Children and Youth Services Review xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

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

Zitha Mokomane [a,*], Tholang Mokhele [a], Catherine Mathews [b,c], Mokhantšo Makoae [d]

[a] Human Sciences Research Council of South Africa, P/Bag X41, Pretoria 0001, South Africa
[b] Health Systems Research Unit, South African Medical Research Council, P.O. Box 19070, Tygerberg 7505, South Africa
[c] School of Public Health and Family Medicine, University of Cape Town, South Africa
[d] Human Sciences Research Council of South Africa, Private Bag X9182, Cape Town 8000, South Africa

ARTICLE INFO

Article history:
Received 24 March 2015
Received in revised form 30 January 2017
Accepted 4 February 2017
Available online xxxx

Keywords:
South Africa
Adolescents
Young people
Health facilities

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.

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, Agampodi, & Ukd, 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, Harris, & Russell, 2013:1), has also been recognised as playing a particularly important role in this regard

* Corresponding author at: Department of Sociology, University of Pretoria, P/Bag X20, Hatfield, Pretoria 0028, South Africa.
E-mail addresses: zitha.mokomane@up.ac.za (Z. Mokomane), tamokhele@hsrc.ac.za (T. Mokhele), cathy.mathews@mrc.ac.za (C. Mathews), mmakoae@hsrc.ac.za (M. Makoae).

http://dx.doi.org/10.1016/j.childyouth.2017.02.001
0190-7409/

(Denno, Chandra-Mouli, & Osman, 2012). Given the centrality of poor access to health care services in perpetuating poverty and inequality (McLaren, Ardington, & Leibbrant, 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, Ardington, & Leibbrandt, 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, Goudge, Ataguba, 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, Meagley, Norris, Geary, and Stein (2014) and Geary, Gomze-Olive, Kahn, Tollman, and Norris (2014); Geary, Webb, Clarke, and Norris (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.; 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.

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.

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

Please cite this article as: Mokomane, Z., et al., Availability and accessibility of public health services for adolescents and young people in South Africa, *Children and Youth Services Review* (2017), http://dx.doi.org/10.1016/j.childyouth.2017.02.001