ORIGINAL RESEARCH ARTICLE

Accessing Sexual and Reproductive Health Information and Services: A Mixed Methods Study of Young Women's Needs and Experiences in Soweto, South Africa

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Abstract

Young women and girls in South Africa are at high risk of unintended pregnancy and HIV. Previous studies have reported barriers to contraceptive and other sexual and reproductive health (SRH) services among young women in this context. We aimed to assess young women's SRH knowledge and experiences and to determine how they get SRH information and services in Soweto, South Africa using quantitative and qualitative methods. Young women, aged 18-24, recruited from primary health clinics and a shopping mall, reported that they have access to SRH information and know where to obtain services. However there are challenges to accessing and utilizing information and services including providers' unsupportive attitudes, uneven power dynamics in relationships and communication issues with parents and community members. There is a need to assist young women in understanding the significance of SRH information. They need access to age-appropriate, youth-friendly services in order to have healthy sexual experiences. *(Afr J Reprod Health 2015; 19[1]: 73-81).*

Keywords: HIV, gender-based violence, contraception, abortion

Résumé

Les jeunes femmes et les jeunes filles en Afrique du Sud sont à risque élevé de grossesses non désirées et du VIH. Des études antérieures ont signalé des obstacles à la contraception et à d'autres services de santé sexuelle et de la reproduction (SSR) chez les jeunes femmes dans ce contexte. Nous avons cherché à évaluer la SSR connaissances et d'expériences de jeunes femmes et de déterminer comment ils obtiennent des informations et des services de SSR à Soweto, en Afrique du Sud en utilisant des méthodes quantitatives et qualitatives. Les jeunes femmes, 18-24 ans, recrutées dans les centres de santé primaires et dans un centre commercial, ont déclaré avoir accès à l'information sur la SSR et savent où obtenir des services. Cependant, il y a des défis à l'accès et à l'utilisation d'informations et de services, y compris l'attitude de non soutien de la part des fournisseurs, les dynamiques de pouvoir inégales dans les relations et les problèmes de communication avec les parents et les membres de la communauté. Il est nécessaire d'aider les jeunes femmes à comprendre la signification de l'information sur la SSR. Elles doivent avoir accès à des services conviviaux pour les jeunes à l'âge approprié afin d'avoir des expériences sexuelles saines. *(Afr J Reprod Health 2015; 19[1]: 73-81).*

Mots-clés: VIH, violence fondée sur le sexe, contraception, avortement

Introduction

Young women and girls in South Africa are at high risk of unintended pregnancy and HIV. By age 17, half of all teenagers are sexually active[1]. HIV prevalence among 15-19-year-old women was 12.7% in 2011, and among pregnant 15-24-year-olds, it was 20.5%[2]. A national household survey conducted in 2003 indicated that one third of 15-19 year olds and over half (59%) of 20-24-year-old women had ever been pregnant and that two-thirds of the pregnancies were reported to be "unwanted"[3].

Data from the most recent Demographic and Health Survey (2003) indicate that a large majority of 15-19 year olds (84.2%) and 20-24 year olds (89.3%) have used a modern contraceptive method, predominantly the pill, injectables and/or

male condoms[4]. However, recent and/or consistent use is less common. Among 15-24 year olds who were sexually active in the previous year, roughly half used a condom at last sex, and less than 50% of women age 15-24 reported using a condom at first sex[4].

Previous studies from South Africa have reported a variety of barriers to contraceptive use among young women including lack of access, fear of adults' and providers' negative attitudes about young women's sexuality, perceived lack of pregnancy risk, peer norms, and concern for confidentiality when seeking health care services[5,8]. Gender based violence (GBV), and the associated power imbalances in relationships, is an additional barrier to contraceptive use[9]. GBV is extremely common in South Africa, in part due to historical structural inequalities and discriminatory cultural norms[10]. Nationally, statistics show that 7% of women have been assaulted in the last twelve months, with 48% indicating that this occurred in their home[4]. However, for certain populations, the burden of GBV is higher. Among women surveyed in an antenatal clinic in Soweto, South Africa, 30.1% report having been sexually assaulted by a male partner in the last year[11].

For young women, the problem of GBV is acute and often involves intimate partners or family members. Data from South Africa indicate that rape and sexual coercion often take place at school and in family homes, where abusers are peers, family members, and sometimes teachers[10,8]. Jewkes et al (2002) reported that among adolescent girls living in urban and peri-urban areas of Cape Town, two thirds had experienced abuse by a partner. They reported that their partners objected to their desire for abstinence, and a majority reported that they had had sex against their will[12].

The main objective of this study was to assess young women's knowledge and experiences with regards to sexual and reproductive health (SRH) and to determine how young women access SRH information and services in Soweto, South Africa.

Methods

The study was approved by Allendale Investigational Review Board and the Human Research Ethics Committee at the University of the Witwatersrand. Permission to perform the research was also obtained from the Gauteng Provincial Department of Health and the City of Johannesburg. All participants provided written informed consent.

The study was conducted in Soweto, South Africa and employed a cross sectional design. Both quantitative and qualitative methods were used. Recruitment took place at a popular shopping mall and three large, public, primary health care clinics. The three study clinics were chosen for their combined offering of reproductive health services and their large catchment areas/patient populations. The shopping mall was selected because of its proximity to the three clinics and its popularity among youth. The mix of recruitment locations allowed for different perspectives: those of young women who were seeking public sector clinic services and those living in the participating clinics' catchment areas but not seeking services at the time of recruitment. At the clinics, young women were recruited from the antenatal care (ANC), abortion (or termination of pregnancy (TOP)), family planning (FP), and HIV-related service departments.

Eligibility criteria for recruitment included being a young woman age 18-24, living permanently in Soweto, and speaking English, Zulu or Sesotho (the three languages in which the survey was available). From February to October 2009, trained interviewers recruited eligible young women and administered short surveys which covered knowledge and attitudes regarding SRH services, the availability of and ease of access to those services, SRH concerns, and who the young women felt they could talk to about their SRH concerns. All survey participants received R30 (approximately $4.30) for their time.

During the same time period, fifteen additional young women were recruited for participation in semi-structured, qualitative interviews. The same eligibility criteria noted above applied. However, recruitment was only conducted at the ANC, TOP, FP or HIV services at the three clinics. Recruitment was not done at the shopping mall. Women participating in the qualitative interviews were not the same as those who completed the survey. The interviews were conducted in the

same study languages and explored topics similar to those covered in the surveys though in more depth. Interviews were conducted in a private setting and lasted approximately one hour. All semi-structured interview participants received R50 (approximately $7.15) for their time. Interviews were digitally recorded, transcribed verbatim, and translated to English where necessary.

Survey data were entered into SPSS statistical software, version 14.0 (IBM Corporation, Armonk, NY), and frequencies generated. Missing values were excluded from the analysis.

Results

Table 1: Survey participant characteristics (% (n) or median [IQR])

	n = 90
Age[a]	21 [19-23]
Currently in school	33.3 (30)
Currently working[a]	16.9 (15)
Currently living with[a]	
Parents	49.4 (44)
Partner	13.5 (12)
Other family member	61.8 (55)
Other	4.5 (4)
Relationship status	
In a relationship, married or living together	14.4 (13)
In a relationship, not married or living together	75.6 (68)
Not currently in a relationship	10.0 (9)
Ever had sex	96.7 (87)
Age at first sex[b]	18 [17-18]
Number of current sexual partners[c]	1 [1-1]
Number of lifetime sexual partners[d]	2 [1-4]
Survey conducted at: % (n)	
Clinic	48.9 (44)
Mall	51.1 (46)

[a] n = 89, [b] n = 85, [c] n = 75, [d] n = 80

Qualitative data were analyzed using a grounded theory approach. An outline of topics of interest was created using the interview guide. Transcripts were then reviewed by members of the research team who developed and assigned codes which correlated with key issues. A preliminary list of codes and code definitions was developed and subsequently refined through discussion. Major themes were identified and summarized. The computer software package ATLAS ti 5.2 (ATLAS.ti GmbH, Berlin, Germany) was used to facilitate coding, sorting and data management.

A total of 90 young women (44 at clinics and 46 at the mall) were interviewed during the two rounds of quantitative data collection. As indicated in Table 1, the median age was 21 (interquartile range (IQR) 19-23). Approximately 33% were currently studying, and 17% were currently working. Most (61.8%) were living with a family member, and currently in a relationship though not living with their partner (75.6%).

Contraception: knowledge and access to services

Table 2: Survey responses: Contraception and TOP (% (n))

	n = 90
Ever heard of…	
Male condoms	97.8 (88)
Female condoms	75.6 (68)
Hormonal contraceptive pills[a]	78.7 (70)
Injectable contraceptives	71.1 (64)
Intra-uterine contraceptive devices	42.2 (38)
Implants	17.8 (16)
Ever used … [b]	
Male condoms	79.8 (67)
Female condoms	11.9 (10)
Hormonal contraceptive pills	13.1 (11)
Injectable contraceptives	34.5 (29)
Intra-uterine contraceptive devices[c]	1.2 (1)
Implants	3.6 (3)
Ever pregnant[a]	58.4 (52)
1 lifetime pregnancy	40.4 (36)
2 lifetime pregnancies	16.9 (15)
3 lifetime pregnancies	1.1 (1)
Ever had an abortion (prior to day of interview)	7.8 (7)*
Knows about a service that provides abortion, or TOP	77.8 (70)
Knows someone else who has had an abortion, or TOP	65.6 (59)
Where young women can get information about family planning:**	n = 68
Health institution/doctor/nurse	73.5 (50)
School	38.2 (26)
Media	23.5 (16)
Family members	20.6 (14)
Friends	16.2 (11)
Other	25.0 (17)

[a] n = 89, [b] n = 84, [c] n = 83

* 4 additional women were scheduled to have a TOP on day of interview

** This question asked only to participants who said that young women get enough information about family planning (68/90).

All of the survey participants had heard of at least one method of modern contraception (data not shown). All but two (97.8%) had heard of male condoms and approximately three-fourths had heard of female condoms (75.6%), contraceptive pills (78.7%), and/or injectable contraceptives (71.1%) (see Table 2). Fewer women had heard of intra-uterine contraceptive devices (IUDs; 42.2%) or implants (17.8%). The majority had used male condoms at least once (79.8%), and one third had ever used injectable contraceptives (34.5%). Around ten percent had used pills (13.1%) or female condoms (11.9%), and very few had tried implants or IUDs (3.6% and 1.2%, respectively).

When asked where young women could get information about contraception, participants listed multiple sources including health institutions, doctors, and/or nurses (73.5%), school (38.2%), the media (23.5%), family (20.6%), and friends (16.2%).

Participants in the qualitative interviews were asked about the ease and/or difficulty of accessing contraceptive information and services. These women thought information was available – mainly at clinics, but also from friends and family. Some specifically mentioned that family or friends had given them information or encouraged them to "go for prevention." Almost all of the respondents also knew that contraceptives were available at the clinic.

Despite knowing where one could get a method, when asked whether it was easy to get contraceptives at the clinic, many respondents noted that it was not. They cited nurses' attitudes and busy schedules as obstacles to getting a contraceptive method.

> *"There is family planning at the clinic … I once went there, I was so shy, I was … doing my matric [final year of high school]. I came there and said I would like to know where [contraceptive] injections are administered, cause I was speaking in a low voice trying to be private with the nurse, but this lady screamed asking, 'What are you here for, what have you come for,' and I said, 'No, I just wanted to ask where injections are done,' and she said, 'Hey sit down here. This is the place for injections.' I just walked out, thinking to myself she is going to cause a scene for me and the others coming for the injection …" [P10:79]*

In contrast, some respondents felt that it was easy to get contraceptives. One noted that it was easy because contraceptives are free at the clinics. However, more suggested that obtaining contraceptives was easy only when one has both the necessary information and the conviction to get a method before going to the clinic.

> *"It is easy for one to get information on how to practice contraception, once you come to the clinic without a sense of shame obviously, if you ask they will give you the information even if they will make a noise, but eventually they will tell you." [P10:175]*

When asked about SRH services more generally in the qualitative interviews, most of the respondents said that information on SRH is available. They said young women can go to clinics, ask their families or "older people", or speak to their friends when they want information. Some also mentioned schools, books, pamphlets, and TV as sources of information. When asked whether it is easy to get this information, responses differed. A few respondents expressed feeling that information is not accessible. However, more respondents said that young women, themselves included, do not have problems getting information at the clinic or talking with their families, but there are limitations or challenges associated with obtaining information at times. For example, some mentioned challenges in communicating with health care workers about their real concerns.

> *"When I come here [to the clinic], they ask, "Lady, have you come here to ask questions or to say what is wrong with you?" They don't have time, so there is not asking them many questions because when you ask them, they ask, "Did you come for that or are you sick? What is it, lady? There are sick people here, who are in pain. Hurry and say what you want." You see." [P8:269]*

Finally, many of the qualitative interview respondents expressed feelings that although the information is available, many young women do not attempt to access it. The respondents expressed feeling that young people must be proactive and persistent in order to get information on SRH. One respondent astutely noted that having information does not mean that it is acted upon.

> *"Yes, they can [get information on SRH]. We get newspapers, magazines, and we learn from the TV, it's just that we ignore these things, but yes, they are informed." [P8::49]*

Abortion services

Over half the survey respondents (57.3%) reported at least one prior pregnancy, and around ten percent (10.7%) reported ever having an abortion, or TOP (see Table 2). The majority of the young women knew where to get an abortion (77.8%), and many knew someone who had had one (65.6%).

We asked the qualitative interview respondents several questions related to knowledge and experience with TOP services. Regarding where young women get information about TOP services, a few commented that one has to know someone who has had an abortion and then get information from her. However, almost half of the respondents mentioned that they have seen or heard of advertisements for potentially illegal abortion in newspapers and posters/pamphlets in their neighborhoods. Only two of the qualitative respondents said that they had no idea where one could obtain an abortion. Several named specific clinics or hospitals where the services are available. However, some also mentioned that for confidentiality reasons some women go to other, illegal, places or even try to abort on their own.

> *"…obviously a person would think to themselves: 'I won't go to the clinic and shame myself' or they just do wrong things on their own: 'let me take pills and help myself, maybe it will help me', she does not want to go to the clinic because she fears the eyes of other people, she wants stuff that will keep her concealed… people should not see me like this, best I do this, nobody will see me doing like this, only I will know. [P3:141]*

Whether respondents knew where one could obtain an abortion or not, most spontaneously expressed feeling that abortion was stigmatized. Further, many of the respondents personally felt that abortion was generally bad or unsafe. Several reported hearing of someone who died as a result of abortion, and a few said that they had been told by health practitioners (i.e., nurses, social workers) that abortion is a life threatening procedure.

> *"Yeah, sisters educate about abortion and they even tell you that abortion is no easy matter because you are then between life and death. They actually teach us about many things." [P1:175]*

HIV testing and condom use

Table 3: Survey responses: HIV testing and condom use (% (n) or median [IQR])

	n = 90
Ever tested for HIV	74.4 (67)
Number of times tested[a]	2 [1-3]
When was the most recent test[b]	
Within past six months	55.2 (37)
6-12 months ago	23.9 (16)
More than 1 year ago	20.9 (14)
Reason for test[c]	
Wanted to know status	53.8 (35)
Pregnancy	35.4 (23)
Compulsory	9.2 (6)
Sexual assault	1.5 (1)
Used a condom at last sex[d]	50.6 (45)

[a] n = 67, [b] n = 67, [c] n = 65, [d] n = 89

Survey participants were asked several questions about HIV testing (see Table 3). Three-fourths (74.4%) had ever tested, and of those, on average, each participant had tested two or three times. Of those who had previously tested, around half (55.2%) had tested within the past six months. The reasons given by the young women for having tested included wanting to know their HIV status (53.8%); pregnancy (35.4%); compulsion for work, training, or blood donation (9.2%); and

sexual assault (1.5%). Only half of the women (50.6%) reported using a condom at last sexual intercourse.

The qualitative interviews provided some detail about both the availability and use of HIV information and services. These respondents overwhelmingly expressed that information on HIV and HIV-related services are available in their communities. They commented that young people can get information on HIV if they are in school, by listening to the radio or watching television, or if they visited a clinic and spoke to a nurse or doctor. When asked where young people can access HIV-related services, the respondents stated that services such as testing and treatment could be accessed at local clinics. They also noted that one could obtain condoms for prevention at clinics.

While commenting on the wide availability of HIV-related information and services, several of the respondents suggested that the availability of information and services does not necessarily mean that young people act on this information or utilize the services.

> *"… cause we all know, okay, if you don't want to get AIDS you use a condom, and you, we all know that, but we don't necessarily do it all the time, I'm not sure why, but ja." [P6:70]*

A common theme that arose in the qualitative interviews regarding the internalization of information on HIV was that stigma and fear of ridicule prevent young people from utilizing SRH services. In addition, the qualitative respondents indicated that young people sometimes ignore the information they receive about HIV prevention because they don't believe they will become infected or they are not afraid to become infected. Other influencing factors for not protecting oneself that were commonly brought up included physical and emotional abuse by partners, pressure from partners to have sex or have a baby (and in one case, from parents to have a baby), and partners not wanting to use protection. Some described poverty leading to young women having to depend on men or put men before themselves:

> *"Women don't protect themselves. If you find a man, and let's say he gives you money and you live with him, once he says he doesn't want a condom, that's that." [P2:462].*

However, others pointed out that young women have the responsibility to choose to protect themselves; the same participant also said:

> *"We have choices, right. And it can't be something…that you say was a mistake, no no…something like that is never a mistake because if you sleep with a man you know what the risks are of falling pregnant and you also know that you could pick up HIV/AIDS." [P2:67]*

Gender-based violence

Table 4: Survey responses: Gender-based violence (% (n))

	n = 90
Ever felt forced to have or pressured to have sex when you did not want to	18.9 (17)
Partner ever made you feel scared or threatened	25.6 (23)
Partner ever kicked, hit, or punched you	23.3 (21)
Where young women can go for support if they experience violence in a relationship or in their family[a]	
Police station	39.3 (35)
Social worker	33.7 (30)
Clinic	31.5 (28)
Health provider/counselor	20.2 (18)
Family	15.7 (14)
Friends	14.6 (13)
Neighbors/community members	10.1 (9)
Other	23.6 (21)
Don't know of any service	10.1 (9)

[a] n = 89

As noted above, whether or not young women are able to protect themselves from HIV and pregnancy can be influenced by relationships and gender dynamics, including gender based violence. Almost one fifth of survey participants (18.9%) reported previously having felt forced or pressured to have sex (see Table 4). In addition, one in four had had a partner who made them feel scared or threatened (25.6%) and/or had kicked, hit, or punched them (23.3%).

Qualitative interview respondents also spoke about their experiences with violence. Several young women said that they had been forced to

have sex by a partner who wanted to impregnate them before they broke up, either because they had cheated, or because their partner suspected that they had cheated. A few of the young women also talked about partners threatening them or making them feel scared, or hitting, kicking, or punching them. One such woman mentioned that her partner slapped her "not in an unreasonable way" since, in her view, she had done something wrong (P9). Further, the majority of interviewees knew of other women who had been hit, kicked, or punched by a partner. Several elaborated on the abuse, saying that it was because the wife was spending too much time outside of the house with friends, or that women saw it as a sign of love from someone that they were dependent on; for example:

> *"If they are beaten up they feel assurance that 'because this person beats me up like this it means that he loves [me]'…I don't think the person affected actually feels bad; of course she does feel the pain but then reckons that even if she considers reporting him to the police…perhaps she survives through his support, you understand? This man is perhaps everything to her, you see. So she has no choice." [P2:426]*

Among the survey participants, responses varied regarding where young women could go for help if they were experiencing violence (see Table 4). The most common responses were the police (39.3%), a social worker (33.7%) or a local clinic (31.5%). Although most of the respondents listed more than one place, 10 young women (9%) indicated that they did not know anywhere to go for help.

Concerns and support systems

To place the issues of family planning, HIV, and GBV in context, survey participants were asked about their biggest concerns in day-to-day life. The young women spontaneously reported that common daily concerns included pregnancy (37.8%); HIV/STIs and/or condom non-use (31.1%); poverty and unemployment (31.1%); abuse, sexual harassment, and rape (27.8%); and drug/alcohol abuse or partying (22.2%; see Table 5). When asked with whom they felt comfortable speaking about personal or family problems, respondents included friends (42.5%), siblings (27.6%), mothers (25.3%) and other relatives (26.4%) as their main confidants. Less than ten percent (9.2%) listed their boyfriend or partner. In addition, less than half (45.3%) felt that young women could speak to their parents about SRH issues.

Table 5: Survey responses: Daily concerns and support system (% (n))

	n = 90
Most common concerns in daily life	
Pregnancy (teenage, unwanted)	37.8 (34)
HIV/STIs or condom non-use	31.1 (28)
Poverty and unemployment	31.1 (28)
Abuse, sexual harassment, rape	27.8 (25)
Drug or alcohol abuse, or partying	22.2 (20)
Education	13.3 (12)
Crime and violence	12.2 (11)
Feels comfortable talking about family or personal problems with:[a]	
Friends	42.5 (37)
Sibling	27.6 (24)
Mother	25.3 (22)
Other relative	26.4 (23)
Boyfriend/partner	9.2 (8)
Other	3.4 (3)
No one	4.6 (4)
Think that young women can speak to their parents about sexual and reproductive health[b]	45.3 (39)

[a] n = 87, [b] n = 86

Women in the qualitative interviews described not having enough support from the community, clinics, or parents. They talked about community members gossiping and mocking instead of supporting them, health care providers not giving the information that young women need because they are overworked, and parents not discussing SRH with their children. One woman pointed out that providers also do not discuss SRH topics with young people because they think it is the parents' responsibility:

> *"When we ask our parents they become aggressive, they shout at us not wanting to talk to us, saying, 'why do want to know about such things,' …sometimes we go to clinics and then they say 'why do*

you want to know, you are still too young, why don't you ask your parents,' we say, 'they also don't want to tell us.'" [P8:101]

Discussion

In both the quantitative survey and qualitative interviews, most young women reported that they have access to SRH information and know where to obtain SRH services if they want them. However, some gaps did exist, particularly related to knowledge of the full range of contraceptive methods or where to obtain GBV or safe abortion services.

In addition, there are some questions around the quality of the SRH information and services received by the young women. Considering abortion specifically, the high proportion reporting that abortion is a "life threatening" procedure or knowing someone who died from an abortion suggests that their knowledge of safe, legal services is limited. Their comments on this issue also underscore the level of stigma in the community surrounding abortion services and persistence of unsafe services despite one of the most of the most liberal abortion laws globally. Abortion is legal on demand in South Africa through 12 weeks and for a range of liberal criteria through 20 weeks of gestation[13].

Further, the young women's comments regarding certain behaviors raise concerns regarding whether they are able to internalize and utilize what they learn or know about SRH services. For example, the survey respondents reported a high rate of HIV testing but low condom use at last sex and high knowledge of family planning methods but low usage rates. This can be attributed to several factors brought out in the qualitative interviews. Some of the young women stated that although they may understand their risks and know how to protect themselves from HIV or pregnancy, they may not act on that knowledge; this was often expressed in the context of their relationships and their inability to negotiate protection. In addition, the young women reported challenges regarding providers' unsupportive attitudes. This is reinforced by Holt et al. (2012) who conducted a related study with health care providers in Soweto. The providers reported feeling that young women should not be sexually active until marriage[14].

Finally, the young women listed several SRH issues as "daily concerns." As half of them were recruited from within SRH services, this may not be surprising, but it is telling that they listed pregnancy and HIV along with poverty and violence. Further, the fact that they felt more comfortable talking to friends and family than partners or boyfriends about their concerns, speaks to the dynamics of their relationships and support networks.

Limitations

Limitations to this study include the small sample size and the minimum age (18 years) for participation. The requirement to recruit from age 18 upward was set by the local ethics committee, but because sexual debut is often earlier than 18 for young women in South Africa, future similar studies should include younger women. Strengths of the study include the mixed methods approach, which allows for quantifying and contextualizing results, and data collection both within and outside of clinics, which contributed to generalizability.

Conclusion

In the past decade, there has been a growing awareness and response in South Africa to the need to expand HIV prevention and SRH services to adolescents and young adults. There have been efforts to create adolescent-friendly services, yet despite these efforts, questions regarding whether services are sufficiently accessible by young people persist. The results of this study indicate that young women in this context are exposed to a significant amount of information on SRH, including HIV and GBV. However, there is a need to assist them in understanding the significance of this information in terms of their actions today and their future goals and achievements. Given the stigmatized nature of abortion services and young women's sexuality generally, special efforts may be required to raise awareness regarding the

availability of safe abortion services and the importance of access to contraceptive services for young women. Yet, having information or knowing where to obtain it is just the first step. Young women also need support from their families and communities and access to nonjudgmental SRH services in order to make responsible choices and have safe and healthy sexual experiences.

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