

# Young people's access and barriers to SRHR services in South Africa

Evidence Brief



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## Why this brief?

In 2021, the world is celebrating the 25th anniversary of the Beijing Declaration through the Generation Equality Movement, which reflects on how to remove the systemic barriers that hold women back from equal participation in all areas of life, whether in public or in private. One of the key areas to enable full gender equality is ensuring the bodily autonomy and SRHR of women and girls.

This is particularly important at the early stages in life, since young people's health and wellbeing is key to unlock their potential and harness many other benefits throughout the lifecourse. However, many young people still do not enjoy full bodily autonomy or access to SRHR services. This brief focuses on young people's access to SRHR services and offers a glimpse of the evidence in South Africa, outlining at the end some key areas for collective action going forward.

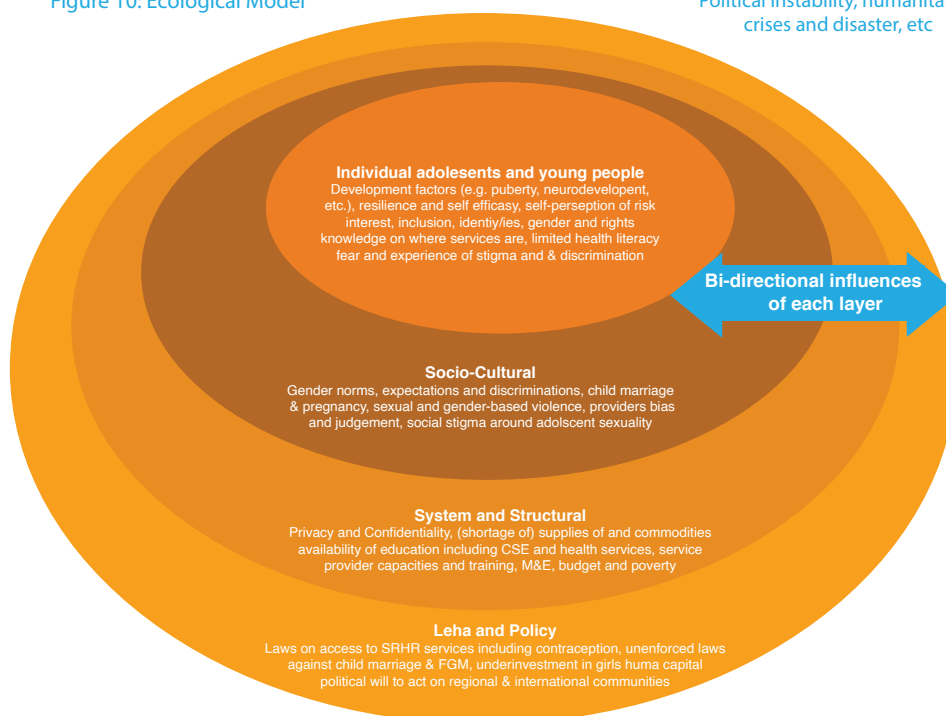


## Adolescents and youth access to friendly health services: key drivers

There are many drivers to enable adolescents' and young people's access to friendly health services: the ecological model below classifies these in system and structural, socio-cultural and legal, and provider bias (UNFPA ESARO, 2017).

Figure 10: Ecological Model

MACRO environment  
Political instability, humanitarian  
crises and disaster, etc



For the purpose of this brief, we will address the legal/ policy and the system/ service levels.

## Youth and SRHR: progresses at the policy level in South Africa

South Africa counts with a comprehensive legal and policy framework and commitment to improve the health of adolescents and young people, especially through the following:

- National Youth Policy (2020-2030)
- Adolescent and Youth Health Policy (2016-2020)
- National ASRHR Framework Strategy (2014-2019)
- National Implementation Guidelines for Adolescent and Youth Friendly Services (2013-2017)
- Integrated School Health Policy (2012)
- The National Strategic Plan for HIV, TB and STIs 2017-2022



### The Adolescent and Youth Health Policy includes critical service-oriented interventions to increase adolescents and youth access, such as:

- A. Single service point-of-delivery models integrating HIV and sexual reproductive health; and where this is not feasible, strengthen referrals for adolescents and youth;
- B. Adolescent and youth-friendly clinic spaces to be adapted including operating hours that accommodate learners' timetables, ensured privacy, and non-judgemental staff;
- C. An expanded and improved contraceptive method mix;
- D. Increased access to medical male circumcision (including school-friendly opening times).

Furthermore, the **National ASRHR Framework Strategy** highlights the need for the following:

- A. Adolescents to be well informed of their rights and accompanying responsibilities;
- B. Health care providers and community members to be provided with adequate information on adolescent rights;
- C. Young men to be involved in SRHR programmes and services;
- D. Health care providers to be equipped with the necessary skills on how to cater for the SRHR needs of neglected and underserved groups such as adolescents with disabilities and adolescents with differing sexual orientation (LGBTI community).

Since 2006, the Department of Health implements the National Adolescent Friendly Clinic Initiative (NAFCI). It has been highlighted as a successful model for implementing AYFHS within a public health system (UNFPA ESARO, 2017).

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***Did you know? Legal ages of consent:***

**In South Africa, the minimum ages of consent are:**

- For HIV testing and counselling: 12 years without parental consent.
- For sexual activity (males and females, in terms of the Sexual Offences and Related Matters Act of 2007): 16 years
- For access to contraceptives without parental consent (as promulgated by the Children's Act 38 of 2005 (Government of South Africa, 2007): 12 years

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## **Youth access (and barriers) to SRHR Services: a summary of the most recent national qualitative evidence (2016-2021)**

The access (and barriers) that adolescents and youth face to health and especially SRHR services have been subject to many studies and analyses over time, both globally and nationally. For the purpose of this brief, the evidence produced in the last five years on adolescents and youth friendly services and SRHR services more specifically was considered (2016-2021) as outlined in the references section at the end of the brief. Most of the evidence was of qualitative nature, and the key elements are outlined below.

## **Facilitating factors (what works) in linking youth to SRHR services? Findings from a recent analysis by HSRC (2021) reinforce the key principles of the AYSRHR and AYFS policies, and confirm that the following factors help increase access:**

- Availability, and wide-ranging services in the same location
- Confidentiality, friendliness and accessibility to young people from all backgrounds and sexual orientations.
- Offer of comprehensive information so youth can make informed decisions;
- Well-trained, sensitised and committed staff
- Meaningful youth participation and organisations' collaboration and partnership with government departments and other civil society organisations.
- Community approach to reaching young people;



# What barriers are still being faced by youth?

Several studies mapped barriers within South Africa and across the region. A literature review undertaken by MietAfrica on youth-friendly health services reported that barriers experienced by adolescents in accessing these services were mainly related to cost, the non-youth-friendly attitude of staff, clinics not being accessible in terms of distance, and clinics not providing privacy and confidentiality (MietAfrica, 2011). The most commonly mentioned barriers in more recent studies reinforce several of these points, especially the following:

- **Confidentiality and privacy:** evidence available points either to the lack of privacy (lack of a space away from adults ) in some services, or also breaches of confidentiality by some service providers - for example, disclosing to parents the content of the conversation. (Mulaudzi et al, 2018; Davies et al, 2016).
- **Operating hours and/or waiting times:** operating hours and/or days need to be adapted to ensure that service provision is convenient for adolescent young people and possible to align with school attendance. In some studies, waiting times were also listed as a disencouraging factor (Mokomane et al, 2017; Mulaudzi et al, 2018).
- **Treatment received from health care providers/ :** some health care professionals might carry prejudices that may limit the success of the adolescent and youth friendly programming. This may result in youth not being treated with respect, or being judged by adults in the services. Cases have been reported in studies where HCW disapprove adolescents' sexual activities and show some times reluctance in providing SRH services to adolescents who engage in sexual activities. The most recent qualitative study by HSRC (2021) indicates that "healthcare workers also admitted to advising adolescents to abstain from sex when they seek contraceptives, and restricted contraceptive provision to women over a particular age or married." Other studies pointed to negative attitudes around sexuality of persons with disabilities, making them more vulnerable to being left behind. However, in the HSRC study (2021) healthcare workers with higher levels of education and informed about adolescent sexuality were more supportive of young people accessing such services (James et al, 2018; Mulaudzi et al, 2018; Davies et al, 2016).
- **Adolescent and youth's fear of judgement:** the above attitudes might result in disencouraging young people (especially adolescents and young women) from attending the clinics. Youth sex workers, as well as Lesbians, Gays, Bisexuals, Transgender and Intersex individuals may experience additional layers of barriers to accessing SRH care. (Delany-Moretlwe, Scorgie, & Harvey, pp9, 2018; Quest Research Services, 2018; Davies et al, 2016).
- **Social norms and perceptions of young people's agency and rights to SRHR:** linked to the above, perceptions of the role and agency of young people may affect the provision of services. Depending on the cultural and societal background young people might be expected to abstain from sex until they are married; and unequal gender norms, allocates more power to boys than girls (HSRC, 2021). The study recommends that "programmes engaging the broader community on SRHR issues should not just address issues of knowledge, but also of attitudes, values and fundamental cultural beliefs."
- **Structural barriers:** physical and communication barriers at health care facilities were also pointed as potentially hampering access of persons with disabilities.



# Key messages:

*Bodily autonomy is related to a young person's ability to make his/her own decisions on contraceptive use, reproductive health care and sexual relations, and requires a conducive legal and regulatory environment. In addition, services are key to enable these provisions. To ensure that young people and adolescents are able to exercise bodily autonomy and SRHR, and make informed choices about their bodies it is important to:*

- Ensure adolescents and youth's access to reproductive rights literacy, and comprehensive sexuality education (CSE) in line with International Standards. The CSE curriculum promotes gender norms change to advance gender equality and human rights. HIV and sexuality education that explicitly addresses gender and power is five times more likely to reduce STIs and unintended pregnancy than education that ignores gendered power dynamics (80% vs. 17% effective). CSE delivered in formal or non-formal settings, makes a significant contribution to the elimination of GBV and harmful practices, including child marriage, FGM and child abuse.
- Provide sexual and reproductive health services that are responsive to the needs of adolescents and youth; this means they are provided in an integrated manner, accessible to all adolescents and youth, respectful, confidential and affordable.
  1. Health and social services workforce must be trained and equipped to deliver high quality, non-judgmental and confidential services to adolescents and youth.
  2. Health facilities must offer necessary commodities, services and information, and make links between health-care services and schools to extend effective outreach and referrals.
  3. Health information systems must be equipped to allow for disaggregation of data on adolescents and youth.
  4. The package of services must include support and care for survivors of SGBV.
- Finally, underlying all these issues is the need to continue working to address discriminatory social norms and gender stereotypes to unlock progress in all areas for women and girls. Social norms sometimes deem them incapable of making their own choices. Blatant violations of their rights may result in sexual abuse as well as other forms of violence. Therefore, all of us - women and men, boys and girls, school teachers, traditional and religious leaders, communities and families - every one of us can do our part in collectively creating a society where women and girls can feel safe.





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