Youth-Centered Clinics: The Voices of Adolescent Sesotho-Speaking Girls From Mangaung, South Africa

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Abstract
Youth-centered health services have become a global practice and South Africa is no exception. This paper describes a project conducted in Mangaung in 2018 using cultural consensus modeling. We conducted 25 interviews and used a combination of hermeneutics, phenomenology theory, and thematic analysis. Our research found that girls in our sample have confidentiality concerns associated with the stigma of attending a clinic and cannot talk openly about sex and HIV. Themes related to negative experiences included the lack of confidentiality, the stigma of HIV, the lack of professional neutrality, failure to understand adolescents, poor service, systemic problems (long queues), and administrative problems. Positive themes included believing that clinics could help prevent pregnancy, provide information, create a safe space, and help with moral support. Moreover, some interviewees reported that services were good and that they provided products and support that were not available from home. However, many said they had to attend public clinics because they could not afford private alternatives. Some said the clinics offered a safe space and staff have positive attitudes. In the absence of discussions about sex at home, the clinics ultimately perform an important function, but systemic problems remain. More can be done by schools and households to reduce the stigma associated with sex and HIV.

Keywords
Youth-centered clinics, adolescent girls, cultural consensus modeling, HIV, teenage pregnancy

Introduction
More than 80% of the population depends on free public health services. Adolescent girls in South Africa are at particularly high risk of unwanted pregnancies and contracting sexually transmitted infections (STIs) such as HIV (Simbayi et al., 2014; Statistics South Africa, 2012). However, South African youth often avoid attending the public facilities because they experience the services negatively (Geary et al., 2015). Providing adequate, youth-friendly services to adolescents at the public clinics could play a role in lowering teenage pregnancies to meet global development goals (Jewkes et al., 2016). Health systems globally have accepted the need for youth-centered health services, but providing such specialized clinics has been difficult as it deviates from existing models and procedures.

Worldwide, health experts acknowledge the critical role of health services in addressing the sexual and reproductive health of adolescents (Geary et al., 2014; United Nations, 2015). Often, policymakers suggest youth-centered strategies to improve the services at health facilities for adolescents. For example, an Australian study among migrant populations concluded that youth-friendly and culturally appropriate care could be integrated into mainstream care (Mokomane et al., 2017).

The research points to several reasons why adolescents were not visiting South African public health facilities for reproductive health purposes: unawareness of available services, service providers’ inability to design reproductive health services that are culturally and developmentally suitable for adolescents, lack of privacy and confidentiality at the clinics, long waiting times, poor quality of care, and a lack of choice of services (Geary et al., 2014, 2015; Mokomane et al., 2017). In a study of the sexual health of adolescents in South Africa, the authors argued that “greater

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effort needs to be made to address the unique attributes, needs, and priorities of this population” (Schriver et al., 2014).

There is a narrow focus of many health facilities on curing rather than preventing disease and on priority populations such as HIV patients, and the sensitivity associated with sexual health services (Botfield et al., 2017). The narrow focus results in an emphasis on diseases rather than prevention. They note that stigma is attached to seeking these services, that insufficient information is available from the clinics, and that the youth are concerned about the lack of confidentiality, especially where an interpreter is present. Adolescent girls may also experience feelings of fear, shame, or taboo after visiting clinics. Research notes the inadequate coverage or implementation of the South African youth-centered programs (Geary et al., 2014).

Youth-centered health facilities emphasize that sexual health services should become more acceptable to the youth, and in practice these services should mean a more comprehensively integrated a positive approach to sexuality at the clinics (Alli et al., 2012). Botfield et al. (2017) suggest that cultural competency training and a more comprehensive approach (e.g., providing education as opposed to only contraceptives) and recommend that staff at youth-centered clinics should listen to the authentic voices of adolescents to improve the services at the clinics, and they suggest a dialogue with the youth.

### Problem Statement

Research to date is vague and there is no consensus about what youth-centered health services are. Furthermore, the idea of youth-centered services is new in developing countries (Alli et al., 2012). Overall, there remains a need for research on health services provided to the youth, the barriers the youth experience, and ways to scale up these services.

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**Table 1. Summary of South African Literature.**

| Source         | Methods                                      | Positive aspects of clinics                                                                 | Negative aspects of clinics                                                                 |
|----------------|----------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Alli et al.    | Qualitative interviews with clients and health | Helpful and friendly                                                                      | Negative attitude of staff<br>Judgmental staff<br>Limited contact time with staff<br>Communication and cultural barriers<br>Age barriers<br>Not obtaining information<br>Accessibility and availability<br>Logistical problems: Lack of human resources, high caseload, long queues, and long waiting times |
| (2012)         | care workers                                  |                                            |                                                                                           |
| Geary et al.   | A cross-sectional survey of young people visiting clinics | Healthcare workers were friendly, respectful, knew how to talk to young people, value them seeking health information. | Having to show soiled sanitary products to obtain contraceptives, healthcare workers expressing negative opinions about young people seeking information, lack of privacy, and inadequate information. |
| (2015)         |                                              |                                            |                                                                                           |
| Geary et al.   | Qualitative. Key informant interviews with    | None mentioned                                                                            | Lack of youth-friendly training among staff, lack of a dedicated space for young people, and breaches in confidentiality |
| (2014)         | staff at clinics                              |                                            |                                                                                           |
| Mokomane et al.| Secondary data Facility assessments Key informant interviews Focus group discussion with young people |                                            | Access to health facilities is not always adequate<br>Operating hours are not always appropriate<br>Limited services available<br>Favoritism |
| (2017)         |                                              |                                            |                                                                                           |
| Schriver et al.| Qualitative. Key informant interviews        |                                            | Lack of resources<br>Long waiting hours<br>Poor quality of care<br>Little choice<br>Perceived inequality<br>Insufficient reproductive health information and the clinic should accommodate both boys and girls.<br>Sessions for discussions facilitated by a professional person and a special program of activities is conducted during school holidays. |
| (2014)         |                                              |                                            |                                                                                           |
| Seekoei       | Cross-sectional survey                        |                                            |                                                                                           |
| (2005)         |                                              |                                            |                                                                                           |
The findings described in this paper derive from one phase of a 2018 project using CCM, an approach in which “individuals define the boundaries regarding a set of knowledge or behaviors shared by a group within a culture using an ethnographic approach” (Brown et al., 2018). The project focused on Sesotho-speaking girls aged 13 to 17 years and the project had four phases (Table 3).

In phase 1 we asked 50 girls (average age 15.7 years), recruited by means of a pamphlet distributed in the community, questions about perceived cultural norms and peers’ behaviors as opposed to their actual behavior and allowed them to use shared cultural knowledge. For example we asked the respondents “What do other adolescent girls in your community think are good ways to prevent pregnancy?” and “What do other adolescent girls in your community think are good ways to prevent HIV?” to avoid individualized questions. The girls identified 41 pregnancy prevention and 29 HIV prevention strategies. Examples of pregnancy prevention strategies were taking contraceptive pills, using condoms, and seeking information from clinics. The responses suggested that their decisions are mostly based on the cost of the prevention method (they chose clinics because the service is free), its side effects, and availability. The most common HIV prevention strategies mentioned were abstinence, condom use, monogamy, and avoiding other HIV risks (such as drug use, or contact with someone else’s blood).

In phase 2 we asked 100 girls (average age 15.6 years) to rate on a 5-point Likert scale the extent to which they valued the cultural beliefs identified by the girls in phase 1 and the acceptability of the strategies listed. The responses to the questions in phase 2 revealed one distinct cultural consensus. Our cultural consensus analysis (similar to factor analysis) revealed one model with four main components: having good peers, abstaining from sex or having faithful relationships, accessing free public health care, and using condoms.

In Phase 3 we interviewed 25 girls chosen as “key informants” from phase 2. From them we gathered in-depth information on the identified determinants of health behavior. We discuss these qualitative interviews in detail in the rest of this paper. Lastly, in phase 4, we conducted a cross-sectional survey of 300 Sesotho-speaking girls to determine how the CCM relates to individuals’ behavior (as opposed to

### Methods

**Cultural Consensus Modeling (CCM)**

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questions about “girls like you”). In phases 1 to 3 the focus was on group behaviors rather than individual behavior. In this paper we only discuss phase 3.

The Phase 3 Sample

We conducted 25 individual interviews with Sesotho-speaking girls, aged 13 to 17, sampled from the 100 we interviewed in phase 2. We selected those whose responses were most consistent with the single cultural consensus model according to the cultural consensus analysis. This is standard practice in CCM. The main reason for this approach was that we wanted the respondents who best fitted the CCM. Two girls did not want to participate and we replaced them with the next two on the list. The girls who participated received a grocery voucher of R100 (approximately 8.16 USD in 2018). The purpose of the study was explained to the girls as trying to understand how society views pregnancy-prevention methods. Thus, the participants were not asked what their direct opinions were, but rather how “girls like you” think about specific pregnancy prevention methods. It is in this context that we received numerous responses in terms of the public-health system.

The Questions

The research team designed the interview guide to clarify and expand the findings from phase 2. The questions required the respondents to reflect on the experiences of other adolescent girls rather than just their own. They were asked four questions about pregnancy and HIV prevention services at clinics: “What is the experience like going there for (1) pregnancy or (2) HIV prevention services for girls in your community?” and “How do nurses and workers in the clinic treat adolescent girls looking for (3) pregnancy or (4) HIV prevention?” The interviewers asked these four questions at different stages during the interview, but we analyzed them together.

Data Analysis

The fieldworkers translated the transcripts from Sesotho to English. The English transcripts were then analyzed thematically. Two postgraduate students did this independently from one another in In Vivo. With the help of the PI, the coders identified themes, segmented the text, and applied codes for the themes to each text segment. The PI also assisted in developing the codebook and in reconciling coding differences. We also annotated the data content and patterns that came to the fore during the analysis. We used an initial classification system to select transcripts randomly, then refined the initial codes, and discussed the possible revisions. We used two independent raters and resolved discrepancies by using a third coder. We based our interpretation on two main grounds. First, we considered both negative and positive experiences (hermeneutics) of visiting clinics. Secondly, we tried to derive meaning (phenomenology) from the experiences.

Limitations

Our study has several limitations. For example, we did not ask the girls whether they attended public-health facilities. Thus, we were not always sure whether the girls referred to their own experiences or not. We also did not know whether the participants were sexually active and it could mean they had limited experiences with seeking sexual health services. Furthermore, we cannot generalize to other South African girls since we recruited Sesotho-speaking adolescent girls in a single region.

Results

We combined the responses to the questions about pregnancy prevention and HIV prevention because the girls’ experiences of these clinic services were similar, even though government policy focuses on the latter rather than the former.

Socio-Demographic Characteristics

The average age of the girls we interviewed was 15.2 years and 24 of the 25 spoke Sesotho as their primary language (the other one was fluent in Sesotho). All the participants were born in the Free State province in which Bloemfontein and the Mangaung township is located. Two respondents had
not completed primary-school education, while the rest were all busy with secondary-school education. Furthermore, 20 participants lived with a mother or father or both, with 5 living with relatives. On average, the girls lived in a household with 1.2 people having a paid job. Only two respondents had access to the internet in their homes.

**Negative Experiences**

We identified seven negative themes from these responses.

First was the major issue of lack of confidentiality. Two possibilities troubled the girls and made them wary: neighbors or friends might see them at the clinic, and the nurse who helped them might not keep their information confidential. One girl said once you enter the clinic “you will be checking who is looking at you,” and others made remarks like “those who saw you start talking about you” or “they will tell their neighbors or someone they know that they saw you at the clinic.” Being seen at the clinic by neighbors and friends, the girls said, leads to rumors and their parents receiving informal notice of their clinic visit. Commonly, girls thought people who see them would gossip about them getting contraceptives or going for an abortion. One girl elaborated the problem, saying “there are those who, after sleeping with a person they did not want to sleep with, contract HIV or even fall pregnant. They become ashamed because it is not something they wanted” and it was not their fault. One respondent compared the public sector clinics’ confidentiality with that of the private hospitals, saying the latter “do not behave in that manner.”

Second, and linked to the issue of confidentiality and openness in talking about sex, was the stigma attached to HIV and falling pregnant unintentionally, which meant that visiting a clinic would get a person talked about. The stigma attached to visiting a clinic is in direct contrast to positive storylines that portray girls visiting clinics to prevent pregnancy and HIV as being responsible. Going to a clinic for an HIV test or services was already frightening enough and the stigma made it worse.

Third was the issue of lack of professional neutrality. Many girls complained about the judgmental nature of the clinic staff’s interaction with them and said they were afraid of the nurses. They complained about how they had been treated, or might be treated. They complained about staff lacking listening skills, being unwilling to answer questions, having “an attitude,” being stubborn, acting in an authoritarian way, being strict, and behaving as if they were parents. These complaints came from girls who felt that the nurses disapproved of them for having sex, or assumed they had visited the clinic because they had had sex. Many mentioned nurses shouting at them, being rude, and scolding them for doing something wrong. They quoted the nurses as saying: “What are you doing here? You are too young,” or “Why are having sex while you are still a kid?” or “Why are you doing bad things?”—remarks based on the assumption that the girls were not supposed to be having sex at their age. Along with this approach was gender stereotyping. One respondent said the nurses often tell them that girls of their age should be at home and doing the cooking and sex should not be on the agenda. The remarks suggest that nurses do not fully understand the socio-emotional makeup of adolescent girls who attend the clinics. Being in a position of authority and having extensive biological and primary health care knowledge, nurses may be insufficiently aware that the authoritarian approach does not help the girls get answers to their questions or the information they need. One respondent said the nurses at the clinics are “very strict, which makes it difficult for us to ask questions,” while other respondents said things like “we are afraid to speak” or “some nurses do not have hearts,” or “some nurses are unwilling to listen to my side of the story.”

Fourth was the issue of failure to understand adolescents. The girls realized that such behavior has implications for how they think about sex and for their self-esteem. One girl specifically said that this judgmental behavior does not take into account the low self-esteem of her peers, while others complained that the nurses do not care about their feelings.

Fifth, although mentioned by only a few, was the issue of poor service. There were some complaints about the nurses deliberately providing bad service or hurting them on purpose when they receive a pregnancy prevention injection.

Sixth were systemic problems at the clinics. We heard complaints about long queues, clinics being too busy and girls being sent back to come another day, and about adults being given better service, and adults being prioritized, which meant that the girls had to wait longer, increasing the likelihood of being seen by someone they know and being embarrassed.

One of our respondents aptly summed up the consequences for an adolescent girl of not getting adequate service at a public clinic: “She ends up not going to the clinic, and she ends up lying to her boyfriend about being on birth control, continues to have sex and falls pregnant.” It is a matter for concern that this will remain the reality if clinics do not develop services that provide girls with comfortable spaces for conversations about sex.

Seven, the administrative system at the clinics was part of the problem. The girls were under the impression that the clinics seated people in different rows according to whether they were HIV positive or simply there for HIV testing. This emphasized the stigma attached to HIV. One respondent also complained that sometimes only male staff provide the services. Receiving the service from a man made her feel uncomfortable.

**Positive Experiences**

We identified six positive themes.

First was pregnancy prevention. Many girls viewed a visit to a clinic as a crucial service to help them avoid falling pregnant.
One said “it is better to prevent pregnancy than to have a child while you are still young yourself.” This shows that what was important for the girls was being able to decide whether to become pregnant or not. This had minimal bearing on whether to have sex or not. Some girls associated the availability of pregnancy prevention services at clinics with being able to find a job or continue their education.

Second was provision of information. For some girls the clinic provided information they could not access elsewhere. This reflects the dependence of poor girls on public clinics. Some girls felt that the information nurses provide does have some authority, as opposed to information they receive from their friends, parents, or the internet.

Third was the availability of a safe space. Some of the girls said the clinics do provide a safe space for discussions on reproductive health. One said that “as friends, we are afraid to talk as we do not want to be judged” and that she was “very happy that we have the clinic services because now you can see the things that you never thought could exist.” At least one respondent said the clinic staff could be trusted and complimented the nurses for providing adequate information.

Fourth was moral guidance. Some girls saw the availability of information as a way to behave morally and abstain from sex. Setting an example by going to a clinic was a way to ensure that the message of abstinence reaches other girls and some saw it as a way to reprimand girls who have sex.

Fifth, in contrast to the negatives above, some girls mentioned excellent service from nurses who pay attention to girls, help them with their needs and treat them well. One respondent added the proviso that good service was possible “if you don’t go there with an attitude.”

And sixth was supplying what the home cannot provide. Many girls contrasted their positive experiences at the clinics with the lack of information in the family setting. One respondent said girls were happy to have the services they could not find at home. She said: “Sometimes you can see that parents are afraid to talk to their children, or you cannot speak to your friends about such issues, so it is best to get the information at the clinics.”

Discussion

Our study revealed that negative experiences of clinics were fueled by confidentiality concerns, the stigma associated with HIV and unplanned pregnancies, the nurses’ judgmental approach, their inability to understand and empathize with adolescents, poor service, and systemic problems. To a large degree these results confirm existing research in South Africa (Alli et al., 2012; Geary et al., 2015). These responses reflect the problems of not talking about reproductive health issues and HIV and pregnancy prevention, or judging adolescent engagement in sexual activity as wrong (Jewkes et al., 2016). Our paper goes beyond these finding and highlight the girls’ suspicions that someone would talk about them visiting a clinic are rooted in their society’s perception that adolescent sex is wrong and lack of openness to these discussions in their family circles. Although there is much room for improved services from the clinics, we think this problem should also be seen against the broader inability of society to talk about reproductive health issues.

The clinic staff’s response is often authoritarian, a point made in the existing literature (Geary et al., 2014, 2015). The authoritarian approach is linked to a biomedical and diagnostic approach, but is also rooted in the local culture of our sample of Sesotho-speaking girls, which does not encourage open discussion about reproductive health. Advice given by the staff at the clinics is often dominated by the government message of abstinence, a message that may also spring from the traditional Christian emphasis. Listening to the girls attending the clinic and giving them an opportunity to ask questions requires a different set of skills, as Mokomane et al. (2017) highlighted.

The positive responses suggested aspects that policymakers could build on. Clinics were valued for the mere availability of pregnancy and HIV prevention services, for being the only place where the necessary and accurate information was available, for providing a safe space to talk about sex, for moral guidance, for providing good treatment, and for filling the gap in pregnancy and HIV prevention information at home. These aspects confirm other research that also indentified positive experiences (Alli et al., 2012; Geary et al., 2015). Although we mostly hear negative aspects, these positive aspects can lay the foundation for improved services.

We also asked the girls for suggestions on how to improve the current service at clinics. We did not receive much advice from them, despite it being obvious that the clinics need to find ways to deal with their negative experiences and improve the service delivery. One piece of advice was that schools could do more about sex education. In contrast to their perceptions of the clinics, two girls said a better atmosphere exists at the schools. Some girls found the school a comfortable environment where peer learning takes place. The second piece of advice was that clinics should place more emphasis on education and enhanced counseling services. This finding confirms that of Seekoei (2015), who also advocated that schools and communities should respond.

Conclusion

Preventing teenage pregnancy and HIV infection is essential in the development paths of adolescent girls. Many governments provide youth-centered health services. The South African government has also embarked on this route, but several problems remain and the services at many clinics are not much different from standard health services and may be significant barriers to receipt of needed sexual health care. Our project brought to light one salient cultural model associated with free pregnancy and HIV prevention services in South Africa.
In principle, our sample of girls saw going to a clinic as an essential step to prevent pregnancy and HIV. Nevertheless, about two-thirds of the respondents experienced the services as inadequate, although one third reported positive experiences. Our findings show that clinics can do more to provide youth-centered services in South Africa. Moreover, the Department of Health should prioritize this. However, the problem will only be addressed adequately once the stigma attached to adolescent sex, pregnancy, and HIV infection receives adequate attention at homes and schools.

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