Availability and accessibility of public health services for adolescents and young people in South Africa

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Highlights

• South Africa has an enabling, comprehensive and progressive legislative and policy framework for the provision of adolescent and youth friendly services in South Africa is laudable.

• However various provider, health facility, and programme design characteristics continue to hamper effective provision and delivery of adolescent and youth friendly health services.

• The need to consider the amendment of some health facility regulations such as operating hours and/or days to ensure that service provision is convenient for young people.

• The provision of all cadres of primary health service providers with on-going professional development and attitudinal training is imperative to break down prejudices that may limit the success of the adolescent and youth friendly programming in the country.

• There is need for more youth involvement in programme design and service provision.

Abstract

Against the background of increasing international calls for the development and implementation of age-appropriate programmes that address both quality and access issues to improve adolescent and youth health, this paper explores the extent to which public health facilities are available and accessible to adolescents and youth in South Africa. The impetus for the study was the current evidence that there was generally poor utilisation of services offered at public health facilities by young people in the country. The overall findings are that despite the country's comprehensive legal and policy framework and commitment to improve the health of young people, there continues to be some structural and systemic factors that hamper effective provision and programming of adolescent and youth friendly services. The paper concludes with recommendations for policy and practice.

Key words

South Africa; Adolescents; Young people; Health Facilities.

1. Introduction

Albeit the healthiest period in life, adolescence (broadly construed as the period between 10 and 19 years) and youth (the period between 15 and 24 years) are some of the most vulnerable and disadvantaged age brackets in society (Agampodi et al, 2008; Mendes & Snow, 2014). It is during this time that socioeconomic, as well as age- and gender-related risks in families, communities and societies interact with individual physical, cognitive, and emotional developmental processes to create conditions that place young people at risk of adopting behaviours that have long-term implications for their health and their ability to grow and develop to their full potential. These include substance abuse; exposure to sexual abuse as well as violence and injuries; early initiation of sexual activity and the associated exposure to sexually transmitted infections including HIV; onset of certain mental disorders that

increase the risk of suicide among young people; poor or lack of physical activity and increased risks of obesity; malnutrition; and high levels of early and unwanted pregnancies which are associated with unsafe abortions and pregnancy-related morbidity and mortality (United Nations, 2012; World Health Organisation, 2014).

It is with this background that making health services accessible to adolescents and youth (hereafter referred to as 'young people') has been an explicit goal of many international instruments such as the United Nations Convention on the Rights of the Child (1990); the 1994 Plan of Action of the International Conference on Population and Development (ICPD); the 2001 United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS; and the 2003 Committee on the Rights of the Child's guidelines on states' obligation to recognize the special health and development needs and rights of adolescents and young people. In Africa the key tenets of these international instruments are echoed and reaffirmed in regional ones such as the African Charter on the Rights and Welfare of Children (1990), the African Youth Policy (2006) and the Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006).

Despite these commitments, the low use of health services by young people is widely documented and has been attributed to various factors such as high cost of services; lack of information and awareness on availability of services; poor skills among service providers on how to deal with young people; stigma associated with using sexual and reproductive health services by young people; as well as lack of privacy and confidentiality in service provision (Agampodi et al, 2008; IPPF, 2008; MiET, 2011). Barriers related to accessibility of services which, within health care, is defined as "the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs" (Levesque et al, 2013:1), has also been recognised as playing a particularly important role in this regard (Denno et al, 2012). Given the centrality of poor access to health care services in perpetuating poverty and inequality (McLaren et al, 2014), improving accessibility is particularly salient in societies where policies "historically privileged certain groups over others, leaving behind large gaps in health status that current policy must take into account" (McLaren et al, 2013:2). It is partly in light of this that access to health for all is constitutionally enshrined in South Africa given the country's long history of apartheid, a system of racial segregation that prevailed in the country between 1948 and 1994 (Meyer, 2010; Harris et al, 2011).

Following the advent of democratic rule in 1994, South Africa began a process of legal and policy reforms, and ratified the international and regional agreements outlined earlier in an effort to address the major health issues including those facing young people. It is noteworthy however, that South Africa's commitment to address the health needs of young people evolved in an environment that had minimal national policy to support it. Thus, using a human rights perspective and adopting participatory and consultative approaches at local and

international levels, the country has since the late 1990s developed and implemented three specific strategies aimed at improving availability and accessibly of health services for young people. These are the National Adolescent Friendly Clinic Initiative (2000-2005); the Youth Friendly Services model (2006-2011); and the revised Adolescent and Youth Friendly Services model (2013-2017). A discussion of the key tenets of these strategies is beyond the scope of this paper, suffice to state that a common thread across them is the aim to ensure that health facilities and services in South Africa are adolescent and youth friendly, that is acceptable, *accessible*, affordable, *available* and effective (Muturiki, 2013).

With this comprehensive legal and policy framework and commitment, to what extent are public health facilities available and accessible to young people in South Africa? The aim of this paper is to explore this question by presenting young people's and public health facility managers' perceptions on the issue using data that were collected in 2014 for a national rapid assessment of adolescent and youth friendly services (AYFS) which was commissioned by the National Department of Health in collaboration with UNICEF and UNFPA in South Africa. This question is important in the context of considerable inequities in access that have been noted in the general South African population (Harris et al, 2011; McLaren et al, 2013). For young people in particular recent studies such as Schriver et al (2014) and Geary et al (2014; 2015) have found that the inequity in access is largely as a result of a myriad of barriers related to provider, facility and programme design characteristics. These include, among others, healthcare workers who are not trained to meet the needs of young people and, overall "lack of resources, long waiting times, and poor quality of care heightened by an underlying lack of choice and perceived inequity" (Schriver et al, 2014:625).

2. Methods

The central element of the rapid assessment was the combination of qualitative and quantitative methods to explore availability in terms of the spread of public health facilities in the country, with particular focus on those facilities that offer basic primary health care services such as clinics, hospitals, mobile clinics, community health centres, and satellite clinics. Accessibility, on the other hand, was explored in terms of the following three dimensions as per Thiede et al's (2007:110) typology:

- *Physical accessibility*: the availability of health services within reasonable reach of those who need them. It can be examined in terms of distance travelled to reach services, and available transport options;
- *Affordability*: the "degree of fit" between the cost of using health care services (for example consultation fees, cost of diagnostic tests, medicines, in-patient services etc; as well as indirect costs such as those related to transportation and special foods); and
- *Acceptability*: "the nature of service provision and how this is perceived by individuals and communities".

2.1. Quantitative component

The quantitative component entailed a desk-top analysis of secondary data from the 2011 population census to undertake a spatial analysis and mapping of public health facilities across the country to illuminate their availability for young people. Programme data from loveLife – South Africa's largest national HIV prevention initiative for young people (loveLife, 2012) – were also used to explore the distribution of youth centres across the country.

2.2. Qualitative component

The qualitative component of the rapid assessment entailed the undertaking of facility assessments; key informant interviews with national, provincial, and district stakeholders as well as with facility managers; focus groups discussions with young people aged 15-24 years.

2.3. Study sites

In each province two health districts and one health facility per district (total of 18 facilities) were purposively selected as study sites. The selection process ensured that there was a combination of public health facilities accredited by the National Department of Health as adolescent and youth friendly and those not so accredited as well as facilities in rural areas, urban areas, with the latter including some informal settlements (Table 1). Only one facility out of the 18 was not public but was run by loveLife.

Table 1. Overview of health facilities assessed.

Province	Health District	Implementing AYFS	Urban/Rural
Limpopo	Vhembe	Yes	Rural
	Waterberg	Yes	Rural
Mpumalanga	Gert Sibande	No	Rural
	Ehlanzeni	Yes	Urban
Gauteng	Tshwane	Yes	Urban
	Sedibeng	No	Urban
KZN	Umgungundlovu	Yes	Urban
	Umkhanyakude	No	Rural
Free State	Lejweleputswa	Yes	Urban
	Thabo Mofutsanyana	Yes	Urban
North West	Dr Kenneth Kaunda	No	Rural
	Bojanala	Yes	Urban
Northern Cape	Pixley Ka Seme	No	Rural
	Francis Baard	Yes	Urban
Western Cape	City of Cape Town	Yes	Urban
	Eden (Mossel Bay)	Yes	Urban
Eastern Cape	OR Tambo (Nyandeni)	No	Rural
	Alfred Nzo	Yes	Rural

2.4.Data collection

As stated above this paper reports only on data obtained from the key informant interviews with facility managers and the focus group discussion with young people aged 15-24 years. The qualitative component of the assessment used the following methods to collect information from both service providers and users.

2.4.1. Key informant interviews with facility managers

The facility managers of all the selected facilities were interviewed using semi-structured interview guides designed to solicit information on operational issues and system barriers; factors that facilitate and inhibit young people's use of health facilities; and suggestions and recommendations to encourage young people to seek health services from public facilities. Thus, in line with the World Health Organisation's guidelines for assessing the quality of health service provision for adolescent clients (World Health Organisation, 2009), the questions asked broadly enquired about facility details; management system support for the effective provision of adolescent and youth programmes; policies and processes to support youth and adolescent rights; accessibility and availability of youth and adolescent services; adequacy of drug supplies and equipment; systems in place to train and develop staff on adolescent and youth issues; individualised care (assurance of privacy and confidentiality); continuity of care (availability of proper referral systems); and managers' views of strengths and weaknesses. With the consent of managers, all the interviews were audio-recorded.

2.4.2. Focus group discussions

To obtain user perspectives, 16 focus group discussions – through which data saturation was achieved – were held with young people aged 15-24 years who had visited public health facilities at least twice in the last two years. This time criterion was meant to ensure that the experiences and perspectives were recent. The main objective of these group discussions was to provide a forum for the young people to discuss their experiences and views regarding AYFS provision, programming, and implementation in their districts and provinces, and to explore ideas for improvement of service delivery. The focus group guides were thus designed to collect information through questions related to, among other things, experience in seeking AYFS from local health facilities; health services currently being received; critical services young people sometimes went without; perceptions on adequacy and quality of services provided at local health facilities; and views on how AYFS provision support could be improved.

As per the United Nations guidelines (Brady, 2011), the focus groups were categorised into two age groups: 15-19 and 20-24 years, and by gender (that is, separate male and female groups). This was done to ensure that the developmental stages and the experiences of different genders were taken into consideration. Measures were also put in place to ensure that the focus groups were heterogeneous and included young people from different socio-

economic strata of society in urban, rural and peri-urban areas. All discussions were conducted in the vernacular and were audio-recorded with the consent of all the participants.

2.4.3. Data analysis

All the key informant interviews and focus group discussions were, with the participants' due consent, audio-recorded, and at the end of the data collection the recordings were transcribed and translated into English and then back translate to the vernacular. This was to ensure accurate translation and capturing of data. Thereafter the first and fourth authors analysed the data using the first six of Colaizzi's seven steps method of data analysis (Colaizzi,1978) which is often used to uncover the genuine lived experience of the phenomenon under study (Thupayagale-Tshweneagae & Mokomane, 2012). The first six steps, according to Goulding, (2005) entail:

1. Reading participants' transcripts, to get a sense of their general ideas in order to understand them fully.
2. Extracting "significant statements" from the narratives by identifying key words and sentences relating to the phenomenon under study.
3. Formulating meanings for each of the significant statements extracted in (2) above.
4. Categorising the participants' experiences and recurrent statements into meaningful themes
5. Integrating the resulting themes into a rich description of the phenomenon under study. In this assessment, this step applied the constant comparative analysis method which involves making systematic comparison across units of data (in this case key informant interviews and focus group discussions) to develop conceptualizations of the possible relations between various pieces of data (Boeije, 2002).
6. Reducing the themes to an essential structure that offers an explanation of the behavior. To achieve this, Narrative analysis, a method that recognizes the extent to which people provide insights about their lived experiences (Chase 2005; Reisman, 2008), was applied.

The seventh step of Colaizzi's method which entails returning to participants to conduct further interviews or elicit their opinions on the analysis in order to cross-check interpretation (Goulding, 2005), was deemed unnecessary for the purpose of this assessment and hence was not applied. All the analysed data from the key informant interviews and the focus group discussions were synthesised and triangulated for the purpose of this paper.

2.4.4. Ethical considerations

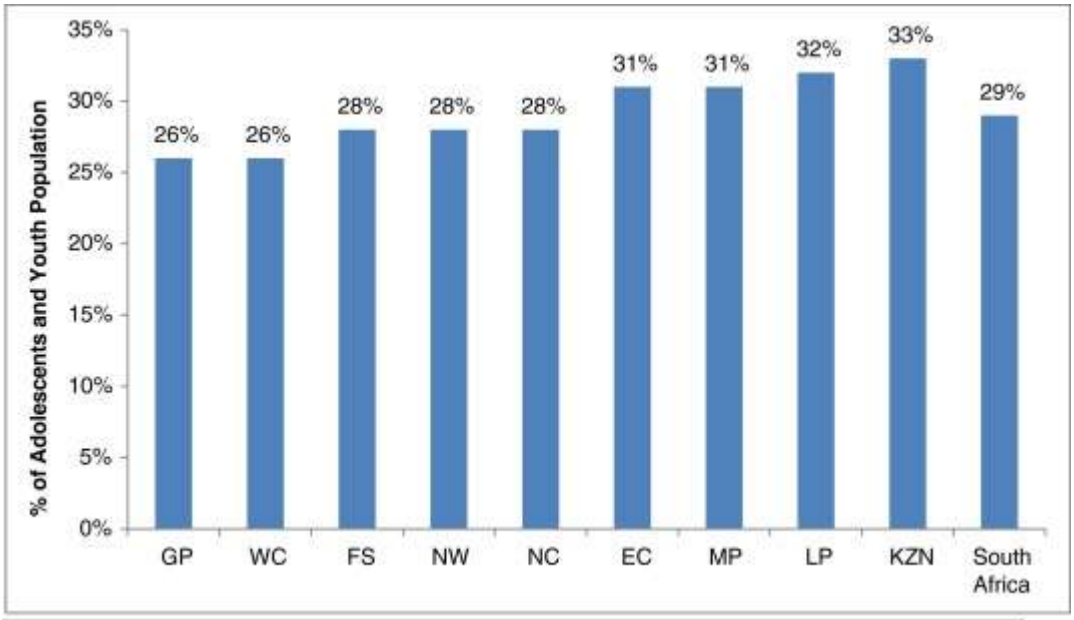
Ethical clearance to undertake the assessment was granted by the Research Ethics Committee of the Human Sciences Research Council of South Africa (REC 13/19/02/14). The paper

published in accordance with the conditions set out in the National Department of Health's Data User's agreement.

3. Findings

3.1. Availability of public health facilities for young people

According to a 2012 Baseline Audit of National Health Care Facilities (Department of Health, 2012), South Africa has a total of 3880 public health facilities, majority of which are clinics or primary health care centres followed, to a lesser extent, by community health centres and district hospitals. In terms of spread, spatial analysis of the 2011 population census suggests that on average there are between two and six facilities per 1 000 km², with the highest concentration of facilities (between 10 and 143 facilities per 1 000 km²) being in the eight metropolitan municipalities and provincial capitals. Given the proportion of young people per province (Figure 1) it can be concluded that there is relatively good availability of health services for this age group, with much of the country having at least three public health facilities per 10, 000 young people (Figure 2).



Source: Computed from the 2011 census data

Fig. 1. Proportion of adolescents and youth population (aged 10–24 years) per province and South Africa as a whole, 2011.

Source: Computed from the 2011 census data.

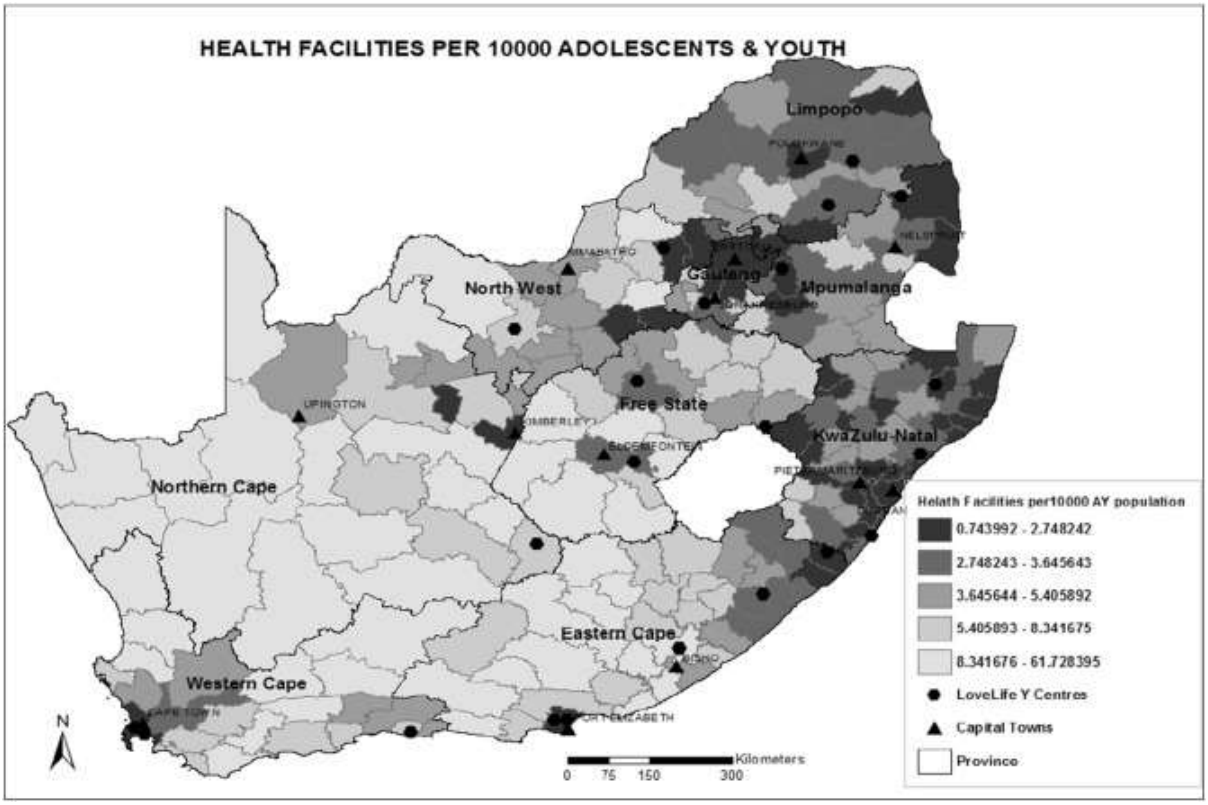
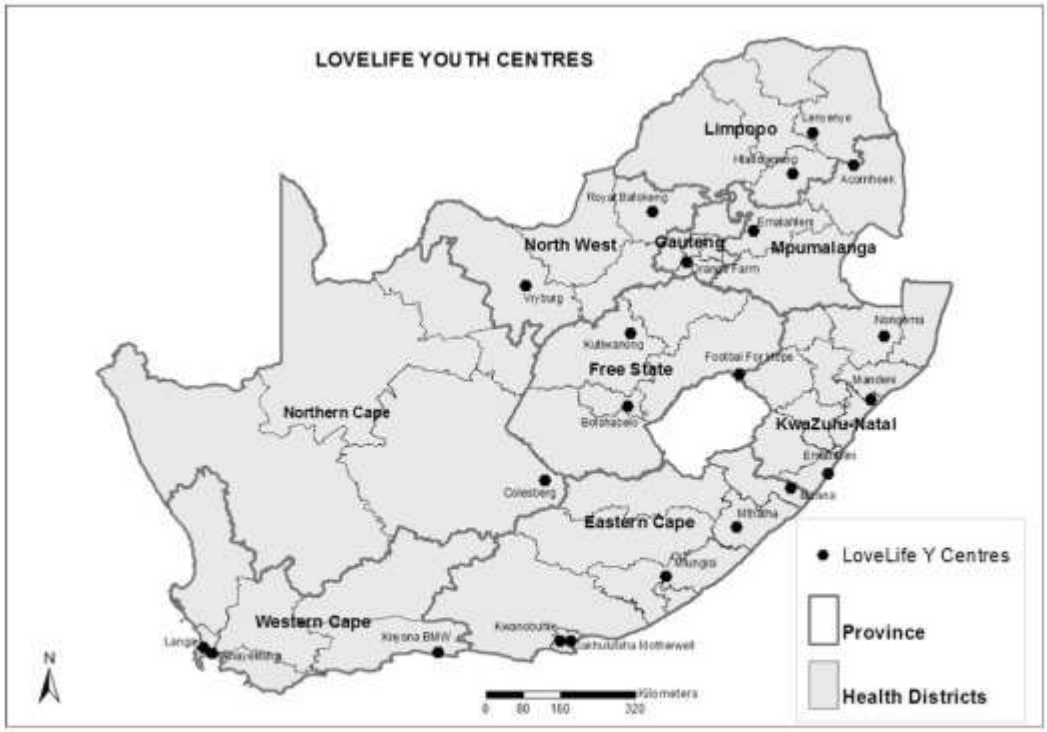


Fig. 2. Number of health facilities per 10,000 adolescents and youth population in South Africa, 2011.

It is noteworthy, however, that very few of the public health facilities offer AYFS, and this was revealed by a 2012 mapping of health facilities undertaken by the Department of Health (2012) in all but three provinces (Free State, Gauteng, and North West). In essence, the mapping exercise showed that no facilities at all were implementing the AYFS model in the Northern Cape and the Western Cape, and that very few were doing so in the other provinces. Furthermore, apart from Limpopo and Mpumalanga where four and eight health facilities, respectively were accredited as AYFS, no other provinces had facilities accredited as such. To this end, the spread of Lovelife youth centres (Y-centres) across the country (Figure 3) extends the availability of health facilities for young people and is also an important source of their health services. Youth centres are typically large multi-purpose buildings designed to provide indoor and outdoor recreation and sports facilities, computer training, community radio, sexual health education, life skills, counselling, and clinical services (Erulkar et al. 2005; loveLife, 2012). There are currently 22 Y-centres across the country and, as Figure 3 shows, most of them are located in communities that have low coverage or availability of public health facilities as was illustrated in Figure 2.



Source: Computed from loveLife programme data

Fig. 3. Distribution of loveLife Y-centres across South Africa, 2014.

Source: Computed from loveLife programme data.

3.2.Accessibility of public health facilities for young people

Data on accessibility was derived largely from the key informant interviews with facility managers and focus group discussions with young people. Although the focus groups were categorised into two age groups and by gender, there were no major variations in the experiences and views of young people by these characteristics. No variations were also noted in area of residence or location (urban/rural) for young people and facility managers.

3.2.1. Physical accessibility

Previous studies (Harris et al, 2011; McLaren et al, 2014) have showed that about 90% of South Africans live within 7km of the nearest public health facility and that two-thirds live within 2km. Consistent with these findings, in the rapid assessment on which this paper is based 15 of the 18 facilities assessed were located less than 1km from the nearest public transport stop and 14 were less than 1km away for the nearest school in the area; the overall suggestion being that public health facilities are relatively accessible to young people who are both in and out of school. However, given that the majority of users of public health facilities, particularly in informal settlements and rural areas, use public transport or walk to facilities for outpatient health services (Harris et al, 2013), the travel time and transport

options for reaching services may pose a significant access barrier for many adolescents and young people. The Department of Health (2012), for example, found that while 96% of the facilities were accessible by road, access by transport means that are mainly used by these young people (bus and train) was more limited at 58% and 9%, respectively (Department of Health, 2012). This, as Harris et al (2013) found, the average travel time to facilities was at least 30 minutes. While other means such as telephone hotlines operated by trained counsellors from clinic sites or outreach workers (IPPF, 2008) could be used to offset these travel barriers, the study found that only four of the 18 facilities assessed provided off-site facilities. Outreach officers occasionally go to local schools to educate young people about the services available and offer peer counselling. It is noteworthy that not only is this outreach work done by a few facilities, but it also tends to exclude out-of-school youth as visits are typically to schools.

3.2.2. Affordability

It is often argued that accessing health services in South Africa is affordable in that basic primary health care is offered freely by the state. In a household survey by Harris et al (2011), for example, "not having to pay" was found to have informed the choice of over half of public sector primary health care users and about a third of both public hospital outpatients and inpatients. However, with the majority of those using the public health sector relying on public transport to reach services, travel costs can be a major barrier. For young people this can be aggravated by their economic status. According to Statistics South Arica (2015a), youth aged 15-24 years are less likely to be employed than older age groups. The unemployment rate for young people increased from 32.7% on 2008 to 36.1% in 2014 while the corresponding figures for adults were 13.4% and 15.6% respectively. Furthermore, according to Statistics South Africa (2015b) over half (55.7%) of those aged 0-17 years and 50.7% of youth aged 18-24 years were living in poverty in 2011. In terms of poverty share, these cohorts accounted for 15.3% of the poor in 2011 meaning that approximately 61.3% of all poor people were under the age of 25 (Statistics South Africa, 2015:29). It is also noteworthy that while poor adolescents and youth aged 10-17 years can receive the mean-tested Child Support Grant through their caregivers, the only form of social assistance available to young South Africans aged 18-24 years is the Disability Grant, if they are disabled.

3.2.3. Acceptability

With regards to young people, acceptability of health services is often assessed in terms of opening times and difficulties in scheduling appointments (Panday et al, 2009). In this study however, other indicators of acceptability – that have not been previously reported in the literature, particularly by South African studies – emerged: perceived limited services; perceived favouritism; and lack of confidence in treatment.

3.2.3.1.Opening hours

It emerged from the interviews with facility managers that the typical opening hours for public health facilities in South Africa is 08h00 to 16h00 during weekdays. Consistent with previous studies (IPPF, 2008; World Health Organisation, 2009; Alli et al; 2013), these hours were perceived as highly inconvenient and unacceptable by the majority of young people as the following excerpts from the 15-19 year old focus group discussions illustrate:

> The hours are not convenient for us because we leave school at 14h00 and then when we get home we are expected to do our home chores and by the time we get to the clinic we are told we can't be helped because the nurses want to knock off *(Female, 15-19 years focus group).*

> Times at the clinic are not suitable for school learners because the clinic's trading hours are 8am to 4pm and during those times learners are at school and by the time the school is out then the clinic would be closed to assist the youth *(Female, 15-19 years focus group).*

> The working hours are not convenient to us like we said before we like to come to the clinic in the afternoon, others after school when our parents are not around the clinic. And we are being shouted at when we arrive in the afternoon so the time is not convenient. The nurses complain why we arrive late *(Male, 15-19 years focus group).*

Although health facilities in South Africa generally do not have separate operating hours or days for the provision of services to young people, virtually all facility managers explained that although young people follow the same registration procedures as other clients, those in school uniform are attended to as a priority and without a need for an appointment:

> The facility does not have separate hours for adolescents and youth however we attend to those who are in school uniforms so that they can go back to school and the registration process is the same as everyone who came to the clinic (*Facility manger, rural area*).

> There are no separate hours for adolescents and youth clients. But in the morning hours only students are given first chance. There is fast lane for school going youths (*Facility manager, urban area).*

> Adolescents and youth can be seen without an appointment especially during school hours and the average time allowed for consultation is one to two hours (*Facility manager, urban area).*

> They register like any other clients, except the students who are not wearing uniform, for them, they have to produce student's cards as a proof that they are students before they are registered *(Facility manager, informal settlement*).

It can be argued, however, that while uniforms can make it easy to identify young people who need to be attended quicker so that they go back to school, the insistence on the wearing of school uniform is excluding and/or increase the waiting time for young people who are out-of-school. Furthermore, despite this provision to accommodate them, young people also lamented that, with the current opening hours, there seems to be an implicit assumption that people came to facilities only for preventive services. As one said, "*when you get sick late in the afternoon, the nurses complain as if I knew what time I will be sick"*. Treatment of injuries was repeatedly cited as an example of services that are often inaccessible due to the current operating hours.

> I am not happy that the clinic doesn't operate on Saturday as this is the day on which most people get injured and require medical attention. They should operate on all the days *(Male, 20-24 years focus group).*

> … most people get injured on Saturdays and Friday nights when people are out partying and the like, so you can imagine what happens when people get injured in the evenings or during the night and the clinic is closed. This clinic must stay opened because most of the people who are injured are the township people and they should at all times be able to utilise this clinic as it is their nearest one *(Male, 20-24 years focus group).*

Overall, the seemingly preferred option was for the facilities to have current operating hours extended:

> Times at the clinic are not suitable for school learners because the clinic's opening hours are 8am to 4pm and during those times learners are at school and by the time the school is out then clinic would be closed to assist the youth, I think an extra two hours should be allocated only for adolescents and youth from 5pm to 7pm in order to cater for youth issues (*Female, 15-19 year focus group*).

> ... and also with us you find that we are only able to use the clinic late after 16:00 so if it closes it becomes difficult for us. They should at least close at 18:00 *(Male, 20-24 years focus group).*

> Clinics should open 24 hours every day just in case we get sick on weekends we should not wait until Monday to get services *(Female, 15-19 years focus group).*

While it has been argued that another strategy for improving accessibility and acceptability would be to offer services to young people at specific times or days (Oxfam 2007; IPPF,

2008), many young people in this study were not supportive of this idea, largely based on their previous experiences with staff at health facilities:

> I once got injured at school and I was given a letter to go to the clinic to wash the wound, but I was told to go back without getting any service because it was not the day for washing wounds and I had to wash it at home. It was not as good as when it is washed at the clinic. So those are some of the problems we will face if there are separate days for young people (*Female, 15-19 years focus group*).

> No I don't think it's a good idea for the youth to have a separate day. Our nurses are rude if you arrive at the wrong day you will be told in front of everyone that it's not the day for blood testing or youth problems, and everyone would know what's wrong with you *(Male, 20-24 years focus group).*

> No it's not okay to do the separate day because you will never know when you are going to get sick. Its better now we can go any day, we don't want to be stopped and be told to come in on certain days, the nurses should just improve their communication that's all. They should be patient with us *(Male, 20-24 years focus group).*

3.2.3.2.Perceived limited services

The need for health facilities to provide a wide range of services – including accurate and complete information, education and communication material that informs young people of their choices and rights – has been widely underscored in the literature (Bearinger et al, 2007; IPPF, 2008; MiET Africa, 2011). While there was evidence of general satisfaction with the provision and effective referral system for most accessing most clinical services, some young people lamented the lack of information and educational services on other health issues:

> For me the services are not enough especially with HIV testing, we need counselling before and after HIV test and I feel that service is lacking here. Another service that is lacking is the alcohol and drug services for people who have a problem of drugs and alcohol abuse. Besides these two I think the services that are being offered here are relevant for people of our age (*Female, 20-24 years focus group*)

> … well on that one there is no help, we do not have service that educate us about drugs and alcohol abuse there are no days set aside to educate us about these things. We only get such help from schools not here at the clinic (*Male, 20-24 years focus group*).

> … and the other thing, we don't have information with other illnesses, the only illnesses that we have information about is HIV and TB. Even at school it is the only information that we get so I think the clinic should provide us with more information about other illnesses besides HIV and TB (*Male, 15-19 years focus group*)

3.2.3.3.Perceived favouritism

There was also a wide perception that service providers showed favouritism, or provided preferential treatment only to those they knew thus rendering the easy accessibility of health facilities and services to those who were "connected". For example:

> I was attending the clinic for asthma treatment and I found that the sisters at the clinic are full of favouritism, if they know you they will make sure that they attend to you as soon as possible … As a result one can enter the clinic at 7 in the morning and only leave at 2 in the afternoon. I ended up not attending the clinic and stopping my asthma treatment (*Male, 15-19 years focus group*).

> You know the only time you receive a warm welcome is when they know you; then you will get treatment. But if they don't know you they shout at you (*Female, 20-24 years focus group*).

> To get services at this clinic is very easy if you have a nurse or someone working at the clinic that you know or you are related with, but if you don't know anyone it becomes very hard to get help because then you will stay on the line till you can't take it anymore (*Female, 15-19 years focus group*).

> You can wait for like two hours and they will say they are on lunch or stuff like that. Maybe you get there at 11am. What works is if you know someone that works at the clinic then you get help quicker. But if you don't know anyone it's very difficult to get help quickly *(Male, 20-24 years focus group).*

3.2.3.4. Lack of confidence in treatment

Some young people recalled incidents that made them doubt the quality of the services or treatment they had received with the general perception being that the same treatment seems to be prescribed for different ailments:

> Well we receive good treatment, but they prescribe the same medicine for everything and that is the problem. For example, the last time I was here having a toothache they recommended Panado also the second time I came with male infection down there I was also given Panado (*Male, 20-24 focus group*).

> Make sure if you have a small child that you cover them on medical aid [health insurance]. Children become ill from different things but if you take them to the clinic you know for sure that they are going to be given Panado or Allergex. You already know the medication you will definitely get. But if you go to [a private] pharmacy you can get a different type of medication. Even though it is expensive you know it works (*Male, 20-24 focus group*).

Further discussions with the young people suggested that lack of confidence in treatment was largely due to service providers not providing adequate explanation about the treatment prescribed and/or their administration:

> I came to the facility suffering from tonsillitis; I was assisted by the facility nurse and gave me some medication. She never really explained how I should apply the medication and that frustrated me (*Female, 15-19 years focus group*).

> I came to this facility with a broken toe hoping to get some assistance; I was just given medication without being examined. I had to return again earlier in January with the same problem. (*Female, 15-19 focus group*).

> Not every service here is of quality. Like what we said earlier we are often given wrong medication. I remember that I was given wrong medication and when I complained about it I was told I think I know it all (*Female, 20-24 years focus group*).

3.3.Conclusions and recommendations

Availability of, and access to health care are some of the important determinants of the level of inequality as they influence human capital accumulation, economic status and the intergenerational transmission of socio-economic status (McLaren et al, 2014;541). To this end, given the high proportion of young people in South Africa, the comprehensive and progressive legislative and policy framework for the provision of AYFS in the country is laudable as is the generally wide coverage and convenient locations of public health facilities. It is also commendable that the prevailing policy in all public health facilities is that young people can access a facility without the need to make first appointment and still receive a wide range of primary health care and services for free. Furthermore, where the requisite services are, for whatever reason, not available at the local facility, effective referral systems are in place to ensure that such services remain accessible. Community outreach work done by some facilities also ensures that services are available and accessible to young people.

At the same time however, there continues to be some structural and systemic factors that hamper effective provision and programming of AYFS. For example, while primary health care is offered freely by the state, the time and financial costs of travelling to health facilities may hamper the physical accessibility of health services by young people, who are among the economically vulnerable segments of society. This is particularly the case in the current context of high levels of poverty and unemployment among young people in the country. To the extent that there is currently no youth-specific social protection or social security programmes (except for those who are disabled) many young people are struggling or failing to make successful transitions from school into employment and other income-generating activities (Altman et al, 2014). This means many of them remain vulnerable to adopting risky behaviours that can have negative health outcomes for them and /or erode the investments that the government continues to make through accessible health facilities for young people.

This paper's findings in relation to acceptability of services offered in public health facilities mirror those of recent South African studies on the subject. In essence as Schriver et al (2014:5) noted, young South Africans generally voice "negative perception [that] stemmed primarily from interactions with service staff and the availability of resources rather than the condition or acceptability of facilities". This paper revealed that young people's experiences in this regard included perceived favouritism, perceptions that services offered in facilities were limited; as well as lack of confidence in treatment offered by the facilities. These findings are important against the background of evidence showing the importance of patient perception of health care quality in efforts to achieve more patient-centred health care systems and better health outcomes (Sofaer & Firminger, 2005; Papp et al, 2014). Studies from several sub-Saharan African countries have also shown that where young people report positive perceptions in relation to availability, acceptability and acceptability of health services, there tends to be use of health facilities and greater uptake of the services (Schriver et al, 2014). To this end, the finding that young people believed that healthcare providers generally prescribed medication with limited therapeutic effectiveness can have far-reaching consequences for clinical care.

Overall, implications for policy and practice that emerge from our findings include:

- The need to mitigate the impacts of long-term-youth unemployment and poverty by ensuring the active implementation of the various policies, strategies, and plans of actions developed over the last 22 years of democracy to improve the socio-economic wellbeing of youth in South Africa. In particular, consistent with the constitutional commitment to ensure that all South Africans have "access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance " (27.1c), the expansion of the social security arrangements in place in South Africa is worthy of consideration. Therefore, it is encouraging that policy

makers and academics have started considering policy options for expanding social assistance to poor youth. A similar exercise to the Lund Committee which introduced the current Child Support Grant, could be undertaken with the aim to identify and/or design the most context-specific and appropriate social security option for young unemployed and/or poor South Africans.

- To the extent that the inconvenience of current opening hours for young people, as reported in previous studies, continued to be a recurring theme in this assessment, there need to consider – through national stakeholder consultations – the amendment of current operating hours by either extending the hours of operation or opening and/or opening everyday including weekends.
- The provision of all cadres of primary health service providers with ongoing professional development and training that develop a sense of responsibility and sensitivity to young people's needs, respect for patient rights; and that break down prejudices that may limit the success of the adolescent and youth friendly service programming in the country. It is imperative for such training to pay particular attention to attitudinal issues, and sensitise service providers about the needs and concerns of young people (including those who are out of school) who seek public health services. Changing the attitudes of staff most directly in touch with young people is likely to rapidly shift the experiences of this clientele; improving experiences of young people with health services is crucial for ensuring sustained access to health facilities. This recommendation for the training of healthcare workers reiterates the calls made by other recent South African studies such as such as Schriver et al (2014) and Geary et al (2014; 2015).
- There is also a need to make concerted efforts to involve young people in programme design and service provision. Given the importance of involving young people in the design, implementation and evaluation of health services meant for them (MiET, 2011), broad-based national consultation should be conducted with this age group to determine their specific needs. There was no evidence from the assessment that young people play a role in efforts to improve the accessibility of health services for them. This consideration is important as study participants raised concerns, for example, that the services were narrowly focused on HIV and AIDS and tuberculosis while ignoring some of the key health problems facing young people in South Africa such as violence and substance abuse. It is critical to acknowledge and take into consideration that young people have a myriad of health needs including treatment, counselling and education for mental health and non-communicable diseases.

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