ORIGINAL RESEARCH ARTICLE

Adolescents' perspectives on barriers and facilitators to accessing youth-friendly sexual and reproductive health services in eThekwini district, KwaZulu-Natal, South Africa

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Abstract

Adolescents and youth aged 15-24 constitute a large proportion of South Africa's population, yet their sexual and reproductive health remains insufficiently addressed. Although Adolescent and Youth-Friendly Services aim to bridge these gaps, implementation and utilisation challenges continue, particularly in KwaZulu-Natal. This study aims to explore adolescents' perspectives on the factors that hinder and facilitate access to Adolescent and Youth-Friendly Services in the eThekwini District, KwaZulu-Natal. A contextual, exploratory, descriptive, qualitative design grounded in a constructivist paradigm was used. Six focus group discussions were conducted with adolescents aged 16-24 recruited via convenience sampling from four community health centres and two primary healthcare clinics. Data were audio-recorded interviews and analysed using Braun and Clarke's reflexive thematic analysis. Five key themes emerged: knowledge and awareness of services; service inefficiency; professional incompetence and negative behavior; community support and service accessibility. Despite policy efforts, adolescents continue to face multiple structural and interpersonal barriers when accessing services. Strengthening provider training, privacy infrastructure, and the provision of patient-centered care, as well as community-based outreach, are vital for enhancing service utilisation. *(Afr J Reprod Health 2026; 30 [22]: 28-39).*

Keywords: Adolescent Health; Sexual and Reproductive Health; Youth-Friendly Services; Health Services Accessibility; Qualitative Research; Primary Health Care

Résumé

Les adolescents et les jeunes âgés de 15 à 24 ans représentent une grande proportion de la population Sud-Africaine; pourtant, leur santé sexuelle et reproductive reste insuffisamment prise en compte. Bien que les services adaptés aux adolescents et aux jeunes visent à combler ces lacunes, des défis liés à la mise en œuvre et à l'utilisation persistent, notamment au KwaZulu-Natal. Cette étude vise à explorer les points de vue des adolescents sur les facteurs qui entravent ou facilitent l'accès aux services adaptés aux adolescents et aux jeunes dans le district d'eThekwini, au KwaZulu-Natal. Un design qualitatif contextuel, exploratoire et descriptif, ancré dans un paradigme constructiviste, a été utilisé. Six groupes de discussion ont été menés auprès d'adolescents âgés de 16 à 24 ans, recrutés par échantillonnage de convenance, dans quatre centres de santé communautaires et deux cliniques de soins primaires. Les données provenaient d'entretiens enregistrés et ont été analysées selon l'approche d'analyse thématique réflexive de Braun et Clarke. Cinq thèmes principaux ont émergé: connaissance et sensibilisation aux services; inefficacité des services; incompétence professionnelle et comportements négatifs; soutien communautaire et accessibilité des services. Malgré les efforts politiques, les adolescents continuent de faire face à de multiples obstacles structurels et interpersonnels lorsqu'ils accèdent aux services. Le renforcement de la formation du personnel, la mise en place d'infrastructures garantissant la confidentialité, ainsi que la prestation de soins centrés sur le patient et les activités de sensibilisation communautaire, sont essentiels pour améliorer l'utilisation des services. *(Afr J Reprod Health 2026; 30 [22]: 28-39).*

Mots-clés: Santé des adolescents; Santé sexuelle et reproductive; Services adaptés aux jeunes; Accessibilité des services de santé; Recherche qualitative; Soins de santé primaires

Introduction

Adolescence is a critical developmental stage characterized by profound physical, emotional, cognitive, and social changes, including the onset of sexual maturation.[1] During this period, young people face heightened vulnerability to adverse sexual and reproductive health (SRH) outcomes, including HIV infection, sexually transmitted infections (STIs), and unintended pregnancies.[2] Globally, an estimated 374

million new STI infections occur annually among youth aged 15 to 24 years.[3,4] In sub-Saharan Africa (SSA), more than 1.5 million young people are living with HIV.[5] Furthermore, approximately 21 million pregnancies occur each year among adolescent girls aged 15 to 19 years in developing countries, nearly half of which are unintended.[3,4] Beyond biomedical risks, adolescents frequently contend with structural and social determinants of health such as poverty, gender inequality, violence, discrimination, and limited educational opportunities, all of which influence their health outcomes and access to care.[6]

In response to these challenges, the World Health Organization (WHO) and national health systems have promoted the implementation of Adolescent and Youth-Friendly Services (AYFS) to improve the accessibility, quality, and responsiveness of SRH services for young people.[7] Addressing adolescents' SRH needs is essential for supporting a healthy transition into adulthood.[8] AYFS are designed to ensure that health services are accessible, acceptable, equitable, appropriate, and effective for adolescents and youth.[9,10] Evidence suggests that well-implemented AYFS can reduce adolescents' vulnerability to STIs and unintended pregnancies while improving healthcare utilization among young people.[11] Despite these efforts, many countries in SSA continue to experience high rates of SRH-related morbidity and mortality among adolescents.[2,12] Implementation barriers remain pervasive and include socio-cultural norms, economic constraints, stigma, provider bias, restrictive legal environments, and limited health-system capacity. [11-13]

Importantly, the availability of AYFS alone does not necessarily guarantee accessibility or utilization. Adolescents often report long waiting times, lack of privacy and confidentiality, negative provider attitudes, financial barriers, limited outreach activities, and shortages of essential medical supplies as barriers to service utilization.[11,14-18] Conversely, facilitators that encourage adolescents to seek and utilize services include respectful and non-judgmental provider attitudes, assurance of privacy and confidentiality, supportive family environments, youth-friendly communication, and adequate SRH knowledge.[19-22]

In South Africa, national and provincial health strategies have prioritized adolescent SRH in response to persistently high levels of HIV, STIs, unintended pregnancies, gender-based violence, and coercive sexual practices, particularly among adolescent girls and young women.[23-25] Although AYFS are implemented within primary healthcare settings, limited qualitative evidence exists regarding adolescents' lived experiences of accessing and utilizing these services in KwaZulu-Natal. Understanding adolescents' perspectives is essential for identifying barriers and facilitators to service utilization and for strengthening the responsiveness and effectiveness of AYFS.

Despite increasing global attention to adolescent sexual and reproductive health, important evidence gaps remain regarding how Adolescent and Youth-Friendly Services are experienced by adolescents within specific local contexts. Much of the existing research in sub-Saharan Africa has focused on service availability, utilization rates, or provider perspectives, with comparatively fewer studies exploring adolescents' lived experiences of accessing and navigating these services within primary healthcare settings. In South Africa, while national policies and programs have emphasized the expansion of AYFS, limited qualitative evidence is available on how adolescents perceive these services at the point of care, particularly within the KwaZulu-Natal province. Without understanding adolescents' perspectives on the barriers and facilitators influencing service utilization, efforts to strengthen AYFS implementation may fail to address the contextual realities shaping adolescents' healthcare experiences.

Therefore, this study explored adolescents' perspectives on the factors that hinder and facilitate access to Adolescent and Youth-Friendly Services in eThekwini, KwaZulu-Natal.

Methods

Study design

A contextual, exploratory, and descriptive design was employed to explore adolescents' perceptions of barriers and facilitators to accessing and utilizing AYFS. The study was underpinned by a constructivist paradigm, which assumes that knowledge is socially constructed through interaction and shaped by contextual realities.[26] This paradigm was appropriate for capturing participants' lived experiences and subjective interpretations of service delivery within primary healthcare settings.

Study setting

The study was conducted in four Community Health Centers (CHCs) and two Primary Health Care (PHC) clinics in the eThekwini Health District, KwaZulu-Natal, South Africa. These facilities were purposively selected because they provided the AYFS package as part of routine primary healthcare services.

Study population and sampling

The target population comprised adolescents and youth aged 16 to 24 years who accessed services at the selected facilities. Participants were considered appropriate informants, as they were primary beneficiaries of AYFS. The inclusion criteria were: aged 16 to 24 years, having used AYFS at the selected facility, and willingness to participate, be audio recorded, and provide informed consent. Individuals outside the specified age range, those who had not utilized AYFS, or those unwilling to participate were excluded.

Convenience sampling was used to recruit eligible adolescents attending the facilities.[27] Six focus group discussions (FGDs) were conducted, with each group comprising 4 to 5 participants. Data collection proceeded iteratively and continued until thematic saturation was achieved. Saturation was reached after six FGDs, when no new codes or themes emerged, and responses became repetitive.

Data collection

Eligible participants were approached at the facilities and invited to participate. FGDs were conducted in a quiet, private consultation room to ensure confidentiality and minimize interruptions.[28] Participants received an information sheet outlining the study's purpose, procedures, risks, and the voluntary nature of participation. Written informed consent, including consent for audio-recording, was obtained prior to participation. Data were collected in October 2023 using a semi-structured FGD guide designed to elicit rich, in-depth information. The guide comprised two sections:

Section A: Sociodemographic characteristics (icebreaker component)

All participants were female and aged 16 to 24 years. Most were out of school, single, and unemployed at the time of data collection. This profile reflects a population that may be socioeconomically vulnerable and highly reliant on public-sector services for SRHR care, thereby magnifying the impact of system inefficiencies and provider behaviors on their health-seeking trajectories. See the summary of the demographic characteristics in Table 1.

Table 1: Description of participants in FGDs (n=26)

Characteristic	Category	*n*
Gender	Female	26
	Male	0
Age	16 - 18	10
	19 - 24	16
School status	In school	10
	Out of school	16
Employment	Employed	0
	Unemployed	26
Marital status	Single	26
	Married	0

Source: Author's own compilation (2026).

Section B: Introductory, key, and closing questions.

Introductory questions explored awareness and understanding of AYFS. Key questions examined participants' experiences, perceived barriers and facilitators to access and utilization, and preferences for service delivery. Closing questions allowed participants to validate or expand on discussion summaries, thereby incorporating on-the-spot member checking. The guide promoted open dialogue and encouraged participants to express collective and individual experiences in a supportive environment.

Each FGD lasted 45 to 60 minutes and was facilitated by the researcher in a neutral and supportive manner to encourage open dialogue. Detailed field notes were documented after each session to capture contextual observations, non-verbal cues, group dynamics, and preliminary analytic reflections. These notes complemented the audio recordings and transcripts, providing contextual depth and supporting the transparency and trustworthiness of the qualitative analysis. The researcher facilitated discussions in a neutral and supportive manner, ensuring that participants felt safe expressing personal views and, where relevant, discussing sensitive issues related to AYFS. All discussions were audio-recorded and transcribed verbatim. Transcripts were cross-checked against recordings to ensure accuracy and completeness.

All audio recordings were transcribed verbatim and anonymized. Transcripts were checked against audio files for accuracy. Field notes complemented the transcripts and enriched the analytic process. Secure storage measures complied with the Protection of Personal Information Act (POPIA) (Act 4 of 2013), ensuring confidentiality.[29] Data collection proceeded iteratively and continued until thematic saturation was achieved. Saturation occurred after six FGDs, at which point no new themes emerged, and responses became repetitive.

Data analysis

Transcripts were anonymized before analysis. Manual coding was used to enable more in-depth engagement with the data while maintaining a transparent audit trail. The data were examined using

Braun and Clarke's six-phase reflexive thematic analysis.[30] This approach was chosen for its methodological flexibility and for its suitability for investigating patterns of meaning in participants' narratives. The analysis proceeded through six phases:

Familiarization with the data involved the researcher reading through transcripts and listening to recordings on multiple occasions.

The researcher generated initial codes systematically, coding meaningful segments line by line.

The researcher looked for themes by categorizing related codes as potential themes.

Themes were then reviewed and refined for consistency and representativeness.

Themes were defined and named to create clear thematic narratives.

Finally, an analytic report was created that incorporated themes from participants' quotations and the literature.

Codes were organized into tables and iteratively refined into coherent themes that reflected participants' shared and diverse experiences. Ongoing consultation between the researcher and the supervisor improved analytic rigor.

Trustworthiness

Trustworthiness was ensured by applying Lincoln and Guba's criteria for credibility, dependability, confirmability, and transferability.[31] Member checking during FGDs, extended engagement with the data, and regular debriefings with the supervisor all helped to boost credibility. Detailed documentation of methodological decisions, along with adherence to Braun and Clarke's analytic framework, improved study dependability and provided a clear audit trail. Confirmability was achieved through reflexive journaling, coding records, and verbatim quotations, which anchored interpretations in participants' accounts. Transferability was enhanced by providing detailed descriptions of the study setting, participant characteristics, and the contextual features of AYFS implementation, enabling readers to assess applicability to similar settings. Reflexivity was maintained throughout the research process. The researcher engaged in ongoing critical reflection on personal assumptions, professional experience in adolescent health, and potential implications for data collection and interpretation.

Ethical considerations

Ethical clearance was obtained from the University Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (HSSREC/00004775/2022) and the KwaZulu-Natal Provincial Department of Health (NHRD Ref: KZ_202212_014) before the commencement of the study. Permission to conduct the study was also obtained from the relevant institutional authorities. All participants provided informed consent prior to participation in the study. Participation was voluntary, and confidentiality and anonymity were ensured throughout the research process.

Results

This section presents findings from six FGDs conducted with 26 adolescents and youth utilizing AYFS in KwaZulu-Natal. The analysis generated five interrelated themes reflecting structural, interpersonal, and contextual determinants shaping adolescents' access to and utilization of AYFS. Participants' accounts revealed a persistent tension between the intended youth-friendly design of services and the experienced realities of care delivery.

Emerging themes

Five overarching themes emerged from the analysis, reflecting structural, interpersonal, and contextual factors influencing adolescents' access to and utilization of AYFS. Table 2 summarizes the themes and sub-themes.

Theme 1: Knowledge and awareness of AYFS

This theme captures adolescents' understanding of the AYFS package and the extent to which awareness influenced service utilization. Adolescents' awareness of AYFS was uneven and largely dependent on informal social networks rather than structured health promotion strategies. This indicates a gap between policy intentions and community-level visibility of youth-targeted services.

Sub-theme 1: Limited Health Literacy

While a few participants were aware of AYFS, many reported learning about it through peers or family members, illustrating the centrality of social networks in facilitating care-seeking, highlighting reliance on word-of-mouth communication:

Table 2: Shows emerging themes and sub-themes

Theme	Sub-theme
Knowledge and awareness of AYFS	Limited Health Literacy
Service Inefficiency	Long Waiting Hours
	Lack of Supplies and Structural Resources
Professional Competency and behavior	Unacceptable Healthcare Provider Attitude
	Autonomy and Informed Decision-Making
	Disrespect, Violations of Dignity, and Rights
	Privacy and Confidentiality
Family and Community Influence	Parent-Adolescent Communication
Accessibility of Services	Proximity of Facility and Transport Availability

Source: Author's own compilation (2026).

"I learned from people in my area who usually come here that I should go to this clinic." (Participant 1, Female, FGD3)

"My friend told me about it after I had asked her where I could get assistance." (Participant 3, Female, FGD3)

Reliance on word of mouth suggests that AYFS are not sufficiently institutionalized within community outreach mechanisms. While some participants reported receiving information from healthcare workers, others expressed complete unawareness:

"No, we are not aware of the service. No one informed us. This is the first time we hear about it." (Participant 4, Female, FGD1)

"I was told by the nurse who was testing us for HIV; he explained everything very nicely to me." **(**Participant 1, Female, FGD6)

Limited awareness operated as a structural barrier to utilization. Participants implicitly linked knowledge deficits to delayed care-seeking and potentially risky health behaviors. These findings suggest that AYFS may exist administratively within facilities but remain socially invisible within communities.

Theme 2: Service inefficiency

Service inefficiencies emerged as a dominant structural barrier. Participants' accounts reflected not only dissatisfaction with waiting times but also a perceived breakdown of accountability and responsiveness within the health system.

Sub-theme 1: Long waiting hours

Participants consistently reported excessive wait times, staff absenteeism, and early service closures. Participants interpreted extended waiting times as signals of low prioritization of adolescents' needs, as seen below:

"Some of us have been there since the early morning… you see the nurse leaving and walk past you." (Participant 1, Female, FGD2)

"According to the notice board, the wait can be 30 minutes or an hour. Here I am, waiting for 3 hours." (Participant 1, Female, FGD6)

Participants contrasted official waiting-time notices with lived experiences of delays lasting up to three or four hours. This discrepancy eroded trust in service standards and created perceptions of institutional indifference. Some adolescents described being turned away before official closing times, further reinforcing feelings of marginalization, as seen below:

"I came here at 3:30 pm seeking help; they turned me away, and the entire staff was leaving." (Participant 1, Female, FGD2)

These experiences generated frustration, embarrassment, and, in some cases, feelings of disrespect.

One participant expressed satisfaction:

"I don't have any complaints whatsoever. It's a good clinic." (Participant 3, Female, FGD5)

However, positive experiences were exceptions rather than the norm. Importantly, long waiting times did not function solely as logistical inconveniences; they generated emotional responses, including shame, embarrassment, and powerlessness, which may deter future help-seeking.

Sub-theme 2: Lack of supplies and structural resources

Medication shortages and inadequate supplies further compromised adolescents' experiences. The following quote demonstrates this evidence:

"I was very ill, and there was no medication. I was informed to go and buy my flu medication. If I had money, I would not have come to the clinic." (Participant 5, Female, FGD 6)

"The nurse informed me that they do not have/any flu medication in stock. I was confused." (Participant 4, Female, FGD4)

Such statements reflect how structural deficiencies intersect with socioeconomic vulnerability. Being instructed to purchase medication externally was experienced not merely as an inconvenience but as an inequity, particularly for unemployed participants. These systemic gaps directly contradicted adolescents' expectations of accessible, reliable, youth-friendly care.

Theme 3: Professional incompetence and negative behavior

Participants consistently described the provider's behavior as a decisive determinant of access and utilization. Interpersonal encounters shaped whether adolescents felt safe, respected, or silenced. This theme has two sub-themes, which are discussed below.

Sub-Theme 1: Unacceptable healthcare providers' attitudes

Participants described encounters characterized by rudeness, impatience, judgment, and dismissiveness as demonstrated in the quotes below:

"The nurses are rude…you might enquire about something and receive a hostile/unfriendly response." (Participant 4, Female, FGD1)

"They jump to conclusions… never want to hear the full story." (Participant 1, Female, FGD4)

These interactions were interpreted as moral surveillance, particularly in the context of sexual health. Adolescents described feeling labelled, disbelieved, or assumed to be sexually irresponsible. Such experiences discouraged open disclosure.

"We then become fearful and deterred from seeking help." (Participant 4, Female, FGD 3)

Coercive contraceptive practices further indicated compromised autonomy:

"Before I could explain my problem, the nurse said I must get an implant." (Participant 3, Female, FGD3)

Participants interpreted these actions as dismissive of their preferences and bodily autonomy, raising concerns about informed consent and shared decision-making. However, isolated accounts of supportive and empathetic care highlighted variability in provider practices.

"The nurse advised me to first think about what I wanted to do." (Participant 1, FGD3)

This variation suggests that youth-friendliness may depend more on individual provider disposition than institutionalized standards.

Sub-Theme 2: Autonomy and informed decision-making

Participants reported instances of coercive contraceptive practices: This is illustrated in the following quotes

"Before I could explain my problem, the nurse said I must get an implant." (Participant 3, Female, FGD 3)

"They always want you to do things their way, not the way I prefer, and my discomfort is not considered." (Participant 1, Female, FGD 3)

"They jump to conclusions, never want to hear the full story, and always want to have the last word." (Participant 1, Female, FGD 4)

These accounts raise concerns regarding shared decision-making and respect for adolescent autonomy. Perceived imposition of contraceptive methods undermined trust and reinforced power imbalances between providers and youth.

Sub-theme 3: Disrespect and violation of dignity and rights.

Participants in this study reported experiencing public scolding and harsh communication as violations of dignity. Leaving them frustrated. This is evident by these quotes:

"They do not treat us well; they always want to shout at us and make inappropriate comments." (Participant 1, Female, FGD1)

"They address us harshly in front of people." (Participant 2, Female, FGD2)

"They have a bad attitude and are rude, impatient, and scornful." (Participant 1, Female, FGD3)

"They do not treat us well; they always want to shout at us and make inappropriate comments, which makes us feel frustrated and angry." (Participant 2, Female, FGD 4)

"They tend to make you feel foolish by sending you back and forth from one line to the next." (Participant 4, Female, FGD 5)

"I want them to stop making a consultation feel like an interrogation or a scolding." (Participant 3, Female, FGD 6)

Adolescents described consultations as resembling interrogations, reinforcing power imbalances between providers and youth. Such interactions diminished adolescents' sense of legitimacy within the healthcare setting and may discourage future disclosure of sensitive concerns.

Sub-theme 4: Lack of privacy and confidentiality

Confidentiality emerged as one of the most critical dimensions of responsiveness. Participants described open doors, loud voices, and staff discussions of patient information, as illustrated in the quotes below:

"The door is open, and many people are sitting outside; they can hear everything you are talking about." (Participant 1, Female, FGD1)

"She asked our peer what pills she was on in front of everyone. There is no privacy." (Participant 1, Female, FGD4)

Breaches of privacy generated mistrust.

"You can't even speak freely." (Participant 1, Female, FGD1)

One participant further described that she had heard what was discussed with the previous patient, although she was not present when he was being attended to. This phenomenon is illustrated in the statement below.

"I don't think they maintain confidentiality because the last time I came here, I was the second patient, and the nurses were whispering about the patient who was coming out of the consultation room." (Participant 2, Female, FGD6)

Participants feared exposure to sensitive information, particularly regarding HIV, pregnancy, or contraception. Loud discussions in shared spaces and staff whispering about patients contributed to perceptions of unsafe environments for patient disclosure. Importantly,

confidentiality concerns were directly linked to underutilization. This suggests that privacy is not merely a procedural issue but a fundamental determinant of adolescent trust and sustained engagement with services.

Theme 4: Family and Community Influence

Family dynamics shaped adolescents' autonomy in service utilization. Parental influence functioned as both a barrier and a facilitator.

Sub-theme 1: Parent-adolescent communication

Certain participants obscured their utilization of services to evade confrontation. For some, parental disapproval necessitated secrecy, as illustrated by the quote:
"I think it's safer when they don't know. I cannot share some things with my parents." (Participant 3, Female, FGD 1)
"Parents are not the same: some are strict and would get angry." (Participant 2, Female, FGD4)
Fear of judgment or punishment discouraged open parent-adolescent communication about SRH. Conversely, supportive parental attitudes were seen as protective.
"I think my parents would be happy and proud of me for using contraceptives." (Participant 1, Female, FGD6)
"I think it depends on the type of parent, because some are friendly with their children on certain matters and less so on others." (Participant 1, Female, FGD5)
These narratives highlight how social norms intersect with health-system interactions, influencing adolescents' confidence in accessing care.

Theme 5: Accessibility of services

Despite the barriers identified, participants also highlighted several enabling factors that promoted access to and utilization of AYFS. These facilitators reflected both the structural and interpersonal dimensions of care, encouraging adolescents to engage with health services.

Sub-theme 1: Proximity of facility and transport availability

Geographic proximity and transport costs influenced access; however, distance alone did not always deter utilization.
"It is easy to come to the clinic. We walk to the clinic." (Participant 5, Female, FGD6)
Others reported long distances and transport costs as barriers. The statements below demonstrate this.
"*The clinic is far; I must walk a long distance to get here."* (Participant 3, Female, FGD2)
"I must take a taxi to the clinic." (Participant 1, Female, FGD5)
However, the distance did not deter some adolescents from seeking services from SHR. This finding shows that adolescents had some level of SHR-seeking behaviors, which should be encouraged. Their need for help and the desire to obtain it from the right source outweighed the obstacles, as demonstrated by the following quote:
"It is far, and we have to cross an unsafe bridge, but we have no choice because we need help from the clinic." (Participant 1, Female, FGD4)
This statement reflects adolescent resilience and agency. Even when structural barriers existed, participants prioritized healthcare-seeking when needs were perceived as urgent. Accessibility thus emerged as multidimensional: while physical distance was relevant, interpersonal safety and service responsiveness appeared more influential in shaping repeated utilization.

Discussion

This study explored adolescents' and youths' perceptions of the barriers and facilitators influencing access to and utilization of AYFS in the eThekwini District of South Africa. Overall, the findings demonstrate a substantial gap between the policy aspirations for adolescent-friendly healthcare and the realities young people experience in primary healthcare facilities. Although AYFS are formally implemented within South Africa's public health system, participants described multiple interrelated barriers, including limited awareness of services, inefficient service delivery, negative provider attitudes, breaches of confidentiality, resource shortages, and restrictive family influences, that collectively undermined equitable access. Conversely, free healthcare services, geographical proximity, affordable transport, and supportive family relationships facilitated service utilization. Rather than representing isolated challenges, these findings illustrate how structural, organizational, interpersonal, and social factors interact to shape adolescents' healthcare experiences. The results, therefore, reinforce growing international evidence that successful implementation of youth-friendly services depends not only on policy availability but also on the quality, consistency, and responsiveness of service delivery.

A prominent finding was the limited awareness of AYFS among adolescents and youth. Many participants were unaware that dedicated adolescent-friendly services existed and relied primarily on peers rather than formal health communication channels for information. Similar findings have been reported across sub-Saharan Africa and other regions, where inadequate dissemination of sexual and reproductive health (SRH) information limits awareness and reduces service utilization.[32-36] Importantly, poor awareness should not be viewed solely as a communication problem but as a health equity issue. When access to information depends largely on social networks, adolescents with limited social capital become disproportionately disadvantaged. Evidence suggests that school-based programs, community outreach, digital platforms, and youth-led communication strategies substantially improve awareness and service uptake.[11,37,38] These findings suggest that AYFS require greater visibility within communities if they are to fulfill their intended public health function.

Service inefficiency emerged as another major determinant of healthcare utilization. Long waiting times, inconsistent operating hours, medication shortages, and

the refusal to treat adolescents discouraged them from continuing to engage with healthcare services. Similar concerns have been documented in South Africa, Namibia, Zambia, and Nigeria, where resource constraints and workforce shortages negatively influence adolescents' willingness to seek care.[17,39-41]

For adolescents, however, inefficient services have consequences beyond inconvenience. Young people often balance school attendance, limited financial resources, transport challenges, and concerns about parental disclosure, making unpredictable service delivery particularly burdensome. By contrast, studies from Rwanda have demonstrated that structured appointment systems and shorter waiting times improve adolescent satisfaction and continuity of care.[37] Collectively, these findings indicate that improving organizational efficiency through appointment systems, adolescent-specific clinic hours, queue management, and digital scheduling technologies could substantially enhance service responsiveness and strengthen adolescents' confidence in public healthcare services.

Healthcare provider attitudes were among the strongest influences on adolescents' healthcare-seeking behavior. Participants described experiences of judgment, disrespect, dismissive communication, and coercive contraceptive counseling, all of which discouraged future service utilization. These findings are consistent with extensive international literature identifying provider attitudes as one of the most persistent barriers to adolescent SRH services.[42-45] Particularly noteworthy was participants' perception that some healthcare providers limited adolescents' autonomy by making contraceptive decisions without adequate counseling or shared decision-making. Similar patterns of paternalistic care have been reported internationally, particularly among young women seeking reproductive healthcare.[36,46]

Although youth-friendly training is widely promoted, emerging evidence suggests that training alone is insufficient to transform provider behavior or organizational culture.[46] Sustainable improvements are therefore likely to require supportive supervision, values clarification, mentorship, accountability systems, and performance measures that explicitly assess respectful, adolescent-centered care. Importantly, participants also reported positive interactions with empathetic nurses, demonstrating that high-quality youth-friendly care is achievable within existing health system structures.

Confidentiality and respect for adolescents' dignity emerged as fundamental determinants of trust in healthcare services. Participants reported consultations conducted with open doors, conversations that could be overheard, and public questioning about sensitive issues, all of which led to embarrassment and reluctance to seek future care. These experiences directly contradict South African AYFS policy and World Health Organization recommendations, which identify confidentiality as a cornerstone of adolescent-friendly healthcare.[4,47] Similar concerns have been documented in South Africa, Nigeria, Rwanda, and high-income countries, where fear of disclosure consistently discourages adolescents from accessing SRH services.[17,34,48]

Participants also described frequent experiences of disrespect, humiliation, and verbal abuse, which they perceived as violations of their dignity and rights. These behaviors mirror reports from sub-Saharan Africa, where verbal abuse and moral judgment are recognized as human rights concerns and strong deterrents to care.[11,49] Embedding rights-based and person-centered care principles in policies, training, and supervision is essential to address these patterns. Confidentiality breaches are not minor operational lapses; they represent violations of adolescents' rights to privacy and dignity. Addressing confidentiality requires both infrastructural and behavioral reforms: dedicated adolescent consultation spaces, soundproofing measures, and clear protocols around information handling must be paired with strengthened professional ethics training. Without such reforms, trust in public-sector services may remain fragile.

The findings further highlight the influence of broader health system capacity on adolescents' healthcare experiences. Medication shortages and inadequate resources limited participants' access to appropriate care, with some instructed to purchase medicines privately despite financial constraints. Similar supply challenges have been reported in Kenya, Australia, Canada, and Sweden.[34,50] Although studies from Ethiopia suggest that resource limitations vary according to local health system contexts.[51] These findings highlight that without essential medicines and supplies, achieving youth-friendly healthcare cannot rely solely on provider training or service guidelines. Strengthening procurement systems, protecting adolescent SRH commodities from stock-outs, and improving health system financing remain essential components of equitable AYFS implementation.

Consistent with ecological perspectives on adolescent health, family and community environments substantially influenced healthcare utilization. Fear of parental judgment discouraged many adolescents from discussing sexual and reproductive health concerns or accessing services independently, reflecting findings from South Africa, Ethiopia, Nigeria, Brazil, and the Gambia.[17,36,52] Conversely, supportive parental communication enhanced adolescents' confidence in seeking healthcare. Similar relationships have been documented internationally, where open parent-adolescent communication is associated with improved sexual and reproductive health outcomes.[53,54] Community-based interventions that equip parents with communication skills can therefore transform family influence from restrictive to enabling.[55] These findings suggest that interventions to strengthen AYFS should extend beyond health facilities to include parents, schools, and communities, recognizing that adolescent healthcare decisions are shaped by broader social environments rather than individual factors alone.

Despite the numerous barriers identified, participants also recognized important facilitators who promoted service utilization. Free healthcare services, nearby facilities, and affordable transport reduced financial and geographical barriers to care, consistent with findings from Ethiopia and Nepal.[51,56] This study

highlights different factors, unlike studies conducted in Cameroon, Uganda, Zambia, Zimbabwe, and Namibia, which found that distance and transport expenses remain dominant barriers.[57-60] Participants in this study demonstrated that physical accessibility alone does not guarantee utilization. Even when services were geographically accessible and financially affordable, adolescents remained reluctant to seek care because of concerns regarding provider attitudes, confidentiality, long waiting times, and inconsistent service delivery. These findings reinforce the multidimensional nature of healthcare access and suggest that improving utilization requires simultaneous attention to structural accessibility, service quality, organizational efficiency, and respectful interpersonal care.

Strengths

This study provides in-depth, contextually grounded insights into adolescents' lived experiences of accessing and utilizing AYFS in a high-burden South African setting. By centering adolescents' voices, the research captures relational and structural dimensions of care such as dignity, confidentiality, autonomy, and provider attitudes that are often underexplored in quantitative implementation studies. The qualitative design enabled nuanced engagement with sensitive sexual and reproductive health (SRH) issues. Reflexive thematic analysis supported interpretive depth and systematic pattern identification, allowing findings to extend beyond description toward conceptual insights relevant to youth-centered service delivery. Rigour was enhanced through strategies to ensure trustworthiness, including iterative data engagement, member checking during FGDs, supervisory consultation, maintenance of an audit trail, and reflexive journalling. Thick descriptions of the study context strengthen the transferability of findings to similar urban and peri-urban primary healthcare settings in sub-Saharan Africa. Ethical sensitivity in engaging adolescents, particularly regarding confidentiality and voluntary participation, likely contributed to the openness and authenticity of participants' narratives. The study therefore offers context-specific yet policy-relevant evidence to inform district-level and provincial improvements in AYFS implementation.

Limitations

Several limitations warrant consideration. First, the study focused exclusively on adolescents' perspectives and did not include healthcare providers or managers, limiting insight into the organizational and systemic constraints that influence service delivery. Second, the study was conducted in one urban/peri-urban district in KwaZulu-Natal. Findings may not reflect experiences in rural areas or other provinces with different resource profiles and sociocultural contexts. Third, convenience sampling may have excluded adolescents disengaged from health services, potentially underrepresenting those facing the most severe access barriers. Finally, all participants were female, restricting the understanding of male and gender-diverse adolescents' experiences. As with all self-reported qualitative data, responses may also have been influenced by recall or social desirability bias. Given these factors, the findings are not statistically generalizable but offer analytically transferable insights into how structural, relational, and contextual dynamics shape adolescents' engagement with youth-friendly services.

Implications for practice

Youth-friendly care must be institutionalized as a routine standard of practice within primary healthcare rather than treated as a specialized add-on. Ongoing in-service training should prioritize relational competencies, respectful communication, non-judgmental attitudes, shared decision-making, and confidentiality, while structured mentorship and supportive supervision are essential to sustain behavioral change. Facility managers should address operational and environmental barriers that compromise adolescents' experiences. Practical measures include strengthening privacy protections through closed-door consultations, improving room layouts, streamlining patient flow, implementing appointment systems, and monitoring waiting times to enhance accountability. Routine measurement of adolescent satisfaction could further improve responsiveness. Community-facing strategies are also critical. Strengthening school- and community-based health education, peer-led initiatives, and digital communication platforms can raise awareness of AYFS and enhance adolescent SRH literacy, thereby reducing reliance on informal information networks.

Implications for policy

Provincial health authorities should integrate youth-responsive indicators, such as waiting times, satisfaction, and breaches of confidentiality, into routine monitoring and quality-improvement systems. Clear accountability mechanisms linking resource allocation, staffing, and infrastructure to defined youth-friendly standards are necessary to reduce implementation variability. Cross-sector collaboration between health, education, and social development sectors is vital to reduce stigma and strengthen parent-adolescent communication, thereby creating a supportive environment for adolescent health-seeking behavior.

Implications for research

Future studies should adopt multi-level, mixed-methods approaches to capture provider and system perspectives and quantify the impact of relational and structural barriers on service utilization and outcomes. Comparative and longitudinal research would further clarify context-specific and system-wide implementation challenges.

Recommendations

Future research should adopt a multi-stakeholder approach that includes healthcare providers, facility managers, and policymakers to better understand

organizational and systemic factors influencing AYFS implementation. Incorporating these perspectives would complement adolescents' experiences and provide a more comprehensive assessment of service delivery challenges. Mixed-methods studies combining qualitative insights with quantitative indicators such as service utilization rates, waiting times, commodity availability, and adolescent satisfaction would strengthen the evidence base and inform targeted quality-improvement strategies. Comparative research across urban and rural districts is needed to distinguish context-specific barriers from broader systemic constraints. Additionally, longitudinal evaluation of interventions aimed at improving provider behavior, confidentiality, and service efficiency would generate evidence on sustainability and scalability. Future research should therefore prioritize actionable, implementation-focused designs that advance responsive and youth-centered adolescent health services.

Contribution

This study provides context-specific qualitative evidence on how adolescents experience adolescent and youth-friendly services within public primary healthcare facilities in KwaZulu-Natal. By centering adolescents' voices, it highlights how structural constraints, provider behavior, and operational inefficiencies shape trust, satisfaction, and continued service utilization. The findings extend existing literature by demonstrating how deficiencies in confidentiality, respect, communication, and waiting times directly influence adolescents' willingness to seek sexual and reproductive health care. The study also identifies practical, modifiable barriers, including privacy infrastructure, appointment systems, and provider attitudes, offering actionable insights for strengthening youth-centered service delivery. By situating local findings within broader implementation challenges, the study advances responsive, rights-based, and equitable adolescent health services in high-burden settings.

Conclusion

This study demonstrates that while Adolescent and Youth-Friendly Services are formally established in the eThekwini District, their intended youth-centered orientation is inconsistently realized in practice. Structural constraints, operational inefficiencies, confidentiality breaches, and dismissive or judgmental provider behaviors collectively undermine adolescents' trust and willingness to seek sexual and reproductive health care. Limited awareness of available services further compounds these barriers, restricting informed health-seeking. At the same time, adolescents continued to use geographically accessible, free public-sector services despite negative encounter signals, showing both resilience and unmet need. Supportive provider interactions, clean environments, and positive family engagement illustrate that youth-friendly care is achievable within existing systems when relational and structural conditions align. Improving adolescent SRH service uptake requires more than policy endorsement; it demands sustained investment in infrastructure, workforce development, accountability mechanisms, and community engagement. Embedding respect, confidentiality, and responsiveness into routine service delivery has the potential to strengthen trust in the health system, enhance utilization, and ultimately improve adolescent health outcomes in KwaZulu-Natal.

Competing interests

The authors, Patience P. Khuzwayo and Sipho W. Mkhize, declare that they have no financial or personal relationships that may have inappropriately influenced their writing of this article.

Author contributions

Patience P. Khuzwayo: Contributed to the conceptualization of the project, methodology, data curation, data collection, data analysis, writing the original draft of the manuscript, and reviewing and editing of the manuscript under the guidance of the research supervisor.
Sipho W. Mkhize: Reviewed the draft manuscript and approved the final version of this article for submission and publication, and took responsibility for the integrity of its findings.

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Data availability

The datasets generated and/or analyzed during the current study are not publicly available due to the qualitative nature of the data and the need to protect participants' confidentiality, but are available from the corresponding author on reasonable request.

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Consent for publication

All authors have received a final version of this manuscript and have provided consent for its publication..

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