness of AYFS from young people's perceptions and experiences of how these services influence HIV and SRH care for them.

AGYW are often disadvantaged and seen as 'passive victims' of the social structures that undermine their agency. In fact, social structures and AGYW's agency are intertwined and are mutually constituted (Giddens 1984). Neither the agency nor the social structures are independent of one another (Giddens 1984, Jones and Karsten 2008). Human agents depend on social structures for their action and their actions in turn serve to create and recreate the social structures (Jones and Karsten 2008). The CCA seeks to address health disparities by fostering opportunities for listening to the voices of those at the margins through a variety of participatory communication methods such as PhotoVoice exhibits (Dutta, 2008). PhotoVoice was the data collection tool employed in this study as it seeks to include participants in the research process and not further alienate them but rather provide a space for them to be co-creators of knowledge. It enabled the researcher to gain "the possibility of perceiving the world from the viewpoint of the people who lead lives that are different from those traditionally in control of the means for imaging the world" (Catalani and Minkler 2010). As such, this approach to participatory research values the knowledge put forth by people as a vital source of expertise (De Lange, Mitchell *et al.* 2007). It confronts a fundamental problem of community assessment: what professionals, researchers,

specialists, and outsiders think is important may completely fail to match what the community thinks is important.

This model therefore, can be facilitated employing participatory data collection tools like PhotoVoice. The aim of this model is to understand the local and context specific issues that influence health at community level. A study conducted in Sweden (Thomée, Malm *et al.* 2016), highlighted that Sweden is one of the few countries that have successfully implemented the AYFS programme within the health care system. The target for this programme is youth who are most vulnerable to HIV. The implementation and the success of the programme was understood within the broader context of the Swedish political, social and cultural norms. In general, the Swedish society has liberal attitudes towards teenage sexual relations, and sexual and reproductive health issues are given priority (Thomée, Malm *et al.* 2016). Taking into account the social and cultural norms of the community enhances the success and the sustainability of health care intervention like AYFS (Thomée, Malm *et al.* 2016).

Further, young women in South Africa specifically are not operating as individuals, but rather, are embedded within families and households and communities through which gendered norms and expectations may be primarily exerted (Mojola and Wamoyi 2019). That is why culture refers to the dynamic contexts in which meanings are defined, structure represents the organising systems that enable/constrain access to resources and agency refers to the capacity of local communities to actively participate in the meaning making process (Acharya 2013).

Discussion: Designing the model from a CCA perspective

The challenge was to design a model that can be used to survey each community, so that the needs and challenges of the local community setting are met, the model also needed to be feasible, practical and affordable for any participating facility. Therefore, the researcher adapted the design of the model from the CCA. In the CCA culture provides a “communicative framework for meanings such that the ways in which community members come to understand that their lived experiences are embedded within cultural beliefs, values, and practices” (Acharya and Dutta, 2013: 225). Cultural context of AGYW is closely connected to the cultural habits of a particular community. For example, in Vulindlela cultural practices and beliefs are ingrained in the

experiences of community members. The model therefore, contains two broad generic components: *localized factors* and *contextual factors*, allowing for some adaptations to be made in each community, recognizing that “one size *doesn't fit all*”.

Therefore, health communication health interventions like the AYFS programme should focus on the contextual and local factors that nurture the adoption of certain identities and behaviors in each community. There is a need to embrace each community within its cultural norms and different identities so that health care interventions that seek to promote HIV and SRH uptake among key populations can be effective. Interventions like the AYFS programme within primary health care clinics, must focus on the contextual and localised factors within the cultural context of AGYW from an assets perspective to encourage health promoting actions. Moreover, this has the potential to help Vulindlela to establish a good foundation for addressing determinants of poor HIV and SRH care among AGYW (Airhihenbuwa, Ford *et al.* 2014).

Context and space in the CCA refers to immediate surroundings, and local setting where cultural members are located (Dutta, 2003). These spaces are part of the everyday life that cultural members live, and make decisions. Localised contexts encompass how health meanings, health beliefs, health practices and health understanding are developed among community members. Local contexts include language, cultural practices, religious practices, and access to healthcare. Contexts are inclusive of the day to day experiences of local community members, these spaces influence and inform how cultural members make sense of health-related issues, and how they make sense of social issues.

Contexts are important when studying public health issues because interventions can only be effective when they have been developed in such a manner where they are contextually relevant. Health-related behaviour cannot be studied outside of an understanding of the context in which the behaviour is enacted. For instance adolescent girls and young women who are a key population group in the HIV and AIDS epidemic in South Africa are mostly located in contexts where they are faced with social and economic factors that contribute to their vulnerabilities (Mojola and Wamoyi 2019).

Recent years in the HIV prevention cascade, research has established a special concentration in the spread of HIV, meaning that there are contexts where HIV prevalence is disproportionately high (Shisana, Rehle *et al.* 2014, Kharsany, Frohlich *et al.* 2015). Research suggests that carefully studying contexts where HIV prevalence rates are perpetually rising due to contextual factors is important in order to develop effective intervention to alleviate the hyper-epidemics.

“The context specificity and dynamic nature of the social factors that can drive HIV risk and vulnerability requires that we gather adequate information about local. Auerbach *et al.* situations in order to make recommendations about interventions that may have a meaningful impact on HIV epidemics” (Auerbach, Parkhurst *et al.* 2011). Context are central factors in the HIV and AIDS epidemic, and intervention that aim to bring a halt to HIV prevalence rates in a particular population, must understand the contextual drivers of the intervention. Public health practitioners and researchers have often abandoned, or ignored, this social perspective, but ignoring the complexity and contexts where epidemics are imbedded does not make them go away.

Dutta (2008) is of the opinion that the health experiences of the marginalised communities are often located at the geographical margins of healthcare systems, making the contexts in which community members live poor in healthcare infrastructures. In South Africa, rural communities are usually characterized by being isolated from large economic activities, having little or no health-related resources, unemployment, lack of sanitation and poverty (Rispel 1992). It is these contextual characteristics that often place young women in vulnerable positions with little or no means to employ safe sex practices. Therefore, initiatives that aim to alleviate the HIV and AIDS epidemic will come about through a comprehensive HIV responses, that include responses to contextual factors that affect HIV risk and vulnerability among key population groups.”

It has been confirmed by several studies that cultural context is important in shaping beliefs and practices related to HIV and SRH, as well as attitudes and perceptions

8 Settings with persistently high HIV incidence, and/or HIV prevalence exceeding 15% of the adult population. Mojola, S. A. and J. Wamoyi (2019). "Contextual drivers of HIV risk among young African women." *Journal of the International AIDS Society* **22**(S4): e25302.

about HIV risk behaviour (Selikow, Zulu *et al.* 2002, Ross and Castle Bell 2017) and the perceived need for HIV prevention among AGYW (Delany-Moretlwe, Cowan *et al.* 2015, Naicker, Kharsany *et al.* 2015, Ranganathan, Heise *et al.* 2018). Culturally appropriate HIV and SRH interventions require that interventionists understand not only individual-level factors but also the contextual and local norms surrounding patterns of HIV prevalence among AGYW, AND eating and activity, and attitudes and beliefs about sexuality and HIV (Jewkes and Morrell 2010, Jewkes and Morrell 2012, Lykens, Pilloton *et al.* 2017). A culture-centered approach to studying behavioral determinants of the HIV epidemic has been shown to promote healthy sexual behaviours among key populations like AGYW (Olufowote 2017, Shumba and Lubombo 2017, Dutta 2019). Furthermore, actively engaging community participants facilitates the development and dissemination of culturally tailored AYFS programmes in primary health care clinics in Vulindlela can help reduce the burden of HIV among AGYW.

Conclusion

This chapter highlights a generic model for further research among key populations at community level. The community is currently at the center of HIV research, with specific calls that community members must be given platforms to voice their challenges and offer suggestions on how to sustain their own health. This study has only focused on AGYW, and the findings are specific to AGYW in Vulindlela. This chapter offers a generic model that should be applied when working with community members, specifically AGYW. Although studies have shown the effectiveness of AYFS globally, framing it with the WHO quality framework. This study has highlighted the lack of effective communication between health care nurses and AGYW, where health care nurses have been identified as a barrier to services. The lack of privacy, hygiene and other specific needs were highlighted by AGYW. For further understanding of how to create an environment for effective engagement between health care nurses and AGYW, this chapter highlights the need to understand contextual and local factors in which these issues are imbedded. This understanding can be fostered by employing participatory methodologies that enhance dialogue and engagement. This chapter concludes that for AYFS to be accessible, acceptable, equitable, appropriate and

effective, a contextual and localised surveillance of structures, cultures and how community members can be handed agency must be employed.

Chapter Eight: Conclusions

The objectives of this study were inspired by the continued vulnerability of Adolescent girls and young women (AGYW) in South Africa. For decades, research has been conducted, highlighting these vulnerabilities and contextualizing them within certain communities. A few of these studies have been user-driven, approaching programmes and interventions related to HIV and other SRH related issues like teenage pregnancy from the grassroots up. Majority of conceptual frameworks and approaches have negated listening to the voices of the human agents that interventions are designed for. Often, interventions take a 'one-size-fits all' approach, yet, 'one-size doesn't fit all'.

The main objective of this study set out to explore adolescent youth-friendly services in health care clinics that offer HIV and SRH related services. The preoccupation of the researcher was to describe youth-friendliness from a user perspective. The inspiration of this investigation was theory driven, meaning that it was from the perspective of the theoretical framework employed in this study that directed the interest to user perspectives about youth-friendly services. The critical role of user perspectives was sewn into this study using participatory research methodology. The principles of participatory research encourage inclusion through dialogue and cooperation between researchers and participants. Therefore, participatory methodology in this study involved specific techniques that were adopted in the research process to collect, assemble and evaluate the data. Tools like PhotoVoice were relevant in gathering user perspectives that would in turn answer the research questions in this study.

The thesis in its endeavor to achieve this objective was guided by the following three key research questions:

1. In what ways are primary health care clinics offering HIV and SRH services for AGYW in rural KZN youth-friendly?
2. What are the current strategies employed to make HIV and SRH services youth- friendly in primary health care clinics in rural KZN?
3. What potential does youth-friendly services have in influencing the uptake of HIV prevention tools and SRH care tools among AGYW in rural KZN?

In its endeavor to achieve the above questions, the thesis has provided key different but coherent chapters that help the questions in a meaningful context. The introduction chapter provided an overview of the global HIV epidemic, interrogating the positions occupied by AGYW in the dominant HIV and AIDS discourse. This was further expounded in the literature review, where studies, policies and global strategies were interrogated in line with AGYW as a key population most affected by HIV and SRH related disparities. The global, sub-Saharan Africa and South African responses to the HIV epidemic in these two chapters, where both the discursive and pragmatic responses to the HIV epidemic are critiqued with the intent of demonstrating the lack of agency of AGYW or the absence of their voices in the discursive spaces where HIV response strategies are discussed and determined.

The concept of youth-friendliness was then discussed from a global perspective and then narrowed down to the African perspectives and specifically South Africa. The purpose of this extensive exploration was to contextualise previous studies, policies and strategies and show that youth-friendliness is not a new concept, and that it is not the intention of this study to present it as such. But the in-depth exploration of youth-friendly services as a potential tool for HIV and SRH uptake among AGYW was necessary in order to establish the premise of the research study. A conclusion was drawn here that while AGYW are now recognised as a key population in the HIV cascade, no signs of success have been recorded in containing the HIV epidemic through adolescent youth-friendly services (AYFS) in South Africa. Although the AYFS programme places much emphasis on tailoring HIV and SRH services in primary health care clinics for AGYW, since its early inception and adoption in clinics in South Africa, there are no studies that indicate that the inclusion of AYFS in the clinic has reduce HIV or teenage pregnancy among AGYW. The focus of various studies, has simply an acknowledgement that AYFS has the potential to drive behaviour change among AGYW.

In line with the main objectives and the research questions, AGYW in this study highlighted that the primary health care clinic is not yet a youth-friendly space for them to access and receive HIV and SRH. The AGYW highlighted their experiences in primary health care clinics in in the data presentation chapter [chapter five]. Their experience highlights individual challenges that discourage them from coming back to

the clinic. One key finding to the investigation of this study, is that primary health care clinics are yet youth-friendly according to the user perspectives of AGYW. Apart from the standard running of the clinic, according to the AGYW there are no strategies identified both by nurses and AGYW employed in the clinic to make it a youth-friendly space. Two out of the three clinics, Mphophomeni clinic and Caluza clinic has a separate room within the clinic designated for the AGYW who for AYFS. Nevertheless, the nurses noted that when the AGYW are unavailable, the AYFS room is re-purposed and utilised for other clinic patients due to the lack of space within the clinic.

In order to answer the research questions, it was critical for nurses' perspectives to be included in this study. Through in-depth interviews in health care nurses, this study discovered that structural issues oragnaisational issues and health care service issues, beyond the clinic capacity were required. Nurses suggested that these issues require an increase in staff members, build clinic infrastructure; which are some of the key issues also highlighted by AGYW that make the clinic not to be youth-friendly. The potential of the AYFS programme was highly recognised as one that could have lasting effect and impact on young people, including AGYW in South Africa.

The methodology of the study was instrumental and a deliberate choice since the research site was deemed as an overly studied research location. Previous research institutions like the Centre for Aids Programme of Research in South Africa (CAPRISA) have conducted multiple studies and demonstration projects with community members, particularly AGYW in Vulindlela. The AGYW in this study were already familiar with the research process and the proceedings of answering "questions" relevant for researchers. It was necessary therefore, for the researcher to employ innovative data collection tools and create spaces that will encourage participation for AGYW to express their experiences of HIV and SRH services in primary health care clinics.

The culture-centered approach (CCA) and the findings of this study directed the development and the design of a generic model for surveying the contextual and localised factors that influence the health care of community members like AGYW in Vulindlela. The CCA in this thesis has acknowledged that the success of interventions like the AYFS programme must be at the center of community members. Ultimately,

the CCA provides a platform for agency in contending with health care structures that direct the lives of community members. Hence, it enabled AGYW in this study to make their voices heard within their contexts and local environments. The CCA presented them with possibilities to enact their agency. Therefore, the model adopted the three pillars of the CCA, and adapted them as three communicative domains that must be understood within contextual and localised factors of community members.

The most pronounced conclusion made in this thesis is the apparent evidence that global strategies and frameworks, like the global WHO framework for the AYFS programme is not always fitting in some social communities. This proves that adaptations to such strategies must be made in line with what is important and contextually relevant in each community. While HIV and SRH strategies should not be simplistically reduced to the application of local solutions divorced from global science, this study has proposed a contextual and locally driven model for tailoring and sustaining the AYFS programme in diverse communities. A portion of literature on the AYFS programme in developing countries reported that majority of AGYW in are beginning to adopt a more technology focused approach in receiving HIV and SRH care in primary health care facilities. AGYW require computers and pre-programmed responses online for key questions related to their health. For an example, AGYW in developing countries preferred that some services be online based, and not meet physical health care practitioners. This was a strategy to avoid discussing their private sexual lives with nurses that can sometimes be judgemental, as research proves nurses often are.

While such strategies are relevant, they are context specific. Findings in this study expressed that AGYW in South Africa, particularly in a rural community like Vulindlela, still require basic health care conditions to be met in primary health care clinics. Basic needs like *hygiene, space in the clinic structure, good administration and privacy*. What these differences mean is that the same quality framework designed by the WHO for AYFS must be adapted to different contexts. AGYW in Vulindlela consider a clean and a hygienic primary health care clinic as being youth-friendly. Strategies, like WHO quality framework for AYFS, in addressing socio-cultural challenges in non-Western societies has long been contested. Alternative approaches such as the

culture-centered approach upon which this thesis is based have since been promulgated.

It is important to end by noting that the findings of this study are by no means more definitive than a particular perspective, and cannot therefore be generalised. It is possible that different findings could have been obtained, for example, had the number of participants been increased and the scope of the study been enlarged. If the researcher (s) [*including my research assistant*] was not actively involved in the recruitment of AGYW from each clinic mentioned in this study, the findings could have taken a different direction. Although a mixed method approach would have yielded a greater sample, with results that could be generalisable, the interest of this study was to make sense of the meanings and experiences of AGYW when accessing primary health care clinics for HIV and SRH services.

Be that as it may, the prospect of transferability of this study cannot be totally rejected. Even though the findings are applicable to a small number of AGYW in Vulindlela, in KwaZulu-Natal in South Africa, the findings and conclusions derived may as well be applicable to other populations elsewhere. The methodological outline presented in chapter Four and the theoretical framework outlined in chapter Three, provide a description of the context within which this study was conducted. This may be insightful to those who believe, if it so, that their situations are similar to those described in this study, desire to transfer the conclusions to their own contexts (Guba and Lincoln 2001).

Evidence offered in this study highlights the need for research to be done in order to strengthen the AYFS programme within primary health care clinics. Particularly research focused on the clinic users. Although the programme is established in all the three clinics which this study was conducted, health care nurses suggested the need to market this programme to young people like AGYW. The response from the nurse professionals point to the fact that the public health system is not yet properly functioning to meet the needs of AGYW in South Africa. Nevertheless, a critical area for future research is *ethical considerations* when working with vulnerable groups like adolescent girls below the age of eighteen years.

Area for future research:

There are no clear ethical reasons for excluding adolescent girls below the age of eighteen years from research due to multiple reproductive health problems, including the high rates of HIV among AGYW. Research shows that existing knowledge cannot solve the complexities found within this age group (Folayan, Haire *et al.* 2015). The complex challenges that have isolated and stigmatized adolescent girls within their families, schools and communities call for researchers to include rigorous ethical considerations when working with them. In this study, the researcher realised that in rural communities, working with AGYW cannot be fixed. Possible benchmarks and ethical frameworks that will be developed cannot be locked or fixed but they should be fluid in order to accommodate the different contexts in which adolescent girls live.

The researcher in this study found that health research in rural communities is largely associated and dominated by 'urban-based' health researchers who go to rural communities without for field work. Ethical considerations in rural communities are constituted by different contextual assumptions. In this study, the researcher suggests that there is a need to consult the context of rurality, accounting both for the diversity of lived experiences, ideas and the drivers that enable or disable the transformation of such contexts (Balfour, Mitchell *et al.* 2009).

For instance, when the researcher conducted this study in rural KZN with AGYW about youth-friendly services, the researcher discovered that including adolescent girls below the age of eighteen was a challenge. Some of the adolescent girls did not have parents nor legal guardians. The researcher initially thought that informed consent was already compromised. Yet, the dynamic of parents and guardians was discovered early during the recruitment phase of the study. The clinic managers advised that we seek consent from the District Manager and the National Health Research Database (NHRD) committee⁹ at the National Department of Health (NDoH)¹⁰ who knew the local laws and ethical guidelines for health research in rural communities, where some homes are child headed households, with no parents or guardians. To the NHRD and NDoH, we had to clearly state how the researcher would address ethical-legal

⁹ <https://nhrd.hst.org.za>

¹⁰ <http://www.health.gov.za>

complexities that may arise during the research process and how we would safeguard participants. Secondary to this, at the community level, the NHRD and the NDoH advised that the researcher to consult the area counsellor who stood as a representative of AGYW without parents and legal guardians. The counsellor was best suited to wear the parental gown for all AGYW, to protect AGYW from being exploited and compromised in the research.

Therefore, ethical consideration when working with vulnerable groups like adolescent girls is a key area that this study identifies for further research. This call has already been identified by numerous authors (Morrow and Richards 1996, Flewitt* 2005, Harcourt* and Conroy 2005, Einarsdóttir 2007, Bekker, Slack et al. 2014, Folayan, Haire et al. 2015, Murray and Nash 2017). These studies, have recognised the complexity of ethical consideration and concurrently advocate for AGYW inclusion in empirical research. Although (Bekker, Slack *et al.* 2014) and other scholars like (Emanuel, Wendler et al. 2004) identified ethical benchmarks and an ethical framework to help identify and systematize the ethical issues relevant to conduct research with AGYW in low- and middle-income countries. The benchmarks and framework identified help identify and systematize the ethical issues relevant to the conduct of research with adolescents in such settings were: *social value, scientific validity, fair subject selection, collaborative partnership, acceptable risk/benefit ratio, independent review, informed consent, and ongoing respect for enrolled participants* (Emanuel, Wendler *et al.* 2004).

Nevertheless, ethical considerations in rural communities must be considered when conducting research. It is important that the implications of identification, background and family should be discussed with the participants early in the research process as their responses in this regard may have implications. It is better to compromise research than compromise the participants (Flewitt* 2005). To protect issues of confidentiality, deciding what to leave out to avoid intrusion into participants' personal affairs is important, but is also dependant on the initial informed consent process. Therefore, more studies that focus on ethics and vulnerable under aged participants within the field of health communication is a critical area for further research.

Appendices

Appendix 1: Ethical Clearance Letter



22 May 2017

Ms Yonela Vukaphi (210513087)
School of Applied Human Sciences
Howard College Campus

Dear Ms Vukaphi,

Protocol reference number : HSS/0212/017D

Project title: Exploring the feasibility and role of youth friendly services in the uptake and adherence to oral PrEP adolescents young women attending primary health clinics in Vulindlela, KwaZulu-Natal, South Africa

Full Approval – Full Committee Reviewed Application

With regards to your response received on 12 May 2017 to our letter of 21 April 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Dr Elizabeth Govender
cc Academic Leader Research: Dr Jean Steyn
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / anymnm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za

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Appendix 2: Gatekeeper Letter (A)



69 West Street
Pietermaritzburg
KwaZulu-Natal, 3200
South Africa

Cell: +27 76 244 6940
Email: info@comosat.org
Web: www.comosat.org

19 January 2017,

Dear Yonela Vukapi,

This is to confirm that COMOSAT team is available to assist you access the Adolescent Girls and Young Women between the ages 15-24 in the Vulindlela community clinics who access antenatal care, family planning and HIV counselling and testing services in the clinics listed below:

- Sondelani
- Mphumuza
- Mafakatini
- Mphophomeni
- Songonzima
- Taylors

For 2 the focus group discussions consisting of 12 participants across all six clinics. COMOSAT will also assist you access Health Care Nurses with the above mentioned clinics for 2 in-depth interviews across all six clinics.

Regards


Gethwana Mahlase
Cell: 079 8333 813

Appendix 3: Gatekeeper letter (B)



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UMGUNGUNDLOVU DISTRICT OFFICE

Physical Address: 171 Hoosen Haffajee, Pietermaritzburg, 3219
Postal Address: Private Bag X9124, Pietermaritzburg, 3200
Tel: 033 897 1002 Fax: 033 897 1078 Email: Thule.kunene@kznhealth.gov.za

DISTRICT MANAGERS OFFICE

Enquiries: Mrs. N. M. Zuma-Mkhonza
26 APRIL 2018

TO: MS YONELA VUKAPI
PH.D. CANDIDATE,
PUBLIC HEALTH COMMUNICATIONS
APPLIED HUMAN SCIENCES | COLLEGE OF HUMANITIES
HOWARD COLLEGE CAMPUS | UNIVERSITY OF KWAZULU-NATAL | DURBAN

Dear Ms Vukapi

RE: ACCESS TO ADOLESCENT GIRLS AND YOUNG WOMEN AGES 15-24 AT CLINICS IN VULINDLELA

Your correspondence regarding the letter of approval to conduct the research refers:

I have pleasure in informing you that support has been granted to you by the District Office to conduct a research on: ***Access to adolescent girls and young women ages 15-24 at clinics in Vulindlela***: will be conducted at UMgungundlovu District

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you,

MRS N.M. ZUMA - MKHONZA
DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4: Gatekeeper letter (C)



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X9051 PMB: 3200,
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management (HRKM)

Reference: HRKM181/18
KZ_201805_008

28 May 2018

Dear Ms Y Vukapi
(UKZN)

Subject: Approval of a Research Proposal

1. The research proposal titled '**Exploring the feasibility and role of youth friendly services in the uptake and adherence to oral PrEP among adolescent girls and young women (AGYW) attending primary health clinics in Umgungundlovu KwaZulu-Natal, South Africa.**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Mafakatini, Mpophomeni, Songonzima, Sondelani, Caluza and Taylors Clinics.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facilities before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 28/07/18

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5: Assent form (participants below 18)



TITLE OF THE RESEARCH PROJECT: Exploring the feasibility and role of Youth Friendly Services in the uptake and adherence to Oral PrEP among adolescent girls and young women attending primary health care clinics in Vulindlela, Kwazulu-Natal, South Africa.

RESEARCHERS NAME(S): Yonela Vukapi

ADDRESS: 62 Penzance Road, Glenwood, Durban

CONTACT NUMBER: 0797351834 / 073 530 4189

What is RESEARCH?

Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about disease or illness. Research also helps us to find better ways of helping, or treating children who are sick.

What is this research project all about?

The research is about explaining your experience of the clinic, what makes the clinic youth friendly and what makes it not friendly. I would like your views and your experience of the clinic from your own point of view and in your own words.

Why have I been invited to take part in this research project?

You are invited to this project because you are a young woman between the ages 15-24 who is a user at the clinic. Your views can help to bring about change in the way young women your age view the clinic.

Who is doing the research?

I am Yonela Vukapi. I am a student at the University of KwaZulu-Natal, I am doing a PhD and this is part of my research project that I come and speak to you today.

What will happen to me in this study?

In this study I would like you to firstly be free to speak to me at any moment where you don't understand something. I want you to express yourself when questions are being asked. You are going to cut and paste for a collage and take photos when you are asked. The facilitator will explain every step so that you understand. At the end of the workshop, you will be asked to answer some questions about the photos you have taken and also more questions on the issue of youth friendly services, this discussion is called a focus group discussion.

Can anything bad happen to me?

The research involves talking about your experience at the clinic. Some of what you may share of services rendered to you can be emotionally draining. The researcher can refer you to the youth sister of the adolescent youth friendly services adolescent youth friendly services (AYFS) programme at the clinic and for counselling if need be. But your participation in the research is voluntary and at any point during the workshop and the focus group discussion, you are free to pull out if you are uncomfortable.

Can anything good happen to me?

I believe that the value you add to this research can improve the way services are given at the clinic to adolescent girls and young women like you. You will be participating using visual methods, meaning that this could also be an empowering experience for you in bringing about change in how health is delivered to young women your age.

Will anyone know I am in the study?

Your participation in the study will kept confidential. No one has to know that you were part of the workshop, unless you request that someone be informed. The researcher will keep your participation and identity confidential.



Who can I talk to about the study?.

You can contact me on: 079 7351 834

Or my research assistant on: 073 530 4189

What if I do not want to do this?

You can stop at any point of the workshop and the discussion if you are no longer comfortable. Your participation is not forced, but it is at your own comfortability. The researcher will not force you to remain in the study if you do not want to.

Please tick the following boxes:

1. Do you understand this research study and are you willing to take part in it?

YES

NO

2. Has the researcher answered all your questions?

YES

NO

3. Do you understand that you can pull out of the study at any time?

YES

NO

Signature of Child

Date

Appendix 6: Consent Form (English)

Information Sheet and Consent to Participate in Research

Date:

Dear Nurse (health practitioner)/,

My name is Yonela Vukapi from the Center for Communications media and Society (CCMS) department at University of KwaZulu-Natal in Durban.

Centre for Communication, Media and Society

Memorial Tower Building |Howard College Campus

University of Kwa-Zulu Natal

4041|South Africa

Phone: +27 031 260 1044

Email: yonela.vp@gmail.com |Website: <http://ccms.ukzn.ac.za>

You are being invited to consider participating in a study that involves research in exploring the feasibility and role of youth friendly services in the uptake and adherence to oral prep among adolescent girls and young women attending primary health care clinics. The fundamental objective of this study is to understand how the clinic is youth friendly or not youth friendly for AGYW who attend the clinic for HIV and SRH services. Young women between the ages of 15 and 24 years are among the key population groups most vulnerable to contracting HIV, unwanted and unplanned pregnancies in South Africa. The study included the enrolment of nurses for in-depth interviews. The duration of your participation if you choose to enrol and remain in the study is expected to be maximum 1 hour for an in-depth interview.

The study may involve the following risks and/or discomforts; discussing your personal experience of receiving services at the clinic for family planning, antenatal care and HIV testing and counselling at the clinic.

This study has been ethically reviewed and approved by the UKZN research Ethics Committee (approval number _HSS/0212/017D_).

In the event of any problems or concerns/questions you may contact the researcher at or the UKZN Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: Ximbap@ukzn.ac.za

Please note that your participation is voluntary, should you not want to be part of the discussion you may withdraw from this activity at any point in time. Your withdrawal from this interview will not disadvantage you in any way. You will not be reimbursed. With your permission, the in-depth interview will be recorded using a sound recorder and ethnographic notes will be written during the interview. This will be transcribed; however your name will not be used in the written research report. To protect your confidentiality pseudo names will be used during this research.

--

CONSENT (Edit as required)

I _____ have been informed about the study entitled "Exploring The Feasibility And Role Of Youth Friendly Services In The Uptake And Adherence To Oral Prep Among Adolescent Girls And Young Women Attending Primary Health Care Clinics In Vulindlela, Kwazulu-Natal, South Africa by Yonela Vukapi

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed that I will not be reimbursed.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher yonela.vp@gmail.com or 079 7351 834.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: Ximbap@ukzn.ac.za

_____ Signature of Participant	_____ Date
_____ Signature of Witness (Where applicable)	_____ Date
_____ Signature of Translator (Where applicable)	_____ Date

Appendix 7: Consent Form (English)

Informed consent – permission to interview.

Please note that this document is produced in duplicate – one copy to be kept by the respondent, and one copy to be retained by the researcher.

Researcher	Yonela Vukapi	079 7351 834	yonelavukapi@yahoo.co.za
Department	Centre for Culture and Media in Society (CCMS)	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)	62 Penzance Road Glenwood	
Supervisor	Dr Eliza Govender	031 260 4690	Govender1@ukzn.ac.za
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za

Please do not hesitate to contact any of the above persons, should you want further information on this research, or should you want to discuss any aspect of the interview process.

Dear Participant,

My name is Yonela Vukapi. I am a Ph.D. candidate at the University of KwaZulu-Natal Centre for Communication Media and Society reading for a Doctor of Philosophy degree. You are being contacted in respect of a research

project titled: “*Youth friendly services in health-care clinics and their role in the uptake and adherence to oral PrEP among young women in South Africa*”

which I am conducting as part of my doctoral study. The study will be fully approved by the University of KwaZulu-Natal Higher Degrees Research Committee once ethical clearance is granted. It is supervised by Dr Eliza Govender.

Goals of the study

I am hoping to find out (1) your thoughts about what Sexual Reproductive Services (SRH) should be like in the clinic for adolescent girls and young women; (2) your experience of SRH services in the clinic as an adolescent and a young women; (3) your thoughts and feelings about that experience; (4) challenges you face; and (5) what you suggest should be done to enhance user-driven youth friendly services.

What Will You Be Asked To Do?

- a) In order to make an informed consent to participate in this interview, you have to read, understand and sign the consent form at the end of this statement.
- b) Your participations entails discussing with me in an audio-recorded interview, above stated issues around user-driven youth friendly services your involvement in the response to HIV prevention and how you feel about it.

Risks and discomforts

HIV and AIDS, prevention and discussions about sexual reproductive services provided at clinics are sensitive issues that are too personal. Sharing such information may cause some discomfort. Your participation in this study is voluntary. You are at liberty not to participate and are free not to respond to certain questions. You may withdraw from the study at any time during the Focus group discussion.

What Happens to the Information You Provide?

While you may withdraw from the study at any time during the interview, once the interview is completed, you cannot ask that the information already provided to be expunged from the study. In the event that you withdraw in the course of the

interview, I will use any information that you provide prior to withdrawal to accomplish the research objectives.

Confidentiality

Your participation in this research will be through interviews and taking part in a focus group discussion; these will be arranged to ensure minimal disruption to your schedule. The information obtained will be treated as confidential; pseudonyms will be used in identifying respondents or participants when necessary. This will be safely stored at the University of KwaZulu-Natal, Howard College Campus.

Further Information

If you would like any additional information about this study or about your rights as a study subject, you may contact my supervisor Dr Eliza Govender

Thank you for taking part in this research study. Your input will add significant value in to the research.

Signed consent

<ul style="list-style-type: none"> I understand that the purpose of this interview or focus group discussion is solely for academic purpose. The findings will be published as a thesis, and may be published in academic journals. 	Yes <input type="checkbox"/> N <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I will remain anonymous. (Please choose whether or not you would like to remain anonymous.) 	Yes <input type="checkbox"/> N <input type="checkbox"/>
<ul style="list-style-type: none"> I understand my name will be quoted. (Please choose whether or not you would prefer to have your remarks attributed to yourself in the final research documents.) 	Yes <input type="checkbox"/> N <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I will not be paid for participating but a souvenir will be given. 	Yes <input type="checkbox"/> N <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I reserve the right to discontinue and withdraw my participation any time. 	Yes <input type="checkbox"/> N <input type="checkbox"/>

• I consent to be frank to give the information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I consent to have this interview recorded.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
* By signing this form, I consent that I have duly read and understood its content.		
<div> <div>_____</div> <div>Name of Participant</div> <div>Date</div> </div> <div> <div>_____</div> <div>Signature</div> </div>		
<div> <div>_____</div> <div>Name of Researcher</div> <div>Date</div> </div> <div> <div>_____</div> <div>Signature</div> </div>		

Appendix 8: Consent Form (IsiZulu)

Ifomu Lemvume – Imvume Yokuxoxisana

Sicela uqaphele ukuthi leli phepha lenziwe kabili – ikhophi eyodwa izogcinwa yilowo okuzoxoxiswa naye, enye ikhophi izogcinwa umcwaningi.

Umcwaningi	Yonela Vukapi	079 7351 834	yonelavukapi@yahoo.co.za
UMnyango	Centre for Culture and Media in Society (CCMS)	+27-31-2602505	
Isikhungo	University of KwaZulu-Natal (UKZN)	62 Penzance Road Glenwood	
Umeluleki	Dr Eliza Govender	031 260 4690	eliza.govender@caprisa.org
USihlalo, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za

Sicela ungangabazi ukuxhumana nanoma omuphi umuntu kulaba abangaphezulu uma ufuna ukuthola olunye ulwazi ngalolu cwaningo, noma ufuna ukuxoxa nanoma yingayiphi ingxenye yohlelo lokuxoxisana

Ngiyabingelela Kozibandakanyayo,

Igama lami nginguYonela Vukapi. Ngingumfundi owenza izifundo ze-Ph.D eNyuvesi Ya KwaZulu-Natal, eCentre for Communication Media and Society, ngenza iziqu ze-Doctor of Philosophy. Uyacelwa ukuba uzibandakanye kulolu cwaningo olisihloko sithi: “*Youth friendly services in health-care clinics and*

their role in the uptake and adherence to oral PrEP among young women in South Africa, engilwenzela iziqu zami zobudokotela. Ucwangingo luzogunyazwa ngokugcwele yi-KwaZulu-Natal Higher Degrees Research Committee uma sekutholakale imvume (ethical clearance). Ngilulekwa uDr Eliza Govender.

Izinhloso zocwangingo

Ngethemba ukuthola lokhu (1) imibono yakho ngosizo olumayelana nezocansi (Sexual Reproductive Services (SRH), ukuthi kufanele lubenjani emtholampilo emantombazaneni asathomba nasethombile; (2) okwaziyo ngosizo lwe-SRH emtholampilo njengentombazane esathomba neseyithombile; (3) imibono nokuphatheka kwakho ngesikhathi uthola usizo; (4) izinselelo obhekana nazo; (5) okuphakamisayo obona ukuthi kungenziwa ukuze kutholakale usizo olukahle entsheni.

Yini okuyothiwa yenze?

- a) Ukuze wenze isinqumo sokuvuma sewunolwazi oluphelele ngokuzibandakanya kule ngxoxo, kufanele ufunde, uqonde bese usayina ifomu lemvume ekupheleni kwalesi sitatimende.
- b) Ukuzibandakanya kwakho kuhlenganisa ngxoxo nami ezoqoshwa ngalezi zinto ezibalwe ngenhla ngosizo olukahle entsheni, ukuzibandakanya kwakho mayelana nokuvikelwa kwe-HIV nanokuthi uzizwa kanjani ngakho.

Ubungozi nokungaphatheki kahle

I-HIV ne-AIDS, ukuvikela nengxoxo mayelana nosizo ngezocansi olunikezwa emitholampilo luwudaba olubucayi futhi oluthinta umuntu ngqo. Ukwabelana ngolwazi olunje kungadala ukungaphatheki kahle. Ukuzibandakanya kwakho kulolu cwangingo kungukuzithandela kwakho. Ukhululekile ukuthi ungazibandakanyi futhi ukhululekile ukuthi ungaphenduli eminye imibuzo. Ungahoxa ocwangingweni nanoma yingasiphi isikhathi sokuxoxisana nethimba okuzoxoxiswana nalo (Focus group).

Kwenzekani ngolwazi olunikezayo?

Nakuba ungahoxa ocwaningweni nanoma yingasiphi isikhathi ngesikhathi kusaxoxiswana, uma ingxoxo isiqediwe, angeke ucele ukuthi ulwazi osewulinikezile ulukhiphe ocwaningweni. Uma kwenzeka ukuthi uyahoxa ngesikhathi sengxoxo, ngiyosebenzisa ulwazi onginike lona ngaphambi kokuba uhoxe ukuze ngifeze izinhloso zocwaningo.

Ubumfihlo

Ukuzibandakanya kwakho kulolu cwaningo kuzofaka ukuxoxisana nokubamba iqhaza engxoxweni yethimba enizoxoxisana nalo (Focus group), lokhu kuyohlelwa ukuze kuqinisekise ukuthi kuncane ukuphazamiseka eshejulini yakho. Ulwazi olutholakele luyogcinwa luyimfihlo, kuyosetshenziswa amagama okungewona ukuze kuhlonzwe abaphendulayo noma abazibandakanyayo uma kunesidingo. Lokhu kuyogcinwa kuphephile eNyuvesi YaKwaZulu-Natal, Howard College Campus.

Olunye ulwazi

Uma udinga nanoma oluphi olunye ulwazi ngalolu cwaningo noma ngamalungelo akho njengozibandakanyayo ocwaningweni, ungaxhumana nomeluleki wami uDr Eliza Govender

Ngiyabonga ngokuzibandakanya kwakho kulolu cwaningo. Ulwazi olunikezile luzobaluleka kakhulu kulolu cwaningo.

Ukusayinela ukuvuma

<ul style="list-style-type: none"> • Nginyaqonda ukuthi inhloso yale ngxoxo noma le ngxoxo yethimba esixoxisana nalo kungenhloso yezemfundo kuphela. Okutholakele kuyoshicilelwa njenge-thesis kanti kungashicilelwa kumajenali ezemfundo. 	Ye <input type="checkbox"/> Ch <input type="checkbox"/>
<ul style="list-style-type: none"> • Nginyaqonda ukuthi angeke laziswe igama lami. (Sicela ukhethe noma ufuna kwaziwe igama lakho noma cha) 	Ye <input type="checkbox"/> Ch <input type="checkbox"/>

<ul style="list-style-type: none"> • Ngityaqonda ukuthi igama lami angeke lisetshenziswe. (Sicela ukhethe uma ufisa ukuthi okushoyo kumataniswe nawe ekupheleni kocwaningo) 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityaqonda ukuthi angeke ngikhokhelwe ngokuzibandakanya kwami kodwa ngiyonikwa isipho esiyisikhumbuzo 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityaqonda ukuthi nginalo ilungelo lokungaqhubeki nokuzibandakanya futhi ngihoxise ukuzibandakanya kwami nanoma yingasiphi isikhathi. 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityavuma ukuthi nginike ulwazi olusobala/olucacile. 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityaqonda ukuthi angeke ngiphoqwe ukuthi ngiphawule ngezindaba engingathandi ukuphawula ngazo nanokuthi nginganqaba ukuphendula imibuzo ethile. 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityaqonda ukuthi nginelungelo lokuhlela isikhathi nendawo lapho kubanjelwa khona ingxoxo. 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
<ul style="list-style-type: none"> • Ngityavuma ukuthi le ngxoxo iqoshwe. 	Yeb <input type="checkbox"/> Cha <input type="checkbox"/>	
* Ngokusayina le fomu ngityavuma ukuthi ngikufundile futhi ngakuqonda okuqukethwe yilo.		
_____	_____	_____
Igama lozibandakanyayo	Isiginisha	Usuku
_____	_____	_____
Igama lomcwaningi	Isiginisha	Usuku

Appendix 9: Interview guide (Nurses)

Interview Guide – Nurses

Section one:

1. Gender
2. Age (20-30; 45-50 or above 60)
3. What is your current position at the clinic?
4. How long have you been working at the clinic? Tell me about your experience of working at the clinic?

Section two:

1. What are the HIV prevention methods that are offered to AGYW at the clinic?
2. What is Oral PrEP
3. What do you know about it?
4. When PrEP is available at public clinics, how do you think it can be made available relevantly for AGYW?
5. Do you think PrEP is something AGYW will take up in this clinic?
6. With all your experience, working with AGYW, how can PrEP be made available in an effective way?
7. How can young people be encouraged to take PrEP and continue taking PrEP?
8. What causes inconsistency among AGYW? When it comes to issues of adherence to treatment?

Section three:

1. What do you understand AYFS? What is it in your own understanding?
2. With the current structure of the clinic, do you think the clinic has enough capacity to run the AYFS programme?
 - Are there enough facilities?
3. Did the South African government have a prescription given to clinics to run the AYFS programme?
4. Do you think the clinic is in a convenient location for AYFS programme to run?
5. Is the current structure of the clinic suitable for AYFS? Is the current structure youth friendly for AGYW? What is your perspective on this?
6. Do you think the current AYFS are accessible to all AGYW in this area?

7. Do you think those AYFS that are implemented in the clinic are fair for AGYW?
 - Do they infringe on their rights?
 - Are they appropriate for them?
8. So far, are they effective? Are you seeing a good response from AGYW?
9. Do you think the AGYW are adjusting and accepting the services as well?

Section four:

1. Have you been trained to facilitate AYFS?
2. What are some of the skills that you have gained through the training?
3. What are some of the challenges you (as a nurse) face in providing service for AGYW?
4. What do you think can be done to tackle these challenges?

Appendix 10: Workshop Guide

Data Collection Participatory Workshops: Date: Participants: 10 (invited) per clinic (3 clinics)

Time	Activity	Facilitators	Materials	Outcome
Day 1				
09h30-10h00	Arrival, Set up,	Phiwe & Yonela	Sweets, juice All Stationary	Facility set-up for participants
10h00-10h30	Phase One: Introduction <ul style="list-style-type: none"> - Welcome. - Who we are. - What we are doing. - Why we are doing this. - Clear understanding of participations. - Display Biomedical chart . - Q and A - Sign consent form 	Yonela (Assistant to be taking down notes)	Flipchart Marker Consent forms Pen	Participants understanding of the research agenda for the day. Signed consent forms
10h30-11h00	Phase Two: Introduction to Art Based Research <ul style="list-style-type: none"> - What is ABR? - Creativity and thinking out the box 	Assistant (Yonela to be taking down notes)	Chart Markers	Establish an understanding of ARB with participants
10h00-10h30	Picture exercise	Phiwe	Pictures	Ice-breaker Participants introduced to one another in a way that gives insight into their lives. Allow participants to share and open up about their personal lives.
10h30-12h30	Phase Three: Collaging	Yonela	Paper, colour paper, magazines,	Establish an understanding of collaging.

	<ul style="list-style-type: none"> - What is a collage? - What is collaging? - How can collaging help us? - Show collage. - Collaging exercise The participants will work on one collage that depicts or represents their dream clinic. What they would like to see the clinic look for it to be youth friendly. 	(Assistant to be taking down notes and photographs)	koki pens, scissors, markers, glue.	The collage complete
12h30-13h15	Phase four: Collage discussion <ul style="list-style-type: none"> - Debrief of collage 	Yonela (Assistant to be taking down notes)	Chart Markers Voice recorder	Understand participants experience of the collage exercise and understand overall findings.
13h30-14h00	Phase five: Photo-Voice <ul style="list-style-type: none"> - What is Photo-Voice? - What is its Purpose? - How can Photo-Voice help us? - Show Photo-Voice exercise 	Yonela	Camera Chart paper	
14h00-14h30	LUNCH			
14h30-15h00	Wrap up & explain next day workshop			

Introduction to Workshop (30 minutes)

Phase 1: Introducing the researcher and the researchers

Facilitators: Yonela and Assistant (30 minutes)

- Welcome.
- Who we are.
- What we are doing.
- Why we are doing this.
- Clear understanding of participation.
- Display Biomedical chart.
- Q and A
- What expectations do you have? Do you have any concerns/worries about the workshop?
- Signing of informed consent form (over 18)
- Signing of assent form (under 18 years)

Phase 2: Introduction to Art Based Research

Facilitators: Phiwe (30 minutes)

- Explain art based research to the participants:
 - ✓ What is Art based research?
 - ✓ How does it work?
 - ✓ Why is it needed etc.?
- Give participants an understanding the concept of participation and how to use art-based methodologies and participatory methodologies for research.

Phase 2: Picture exercise

Facilitators: Phiwe (30 minutes)

Icebreaker exercise to provide participants with the opportunity to introduce themselves in a way that gives insight into their lives.

- Place cut out pictures on the floor, making sure all of them are visible.
- Ask participants to walk around, looking at the pictures, and to pick any two pictures that they feel represents something about themselves. (This could be a picture that reminds them of someone in their lives, an event in their lives, their hopes and dreams for the future).
- Once everyone has picked their two pictures, ask participants to sit down in a circle.

- Ask each person to share their two pictures and why they picked them.

Phase 3: Collaging

Facilitators: Yonela and Assistant (2 hours)

- What is collaging?
- How can collaging help us?
- Show collaging.
- **Collaging exercise (Follow PhotoVoice schedule)**

Phase 4: Collage discussion

Facilitators: Yonela & Assistant (30 Min)

- A short discussion session where participants discuss what their particular Collage charts entail, and explain the significance of the picture cuttings and drawings.
- Allow two participants who want to share their Collage charts to share.
- The discussion session is intended to allow participants to debrief about their Collage chart, specifically discussing what they currently experience and what they would like to experience.
- Discuss whether HIV and SRH services are youth-friendly, as reflected in the Collage charts.

Phase 5: PhotoVoice discussion

- A short discussion session where participants discuss what their particular PhotoVoice charts entail, and explain the significance of the photographs.
- Allow two participants who want to share their PhotoVoice charts to share.
- The discussion session is intended to allow participants to debrief about their PhotoVoice charts, specifically discussing what they currently experience and what they would like to experience.

- Discuss whether HIV and SRH services are youth-friendly, as reflected in the PhotoVoice charts.

Closure for the day

The researcher thanks for participants for their participation and explains day two of the workshop. Give participants their interview times for the next day.

Appendix 11: Focus Group Discussion

Focus group guide

Research title: *Exploring the role of adolescent youth-friendly services (AYFS) in primary health care clinics that offer HIV and Sexual reproductive health (SRH) services for adolescent girls and young women in Vulindlela, Kwazulu-Natal, South Africa.*

SECTION A – 15 minutes

Introduction (by facilitator)

- *Warm welcome to everyone and introduction of the facilitator to all the participants*
- *The facilitator asks each all the participants to briefly introduce themselves and a mention of one of their hobbies (ice breaker for focus groups).*
- *Purpose of the focus group stated by the facilitator*

The purpose of this focus group discussion is to explore the current state of HIV and sexual reproductive health (SRH) services in the primary health care clinics in Vulindlela. It is to explore what youth-friendly services are provided for adolescent girls and young women and in what ways these services are youth-friendly for them. Since adolescents girls and young women face the largest burden of the HIV epidemic in South Africa, the scale up of interventions like AYFS are critical. Therefore, the direct input of adolescent girls and young women who are clinic user is crucial in order to understand the effectiveness of AYFS in the clinic. Moreover, secondary to the overall study is the interest to know how adolescent girls and young women desire the AYFS programme to be facilitated in the clinic.

Explaining of ground rules

It is encouraged that everyone be part of the discussions in a respectable manner; anyone can contribute after the previous speaker is done talking. Freedom of expression is acknowledged with the understanding that this may be exercised in a respectable manner; no one may make reference to individuals who are not present in the discussion. Everyone should express their opinion as there are no wrong or right answers. The focus group will have a duration of 1 to 2 hours with a break in-between for lunch

Read out a consent form, and then participants may sign their consent forms.

SECTION B- 10 minutes

The problem: a brief explanation of this study

Literature highlights that there is a need for sexual reproductive services that are user-driven and youth friendly for adolescent girls and young women. Much of the already existing HIV prevention methods have not been effective for young women in this age group. This will also be a response that will aid already existing HIV preventative methods and new technologies such as Oral PrEP. Services at the clinic have been highlighted as one of the barriers and challenge for the lack of adherence to HIV prevention methods. This study hopes to understand how user-driven youth friendly services can be created with the health care clinics in Vulindlela.

SECTION C- 20 minutes

Discussion on HIV prevention

1. When I say HIV, what is the first thing that comes to your mind?
2. How do you think people get HIV?
 - If most say through sexual intercourse, ask for other ways
3. How would you know if you have HIV?
4. Do you think HIV is a serious disease?
5. Do you think people can be infected with HIV and not be sick?
6. How worried are you about getting HIV?
7. What do you think you can do to prevent yourself from getting HIV?
8. Do you think some people are more likely to get HIV than others? Who? Why?
9. What do you think has caused adolescent girls and young women to be more vulnerable to HIV?
10. Do you think adolescent girls and young woman are in control of protecting themselves from sexually transmitted diseases including HIV?
 - Do you think men are in control of safe sex practices?
 - Do you think adolescent girls and young women have sufficient resources of protecting themselves against HIV infection?

11. Currently male condoms are the most commonly used methods of HIV. Do you think the male condom is an adequate means of protection for adolescent girls and young women?

- Why do you think many young women do not use a male condom for protection?
- What are your personal views of the male condom?

12. As a young woman in KwaZulu-Natal, do you think you are at risk of HIV infection?

SECTION D- 20 minutes

Discussion on current Services at the clinic

1. How do you prefer to receive information about your health?
 - Oral (discussion with people), Television, Radio, Newspapers, Written information (Pamphlets).
2. Tell me about the different ways you have received about your health?
3. Where do you go when you need help or information on SRH service? At the clinic? At school?
4. Has there been a time when you were sick and you thought it would be helpful to go to the clinic and see a nurse but you didn't go?
 - Tell me what prevented you from going to see the nurse at the clinic?
5. When was your last visit to the clinic?
6. How do you feel about the clinic?
 - How do the nurses and at the clinic treat you?
 - Do the nurses at the clinic try to help you with other concerns? Other health issues?
 - If not, would you have liked assistance for these issues?
 - Was the clinic open at a convenient time for you?
 - Were the nurses at the clinic available when you needed them?
7. In your own words, what is a clinic?
8. What do you see that tells you that is the clinic?
9. What is the clinic for? Give examples
10. Do you know anyone around you or in your community who uses the clinic?
11. What do you usually see people do at the clinic?

12. Have you or any of your friends been to the clinic?

13. Is there a clinic close by to where you live?

- From where you live, how far is the clinic?
- How long does/would it take you to travel from home to the clinic?

Lunch Break: 20minutes

SECTION E – 15 Minutes

(Continue) Discussion on services

1. What age group of people do you meet at the clinic?
 - Is it old men and women?
 - Is it people your age?
2. Have you or your friends been to your local clinic?
3. What made you decide to go to the clinic?
4. Can you share the first thing that you come across when you enter the clinic?
5. Who is the first person you meet at the clinic
 - Can you describe step by step what happens inside the clinic once you enter
6. Do people talk to each other at the clinic?
7. Do you speak to anyone when you are at the clinic?
8. Who do you speak to when you are at the clinic?
9. Why do you speak to that person?
10. Would you recommend the person you speak to at the clinic to your friends who want to go to the clinic? Why and why not?

SECTION F 15 Minutes

Discussion on user-driven services

1. What do you like about the clinic?
2. What don't you like about the clinic?
3. When you are at the clinic, what would you change about it?
4. If there was somewhere else to go for HIV and SRH services besides the clinic in your community, would you go? Why and why not?
5. Do you think it is important for you people your age to get involved in the clinic service delivery?
6. Do you think you people your age should be involved in decisions the clinic makes?

- Would you like to get involved in the decisions the clinic makes?
 - How would you like to get involved? Would you like to get involved in the decisions the clinic makes?
 - How would you like to get involved?
7. If nurses at the clinic asked you to share what you wanted to change about the clinic, what would you change?
 8. Do you think the clinic should involve young people by asking what services they need?
 9. How do you feel after coming to the clinic for HIV and SRH services?

RECOGNITION OF THE PROBLEM

Statistics shows that HIV prevalence is highest among women;

In your opinion, what factors have led to the high HIV prevalence among women?

IDENTIFICATION AND INVOLVEMENT OF LEADERS AND STAKEHOLDERS

In your opinion which stakeholders or government agencies has played a key role in the promotion and uptake of female condoms?

RECRUITMENT SCREENER FOR YOUNG WOMEN

This screener is for recruiting participants for a participatory workshop on oral PrEP implementation in sexual and reproductive healthcare services for young women.

Using this screener: Please keep a record of the number of people in each category who do not end up being selected.

Please recruit:

- Adolescent girls and young women
- All participants should be aged 15- 24
- Able to participate using English or IsiZulu language
- Participants should be drawn from three primary health care clinics: Mafakatini, Mphophomeni and Caluza.
- All adolescent girls and young women must be accessing the primary health care clinic for: HIV, prevention, HIV testing and counselling, antenatal care and family planning.

Note: It is very important to ensure that the participant selected are available and committed to attending the two-day workshop.

Introduction for persons being screened for participation

- Good day. I am _____ from (organisation) _____.
- We are bringing together a small group of adolescent girls and young women to participate in a two-day workshop that will take place in the coming 1 to 2 weeks.
- I would like to ask you a few simple questions to see if you fall in the category that we would like to invite to participate in the workshop. Do I have your consent to proceed with these questions?

Screenener questions

Q1. Are you comfortable participating in part a discussion that is held mostly in English and Zulu?

A	Yes	Continue
B	No	IF NO, END INTERVIEW: <i>Thank you, but unfortunately we are looking for people who are with a discussion held mostly in English and Zulu</i>

Q2. How old are you?

A	Below 18 years	IF <18, END INTERVIEW: <i>Thank you, but unfortunately we are looking for people who are within a different age group</i>
B	18-35 years	Continue
c	Older than 35	IF >24, END INTERVIEW: <i>Thank you, but unfortunately we are looking for people who are within a different age group</i>

Q3. What is the highest level of education you have completed?

A	Less than a high school leaver's certificate	Continue (Select at least 1, maximum 4)
B	Completed high school	Continue (Select at least 1, maximum 4)
C	Some post-school training	Continue (Select at least 1, maximum 4)
D	Post school degree / diploma	Continue (Select at least 1, maximum 4)

Q4. What is your current employment status?

A	Unemployed	Continue (Select at least 1, maximum 4)
B	Student (full or part-time)	Continue (Select at least 1, maximum 4)
C	Employed (part-time)	Continue (Select at least 1, maximum 4)
D	Employed (full-time)	Continue (Select at least 1, maximum 4)

Q5. In the past five years, have you taken part in campaigns or projects that support any of the following?

A	Local community issues	Continue if yes OR no
B	Employment related issues	Continue if yes OR no

C	Environmental issues	Continue if yes OR no
D	Gay or lesbian issues	IF 'YES', END INTERVIEW AFTER ASKING QUESTION E.
E	Sex workers	IF 'YES' to D or E, END INTERVIEW: <i>Thank you, but unfortunately we are looking for people who have been involved in a different combination of issues</i>

Ensure that you have a contact number and alternate contact for each participant. Enter onto list.

- Where is the workshop and when will it be held?
Indicate the time and place of the workshop
- How will I get to the workshop?
You will be reimbursed for travelling to the workshop R50
- *How long is the workshop?*
Day 1 will be from 8:30am till 2:00pm and day 2 will be a 45-minuet focus group. Refreshments will be provided
- *How many other participants will there be?*
The total number of 10 participants are invited
- *What is the exact purpose of the workshop?*
The facilitators are interested in understanding the youth-friendliness of HIV and SRH services in primary health care clinics for adolescent girls and young women.

LIST OF PARTICIPANTS

Number	Participant Name	Contact cell	Alternative contacts
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