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Young people's perceptions of access to sexual and reproductive health services in Manzini, Eswatini: a qualitative study

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Abstract

Despite the global agreements on adolescents' sexual and reproductive health and rights (SRHR), access to and utilisation of these services among the young people including adolescents remain unsatisfactory in low- and middle-income countries including eSwatini. This study aimed to explore and describe young people's aged 10-24 perceptions of accessing SRHR services. Convenience purposive sampling was used to recruit fourteen (14) participants who were seeking SRHR services at Family Life Association of Swaziland clinic in Manzini. Semi-structured interviews were used through face-to-face in-depth and audiotaped interviews, in October 2017. Colaizzi's seven steps of data analysis was used. Barriers to service access include low health literacy, stigma, privacy and confidentiality. Enablers of utilisation of the services were mostly structural in nature which included community outreaches and health education. Providing young people with SRHR information and services through the existing healthcare system, presents an opportunity that should be further optimised. *(Afr J Reprod Health 2026; 30 [4]: 13-21).*

Keywords: Access, perceptions, sexual and reproductive health, young people

Résumé

Malgré les accords internationaux sur la santé et les droits sexuels et reproductifs (SDSR) des adolescents, l'accès à ces services et leur utilisation par les jeunes, notamment les adolescents, restent insuffisants dans les pays à revenu faible et intermédiaire, y compris en Eswatini. Cette étude visait à explorer et à décrire la perception qu'ont les jeunes de 10 à 24 ans de l'accès aux services de SDSR. Un échantillonnage raisonné de commodité a permis de recruter quatorze (14) participants qui sollicitaient des services de SDSR à la clinique de l'Association pour la vie familiale du Swaziland à Manzini. Des entretiens semi-structurés ont été menés en face à face, approfondis et enregistrés, en octobre 2017. L'analyse des données a suivi la méthode des sept étapes de Colaizzi. Les obstacles à l'accès aux services comprennent un faible niveau de littératie en santé, la stigmatisation, le respect de la vie privée et la confidentialité. Les facteurs favorisant l'utilisation des services sont principalement d'ordre structurel, notamment les actions de sensibilisation communautaire et l'éducation à la santé. Fournir aux jeunes des informations et des services de SDSR par le biais du système de santé existant représente une opportunité qu'il convient d'optimiser. *(Afr J Reprod Health 2026; 30 [4]: 13-21).*

Mots-clés: Accès, perceptions, santé sexuelle et reproductive, jeunes

Introduction

In many countries worldwide, there is a significant concern regarding inadequate sexual and reproductive health and rights (SRHR) among adolescents and young people[1].One of the 2030 agenda for Sustainable Development Goals (SDGs) is to achieve universal access to sexual and reproductive health and rights (SRHR) services.[2] It requires that services are of adequate quality and that providers do not discriminate based on sexuality, gender, ethnicity, and age.[3]Young people (10-24 years) require services that support their physiological, cognitive, emotional, and social transition into adulthood.[4] Globally, there is a significant concern regarding inadequate sexual and reproductive health and rights (SRHR) among adolescents and young people.[1] This population group faces an elevated risk of acquiring sexually transmitted infections (STIs) such as human immuno-deficiency virus (HIV), as well as experiencing violence and unintended pregnancies,

particularly among young girls. In addition,adolescents and young people encounter various inequalities such as limited access to information, discrimination, exclusion, and violence.[5] According to Morris and Rushwan,[6] approximately 1.8 billion individuals, representing a substantial portion of the global population, fall within the age range of 10 to 24 years. Therefore, addressing SRHR risks is a matter of global health concern.In low and middle-income countries (LMICs), adolescents and young adults aged 15–24 account for approximately one-fifth of the population.[7] However, the needs of this population, especially regarding SRHR, are often unmet, overlooked, and underfunded. The challenge of SRHR risks is a concern particularly, in sub-Saharan Africa where its young people continue to grow substantially.[8,9] Poor SRHR service provision among young people threatens their future. This is particularly true in developing countries where the weak and staggering health system is the only means to address the SRHR needs of young people.[10]To address this issue, African countries have been implementing strategies like comprehensive sexuality education (CSE), peer education, mass media campaigns, and establishing youth-friendly centres both at community and facility levels.[11] Aligned to HIV care and prevention among young people, especially for adolescent girls and young women (AGYW), is access to SRHR services, particularly safe, voluntary family planning. Family planning is central to gender equality and women's empowerment and is a key factor in reducing poverty. It enables women to plan the number and timing of their pregnancies including the choice to have a child.[12,13] Yet globally, in 2022 about 160 million women who wanted to avoid pregnancy did not use safe and effective family planning methods, for reasons ranging from their partners or communities.[13]

In Eswatini, the total fertility rate for women in the reproductive age group of 15-19 years is 3.3.[14] The percentage of women aged 20-24 years who have at least one live birth before age 18 is 16.7%, and contraceptive use stands at 66.1%.[14] The unmet need for family planning stands at 28.6% among adolescents.[14]HIV prevalence among adolescent girls aged 15–19 years is 10.2% compared to 1.9% for males of the same age.[15] In the age group 20–24, HIV prevalence among females is 38.2%, HIV incidence among adolescent girls aged 15–19 is 3.8%;[15] , while HIV suppression is at 55.5% among women 15-24 years.[16] Where there has been a slight drop in the prevalence of HIV among AGYW five years later from the SHIMS 2 findings, the prevalence is still higher when compared to males of the same age group.[17] For instance, females 20-24 years had 4 times higher prevalence than males of the same age 17.2% among females vs 3.9% among males, and those aged 25-29 years had a 5 times higher prevalence than their counterparts 30.3% among females vs 5.4% among males.[17]

This shows the need for improved access to available SRHR services in facilities for AGYW, hence the aim of the study was understand the perceptions of accessing SRHR services among young people. The specific objective of the study was to describe the perceived barriers and enablers to the access of SRHR services among young people in Manzini. Findings of this study are novel in that they highlight the perspective of AGYW as the affected population to inform policy and strategies for reaching them with SRHR services in a manner that meets their needs and perceptions.

Methods

A descriptive exploratory study design was used to solicit, explore, and describe the perceptions of young people on issues related to their SRHR. The study took place at the Family Life Association of Swaziland (FLAS) in Manzini, Swaziland. FLAS is a non-governmental organisation providing mainly SRHR services. This site was selected because it implements the ASRH program, especially among young people. The accessible population in this study consisted of young people, both females and males, seeking SRHR services from FLAS. To be included in this study, the participant had to be a young person aged 10-24 years and either female or male, seeking SRHR services at a health facility.

Sample size and sampling method

The guiding principle in sample size was determined by data saturation, that is, sampling to a point at which no new information is obtained and

redundancy is achieved. Therefore, the sample size for this study was determined by data saturation. Sampling was terminated when category saturation was reached, that is, the point in data collection where new data no longer brought additional insights into the research questions.

The researcher used convenience purposive sampling to select the study participants, that is, the target study population of clients aged 10-24 years was categorized into 10-14; 15-19 and 20-24 to ensure the inclusion of a range of young people in the sample. Participants in these age groups who were available at the time of data collection and willing to participate in the study were enrolled. Participants in this study were able to converse in both English and siSwati since these languages are official in eSwatini.

Data collection methods

The interviews were conducted in a waiting area, which was adjacent to the consultation rooms. However, participants were requested to move away from the crowd. The researcher used a semi-structured interview guide to collect data from young people seeking SRHR services who had consented to participate in the study. The researcher took verbatim notes while noting down non-verbal responses. Where necessary, questions were explained. Each interview lasted for about 25 minutes. A voice recorder was also used to record the interviews. The researcher had developed an interview guide comprising mostly of closed-ended questions on biographical information. Open-ended questions were designed to understand accessibility of SRHR services for young people.

However, probing was done where necessary. The probing questions were not the same for each interviewee and did not follow any order. The questions in the interview guide were simply to direct the conversation to capture the young people's perceptions of the reproductive health services in Manzini, eSwatini.

The interviews explored the following: identify and describe SRHR services for young people, views and perceptions of available SRH services, barriers to and facilitators of seeking health care and suggestions for improving access and utilisation of services.

Data analysis and management

Data analysis and management began during the data collection process. The data gathered from young people through face-to-face in-depth individual interviews were audio-recorded to ensure verbatim accuracy. Transcription of data was done within 24 hours of each interview.

This assisted the researcher to immerse herself into the data and data organisation. The interview guides and collected data were kept under lock and key throughout data collection and analysis. The data collected were checked for completeness, accuracy and clarity by the researcher. Appropriate measures were taken on time to ensure completeness before the analysis. Data analysis in this research has been adapted from the work of Colaizzi (1978:58) who emphasised that one must match the appropriate source of data with the appropriate method for data collection. Statements began to emerge and were recorded as a word in the right margin beside the relevant text.

Where there were two statements in any excerpt, the researcher saved the statement in two MS Word documents. The researcher conducted 14 interviews, meaning units emerged and some meaning units were similar. These meaning units were grouped together and saved in another Word document. Other meaning units remained singularly and remained on their own. To aid in the development of theme clusters, the researcher read the transcripts and listened to the tape recordings of the interviews again. Following this, the researcher reviewed each meaning unit and found that some meaning units were related to others and could be grouped together to form "theme clusters". These "theme clusters" were used by the researcher to give a full description of how the participant's perceived access and utilisation of SRHR services.

Ethical considerations

Before conducting the study, research protocol was submitted for comment, guidance and approval to the research ethics committee; Unisa Ethics Committee: Department of Health Studies.After feedback and corrections in some elements of protocol, the study was ethically approved to carry out in respective site. Hence, the letter for ethical

approval was attached to the letter requesting to conduct the study from FLAS.The study was conducted after FLAS authorities granted a letter for permission. In the IDIs, informed consent was obtained from each young person, who signed a consent form, after a detailed explanation about the purpose of the study had been given.

Results

Demographic details of young people

All 14 participants were young people aged 10-24, both males and females. A close look at Table 1 reflects that there were more females, that is, twelve, compared to only two males. Most participants, eleven, were aged between 20-24 years, followed by only three aged 15-19 years. There were no participants aged 10-14 years. Seven of the participants have reached a tertiary level of education, five had high school education and two had secondary level education.

Barriers of access to SRHR services for young people

All 14 participants viewed SRH services to be inaccessible owing to the following obstacles: Lack of privacy and confidentiality, Health workers' negative attitude, Lack of knowledge about availability of SRH services, Inaccessibility of services, Fear of parents, community and peers, young people's ignorance, religion.

Lack of privacy and confidentiality

Participants (ten) in this study viewed lack of privacy and confidentiality as limiting factors in accessing SRH services. Young people feared that being seen at the health facilities might raise suspicions and questioning about their reasons for seeking health care services, and were anxious that their parents might know that they had sought SRH services.

One participant commented: *"Young people don't even know how condoms are used and where to get them even those which are free. But even if they know where they can get them especially in the shops, they become scared to take them because the shopkeeper is from the same community would say "…the boy has started sleeping [around]." Nisoo (23 years [Male]).*

Young people expressed those services were inaccessible owing to many factors. Inaccessibility of health services. In this study inaccessibility included long distance to clinics and inconvenient operating hours, lack of money for transport, services regarded costly, access to health information, and long waiting time especially in public health facilities. SRH services were available from Monday to Friday from 8 am to 4 pm, and usually closed on Saturdays and Sundays, which youths perceived to interfere with their school time.[18-22]

Health care workers' negative attitude

Participants (nine) strongly perceived that health professionals' behaviour and attitude toward their work and toward young people discouraged them from accessing SRH services.

One participant expressed: *"You know my sister, the nurses there in the clinics shout at you especially when you are young and they become judgemental, act like mothers. For example, if I go for family planning service they will say "you have started sleeping around with different boys so you are scared that you will be pregnant, and you won't know the owner of that pregnancy" then you end up delaying to go for the services." Zwile (21 years [Female]).*

This statement was also stated in a study conducted in Thailand on youths' perceptions regarding access to SRHR services.[18] Findings from other studies revealed that negative attitudes of the healthcare providers challenged them to access the SRHR service. For instance, confidentiality and privacy related to the services provided.[21]

Fear of parents, community and peers

In a study conducted in Thailand, the results showed that community people labelled youths as bad children who were sexually active when they saw them take oral contraceptives, even though it was for treatment purposes. Such negativity discouraged youths from utilizing the services.[18]

From this study, participants cited fear as a hindrance to access SRHR services.

Table1: Description of study participants

Parameter	Total
All participants	14
Sex	
Male	2
Female	12
Age (years)	
10-14	0
15-19	3
20-24	11
Educational level	
None	0
Primary	0
Secondary school	2
High school	5
Tertiary education	7
SRH Services accessed	
Family planning	11
STI services	5
Pregnancy related services	9
Cervical cancer screening	3
VMMC	2
HIV-related services	6

Six participants stated fear of parents, while three mentioned fears of being spotted other familiar young people (peers). One participant commented: *"Parental fear is the key hindrance, as telling my parent that I am going to hospital for a STI care and treatment. My parent would ask me how I contracted the disease. My mother would start to accuse me at home hence I will hide my illness. I will tend to worry that if my own mother is questioning me, how much more the person who doesn't know me such as a health professional… then I will stay and not seek health care help." Nisoo (23 years [Male]).*

Fear of parents was also associated with lack of knowledge of parents about SRHR services. Young people understood that if parents were not educated on these services, they would not be able to encourage them to seek services. Donald expressed the same sentiments as follows:"*Most parents are not educated and they are not aware of the SRH services for young people, thus parents will not discuss SRH issues with their children." Donald (17 years [Male]).*

The findings concurred with the results of a sequential mixed-methods study conducted in Ethiopia. In that study adolescents identified that the parents and community members limit access to SRH services for adolescents. This might affect the accessibility to SRH service because adolescents were afraid, had self and social stigma from community in looking for the SRH services.[21]

Enablers of access to SRH services for young people

Becker (1978) in the Health Belief Model postulates that one of the reasons for behaviour change is the perceived benefits of preventive action. Hence, people are more likely to conform to health advice when they believe that a particular intervention will be helpful in preventing, detecting or treating disease and consequently reduce the threat to them (Becker 1978). The study revealed knowledge of available SRH services and information, socio-cultural support, youth-friendly delivery services, awareness campaigns, school visits, and prolonged exposure to illness to be promoting access of SRH services in Manzini, Swaziland.

Knowledge of available SRH services and information

From the fourteen participants, six participants mentioned that having knowledge of SRH services and information and where these services are provided could promote access to service utilisation. Participants believed that having knowledge about the services would empower them. One participant commented as follows:*"Young people should be given information through sensitisation; share motivational information other than scary information and the information should be proper and detailed" Nokwethu (22 years [Female]).*
Young people indicated that channels of awareness creation could be used to provide educational materials, including giving informational pamphlets to clients visiting the facility. The materials could be placed on the exit point at facilities, in libraries and other places which young people frequent in visiting them.

Awareness campaigns

Out of the 14 participants, four stated that awareness campaigns such as roadshows on SRH services can increase uptake of services. The same results were

shared in Kenya where young people stated that campaigns could be done through outreach activities in the community, schools and churches. One participant's view is as follows:
"I think campaigns do promote access of SRH services by young people such as roadshows. Also, on newspapers there should be columns about reproductive health issues and the types of services that are available." Rosemary (19 years [Female]).

School visits

Participants from this study viewed visiting schools especially high schools and colleges as another promoting factor on access of SRH services for young people. Extracts from the participants are as follows:
"Schools' visitation both high and primary schools for empowering the young ones to avoid teenage pregnancies and teenagers will have knowledge about prevention of STIs." Zwile (21 years [Female]).

Interventions to improve access to SRH services for young people

Participants made several suggestions on how access of SRH services could be improved. An increase of SRH service availability, suggested by five (5) participants; community outreach activities on available SRH services was recommended by eight participants; health education through peer educators mentioned by four participants and only two participants were the main suggestions that were raised. These were to be the responsibility of the MoH all in an effort to address the SRH problems of young people.

Discussion

This study's findings illustrated young people's perceptions regarding access to SRH services. Young people perceived that they were unable to access existing services because they lacked information about the available SRH services and their rights. Confidentiality and privacy came out strongly in this study as a worrying barrier to young people's access to SRHR services. This finding aligns with a recent study conducted in Zambia which highlighted hesitancy of youth in accessing SRHR services due to concerns about their privacy being compromised. Youths feared that others would overhear or become aware of their personal health conditions.[20] Privacy and confidentiality had been identified as strong barriers to care from other reviews conducted. Young people were concerned about confidentiality as they don't want their personal information to be shared with other people or be heard when discussing their health issues as they don't want to be seen by friends or a familiar face in the clinic.[25] Similar findings were identified in a content analysis of young people's experiences in accessing SRH services in Sub-Saharan Africa where it was recognised that young people may be particularly reluctant to seek services where breach of confidentiality and privacy exist or are perceived to exist, which could be linked to bad attitude of health service staff.[26] In a study conducted in Ethiopia, findings, showed that youths in western Ethiopia feel ashamed if someone from their parents or whom they know sees them in the youth sexual and reproductive health (YSRH) service unit because of prevailing negative cultural attitudes toward premarital sex.[21] It is therefore very imperative to avail youth friendly SRHR services at sites where youths can easily access them.Another concern was that health professionals' behaviours and attitudes toward their work and toward young people discouraged them from accessing SRH services.

These barriers were also highlighted in a systematic review aimed at synthesizing evidence on barriers and facilitators affecting access and utilisation of YFSRHS together with recommendations to improve and scale-up these services for youth/adolescents in sub–Saharan Africa.[19] Healthcare providers' negative attitudes concerning youth SRH services affect youth's access to services practically worldwide. According to reports of adolescents' access to healthcare in various regions of Thailand, one of the reasons adolescents were nervous to receive treatment was their embarrassment and fear of healthcare providers and worries of being judged as troubled adolescents. Additionally, the adolescents who had been pregnant and received SRH services admitted feeling hesitant to ask healthcare providers questions, believing they would be perceived negatively by the providers.[18]This study results

showed that enablers to improve access to and utilisation of SRHS included community outreaches and involvement, school health education, peer-led education and mass media campaigns, and sporting activities and entertainment activities at youth centres which were sources of information preferred by the youth and improved YFHRS access and all were structural in nature. The same sentiments were also reviewed in other studies.[23,27] The study suggests that young people are more likely to seek sexual health information from community outreaches and health education in schools and among peers. The health workers' attitude and limited skills should be assessed critically and prioritized as adolescents/youth are willing to access these services through them. From a review conducted in South East Nigeria, there should be healthcare intervention that will enhance accessibility and utilization of healthcare services among young people, creation of awareness about SRH in the communities, positive reinforcement to healthcare workers, and training to be able to accept and educate young people in good decision making.[25] To overcome the hurdles associated with opposition and disapproval for young people accessing SRH information and services, young men and women in Pacific Island Countries and Territories (PICTs) reported that greater awareness was needed to increase parents' SRH knowledge. To overcome this hurdle, young people have proposed ways to increase their own SRH knowledge. One way was for peer educators and nurses to visit schools and share sexual health information.[28] Other studies,[19,29,30,] conducted shared the same sentiments were Access to SRHR information requires using relevant sources at community level. Echoing other studies.[31,32] This study found that one potential avenue for this information is through sexual health education in schools and other settings. Sexual health education programs can directly address adolescents' questions and concerns, such as discussing practices to ensure privacy and confidentiality in clinics, as well as providing local clinic information including available services, hours, location, and cost.Recommendations on the implementation of healthcare service provision should be characterized by a prompt, entertaining and welcoming environment that would encourage adolescents to interact freely. regular training of service staff to develop and maintain youth-friendly personal characteristics, promotion of the friendly and welcoming nature of local SRH services, and close collaboration and networking with school-based youth health nurses. The study findings not only concur with previous studies on some issues but also highlight new information to understand youths' perception toward access to SRH services that is less often explored in eSwatini. The findings contribute to promoting SRH knowledge and offer information to provide SRH services that suit youths' needs and context.

Limitations

Firstly, this was a qualitative study, which took place in an urban youth facility. Hence, the results presented may not be generalised to the whole region. The study was based in one youth clinic in Manzini, eSwatini. Other young people in different settings may not share the same views. Urban young people may differ in their knowledge, experience and practices related to access and use of SRH services and how gender power relations impact on them compared to rural young people.

Strengths

The study provides ample evidence that young people face sexual health risks that justify their need to access and utilise SRHR services. Sexual and reproduction related issues are considered as private matter and sensitive. Therefore, the use of qualitative approach with in-depth interview as a method of data collection was found to be effective. The qualitative insights enable the researcher to capture diverse view of young people's reproductive health issues. This study provides important results, which can have practical significance to promote SRH among young people. The research also adds to the available evidence-based findings for the need to integrate comprehensive young people's SRH care to the reproductive health and rights program in eSwatini. It also highlights current inadequate access to appropriate SRH services for young people in eSwatini.

Recommendations

This study has contributed important information that can help narrow the gap between reality and the perceptions on access and utilisation of services by young people in eSwatini in Manzini. However, more research needs to be done to get more insight into young people's perceptions about access to SRH services in other areas of eSwatini. A comparative study between urban and rural adolescents or young people is recommended to gauge their access and utilisation patterns for reproductive health services and to inform policy adjustments and formulation. A study is also recommended to explore how the social and cultural norms of the community can be more supportive of ASRH needs

Conclusion

The study found that young people in Manzini, eSwatini had an understanding of SRHR services offered in both public and private health facilities. The findings revealed that access to service is an important but complex element of quality care, as it determines whether a client even gets to the service provider. The interventions such as community outreach activities; health education through peer educators and policy formulations could counter barriers to inaccessibility such as lack of knowledge about existing SRH services and lack of privacy and confidentiality. At policy level, the best approach to scaling-up health service interventions is to ensure that issues concerning ASRH are on the policy agenda. It is crucial that government health providers are given proper guidelines on how to provide services to young people, and that reporting requirements are rationalised to meet young people's needs for privacy and confidentiality when formulating the SRH policy.

Author's contributions

SF conceived the original idea of the study. SF collected the data. SF and RM analysed the data. SF and RM interpreted the results. SF and RM wrote the original draft of the paper. SF and RM reviewed the paper. All authors reviewed and approved the final version.

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