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'The not talking is actually what kills you'– young South African women's communication barriers about sexual health

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ABSTRACT

Conversations about sex and sexual health are often stigmatised and shaped by socio-cultural influences. For young women, lack of adequate communication can influence access to information, knowledge and behaviour and therefore increase vulnerability to negative outcomes such as sexually transmitted infections (STIs) and unintended pregnancy. This qualitative study investigated the barriers young women face when seeking dialogue about sex, their sexual health and relationships. Seven isiXhosa-speaking young women (aged 21–25) participated in a six-session art-based engagement, creating large-format paintings reflecting their sexual health experiences. Data collection included in-depth interviews and a focus group discussion, which were transcribed, translated and thematically analysed. Findings revealed that communication about sex and sexual health was hindered by the attitudes of family, partners, communities and health care providers. The need to please and retain partners also restricted young women's ability to express their sexual health needs and desires. Young women felt that with age and maturity they gained confidence, agency and capacity to navigate difficult conversations. Empowering tools and strategies to improve communication could enhance young women's agency, enabling them to overcome barriers for communication and actively seek sexual health information and services.

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Introduction

Sexual health as defined by the World Health Organisation, includes the right to physical, mental, emotional and social wellness, possible pleasure and not merely the absence of disease (Loeber et al. 2010). Promoting sexual health therefore requires communicating about sex and sexual relationships, including needs and desires, accessing information, and utilising health care services to achieve sexual health and overall wellness (Glasier et al. 2006).

Difficulty talking about sex, sexual health and sexual relationships for young South African women poses a potentially major barrier to sexual health. Communication skills are typically learned through close relationships, with mothers and caregivers typically serving as role models (Bastien, Kajula, and Muhwezi 2011). Socio-cultural and community factors influence the development of these skills, and life experiences inform the ability to interact optimally within diverse environments (Cain, Schensul, and Mlobeli 2011; Tsakani, Davhana-Maselesele, and Obi 2011). The ability of young women to communicate about sex, sexual health and sexual relationships within close family relationships, with their peers and sexual partners, within their communities and with health care professionals, can facilitate access to knowledge and information about sex and sexual health but also enables negotiation for safer sex and access to sexual health care and services. It is therefore key to ensuring positive sexual and reproductive health care outcomes.

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Understanding such interactions can be aided by the use of the socio-ecological model (Bronfenbrenner 1986), which views health behaviour as shaped by influences of multiple kinds at the individual, interpersonal, community and institutional levels. The use of the socio-ecological model enables a nuanced understanding of how factors at each of these levels interact to influence behaviour, and can inform the development of multi-level programmes and interventions. In this study, the model was used as a conceptual framework to examine communication about sex, sexual health and sexual relationships.

Although there is a wealth of available information about prevention in South Africa, young women continue to acquire STIs and HIV, with a high prevalence of these and also unintended pregnancy (Dabee et al. 2019; Woldesenbet et al. 2021). Open discussion about sex and sexual relationships is heavily stigmatised in many communities (Duby, Verwoerd, et al. 2022; Nkosi et al. 2019). Adolescents and young women in particular may encounter shaming attitudes and power imbalances, especially when they are younger, within their families, from peers and partners, within their communities and when they seek healthcare. Together, these can influence willingness to seek information, have conversations or access healthcare (Bastien, Kajula, and Muhwezi 2011; Cain, Schensul, and Mlobeli 2011; Duby, Verwoerd, et al. 2022; Lambert and Wood 2005). However, studies show that more open communication about sex and related issues can improve sexual health outcomes (Nkosi et al. 2019; Pascoe 2021).

This paper uses the *Stories from the Edge* methodology to explore the barriers and facilitators influencing young women's (21–25 years) ability to communicate about sex, sexual health and sexual relationships. The narratives shared provide important insights into the facilitators and barriers to communication that they faced.

Methods

Study overview and setting

Seven young women, aged 21 to 25 years, were purposively recruited through the Desmond Tutu Health Foundation in Cape Town, South Africa in 2021. All were previous participants in the WISHing for Wellness study (2017–2018), in which the Stories from the Edge methodology, which employs art making, specifically painting, to facilitate communication about a range of issues related to sexual health, was piloted. This methodology emphasises process and not outcomes. After being informed about the study, the young women provided informed written consent. Ethical review and approval for the study was provided by the University of Cape Town Ethics committee (Reference: UCT HREC #368_2019).

As described in Hartley et al. (2023), each session began with a check-in, informal participant-led discussion and introduction to the day's theme. These themes included sources of sexual health information pre- and post-puberty (Session 1); an introduction to painting and the concept of using art-making to express agency, to build participants' confidence in using painting to communicate their feelings (Session 2); sexual health practices and supports young women encountered in their sexual relationships (Session 3); barriers to accessing SH services (Session 4); and access to sexual health services (Session 5).

A series of in-depth interviews were conducted on completion of all the painting sessions, using the finished paintings as prompts for discussions about young women's sexual health experiences. The paintings encouraged the recall of the emotions and embodied reactions related to their experiences and offered the participants an opportunity to verbally share their sexual health experiences. The paintings themselves were therefore not analysed for content but were used to remind the participant of their feelings when talking to the researcher (FH). This offered participants an opportunity to verbally share their sexual health communication experiences. A distress protocol provided the young women with resources containing contact details and a trained counsellor (PN) was available nearby during the sessions in case discussion or a memory triggered participants' distress.

Study fieldwork concluded with a focus group discussion probing group comfort when discussing young women's communication experiences with partners and seeking sexual health services. All sessions were conducted and recorded in the language of participants' choice. Two first language Xhosa speakers transcribed the data verbatim, which was then checked by the researcher (FH). Young women each checked their own transcriptions and modified them if needed.

Data analysis

In addition to the seven interviews and the discussions, notes from informal discussion during the sessions and FH's field notes were also included as data for analysis. Thematic analysis was used to explore young women's accounts of communication and discussions relating to sexual health with those in their social network (Braun and Clarke 2006; Silverman 2010). The data analysis process started with immersion in and familiarity with the data to provide an understanding of young women's stories and initial insights into patterns and recurring topics.

Guided by the research aim and the literature, a deductive codebook was developed by the primary researcher to systematically guide an initial round of analysis. Further rounds of coding allowed for more inductive thematic data analysis allowing additional codes to emerge and be added to the codebook. Codes were refined and reorganised by repeated comparisons across transcripts and fieldnotes. Common patterns were categorised to capture young women's communication experiences. The development of themes and reorganisation of the data was guided by the socio- ecological model which highlighted how influences and processes at the individual, interpersonal, community and organisational level influenced communication about sex, sexual health and sexual relationships. This multi-level approach enabled an exploration of the young women's individual beliefs, relationship dynamics, health care access and socio-cultural norms. NVivo14 software was used to manage coding, track data analysis and support the transparency of thematic development.

The socio-ecological model (Figure 1) places the individual at the centre of their worldly experiences, recognising the multi-level interacting influences that impact on behaviour and experiences, in this case young women's communication about issues relating to sex. These levels (individual, interpersonal, community and institutional) underscore how individual values, relationship dynamics, community networks and socio-cultural norms intersect, to shape communication. Communication barriers, both implicit or explicit, shape an individual's sense of agency when negotiating with a partner or seeking services from health care providers.

Figure 1. The socio-ecological model.
Source: Adapted from the Centres for Disease Control and Prevention (CDC), The Social Ecological Model: A Framework for Prevention, http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html (Retrieved April 21, 2014).

Findings

The data analysis identified three key themes: (1) barriers to sexual health communication; (2) facilitators of sexual health communication; and (3) communication to facilitate health care.

Barriers to communication about sex and sexual health communication

The young women in the study reported several factors and experiences that directly or indirectly impacted their ability to have open and honest communication about sex and sexual health. Young women reported receiving little to no direct communication about sex and sexual health when they were younger. In addition, they felt that their primary caregivers, usually their mothers and grandmothers, tacitly taught them that discussing sex and sexual health and relationships was shameful and taboo. Where discussion did happen, it was vague or avoided, together with admonitions such as 'stay away from boys'.

As young women matured, their families, particularly their mothers, remained hesitant to discuss partners and sex. However, some mothers did address sexual health and contraception with the young women, recognising that avoiding discussion could risk negative outcomes. Participant 9 remembered her mother saying,

> '…you are getting your periods so you have to go to the clinic', and all of the information we got from the clinic from the doctors, like more deeper, that there's also STIs, HIV, condoms…'So you need to be careful, if you are sexually active now you need to do this, use condoms'. (P9, aged 21 FGD)

Participant 2 confirmed that her mother had also talked about sex and relationships when she reached puberty.

> She talked about relationships …then she will go into sex, like 'I know that you might say you will never have sex now but…if you get into a relationship the best thing to do is to go into the Youth Centre [non-governmental clinic] and make sure that you prevent' [use contraceptives]…she would always emphasise on that [contraceptives] because she was really not against us being in relationships. (P2, aged 21 FGD)

Young women expressed the desire to freely talk about their sexual relationships with their family members and a depth of communication which suggested that they trusted and had regard for the advice they might provide.

> I wish I could also be that free [to have discussions], like the way that I am in my relationship with the person that I am dating, be like 'guys we need to talk to someone' or 'guys we need to talk like this'. But at home I am always treated like 'you are young', …my brothers, brushing me off. (P1, aged 25 IDI)

Participants described discovering relevant information independently:

> I discovered that [contraceptives] by myself (laughter) I won't lie (other participants agree)… It's hard because now, it's like they [were] actually encouraging me to have sex, but not be safe. So, rather [they did] not discuss it at all because it's not something you meant to be doing (laughs). (P7, aged 22 IDI)

As the above participant notes, sex was not something you discussed because it was not 'something you meant to be doing'. Participant 7 also suggested that the lack of information she had hoped to get from caregivers and close family, might in some ways may have facilitated unsafe sex. These stories of silence or vague information from caregivers suggests a reinforcing cycle of avoidance about talking about sex and sexual health, which curtailed young women's opportunities for learning and open discussion.

Community attitudes towards sex shaped young women's willingness to disclose, and therefore have discussions about their sexual relationships. Gossip prompted them to hide their partners and avoid public discussion about sexual health, fearing that the information would reach their families, leading to judgement, shame, or even physical punishment.

> … I don't know, it's just like your parents [say] 'Boys, no' because you will get into trouble… Even if you see an adult that you know there, coming from the station, you need to run (others agree) … They must not see

> you because your mom is going to know. And the next day you'll be in trouble, like 'Your daughter was standing in the road with a boy…'. (P3, aged 21 FGD)

In the same focus group discussion, this statement was followed up by Participant 2, aged 21, who interjected 'We'd be beaten for that, Tjo, tjo, tjo'. Participant 8, aged 25, agreed 'So, it's a no-go zone until a certain age…'.

Through such comments, young women highlight dominant attitudes to sex and age, with those who are younger not being seen as sexual beings. The existence of these norms also discourage young women from participating in conversation and discussion that may have provided them with both information and support to make healthy decisions.

Challenging learned communication patterns was difficult and talking to their partners about sex, love, and sexual relationships required careful navigation. Young women felt that it was difficult to speak up for themselves but realised that clear communication was vital for sexual wellbeing.

> The not talking is actually what kills you [puts you at risk], I've learned. So, that's why I've learnt…to actually express myself because… me not communicating I'm not going to see any improvement… So, talking and voicing my opinion is actually going to give me what I want. (P8, aged 25 IDI)

The desire for a loving sexual relationship was a major influence in young women lives. It could however lead to restricted communication about their own needs and desires in order to increase the likelihood of 'successful' partnering. Some young women reported feeling cautious about saying too much after experiencing heartbreak, betrayal and abandonment. Here, withholding the expression of desire was a strategy to protect emotional wellbeing and manage relationship dynamics.

> I would say being afraid of… the partner leaving you, is one thing that makes you kind of scared to set the boundary. (P2, aged 21 IDI)

Communicating with partners about condom and contraceptive use, sexual desires and needs early in a sexual relationship also challenged young women's confidence and feelings of agency. Participant 6 acknowledged that she did not initially insist on her partner using a condom, allowing him instead to have control over the sexual act, but recognised that she needed to speak up since her partner had put the onus on her to initiate condom use.

> …he didn't put it [the condom on], we did it [had sex], the first round and then I was like 'no man where is the condom?' and then he said… 'you see there was no condom so why you asking now after we done it', so sometimes we girls we have a lack of communication… Maybe you don't speak; we also have to speak when you see that now you're going to do [sex] say 'let's take a condom'. (P6, aged 23 IDI)

Initially agreeing not to use a condom could 'soften' a man up said Participant 3, aged 21, in her interview, reflecting a mutually understood trade off within the context of early relationship formation. While this may be considered a demonstration of agency, it also shows the gender compromises young women feel compelled to make to sustain sexual relationships. In Xhosa culture, a man is considered the relationship leader, and for a young women to initiate discussion of condom use can trigger accusations regarding her own or her partner's fidelity, with implications of judgement and mistrust of HIV and STI status (Pascoe 2021).

Importantly, young women in this study did not expect partners to be honest about their HIV or STI status or their fidelity, particularly in the early stages of sexual relationships. In fact, they reported feeling vulnerable to negative sexual health outcomes in a new sexual relationship, especially in the 'heat of the moment'. Participant 3 explained,

> The condom topic, tjoo. I mean, when you get into a relationship, you can't just ask the person, 'Are you HIV positive?' I mean, yes, you could maybe try and ask, but then they will never tell you, 'Oh, yes, I am or no, I'm not'. (P3, aged 21 IDI)

This quote illustrates how communication is shaped by unequal power relations where a young woman's ability to question or negotiate reflects the relational imbalance and risks of disclosure. This highlights how power shapes the possibilities for sexual health communication.

Facilitators of communication

The findings from this study demonstrate that there were factors that facilitated communication about sex and sexual health for young women. Fear of potential negative implications may have resulted in some caregivers or family providing young women with advice. Peers and partners were also important sources of information about sex and sexual health. As young women matured, their sense of agency and confidence also increased, enabling them to have sensitive conversations especially with their partners.

In South Africa, unintended pregnancy for young women who are still in school can create challenges for completion and limit education. Recognising these risks, some young women described how their mothers encouraged them to seek contraception and other sexual health services as soon as they reached puberty. One participant reported on her mother's advice:

> Yeah, so you can just go [to the clinic to get advice]… You're going to take care of everything yourself now. When you're there you need to ask questions and everything like that. (P2, aged 21,IDI)

Talking to peers was often described by young women as easier than discussions with caregivers or family, because they had shared assumptions and experiences. Gossip and conversations with friends were easy ways to learn from one another about sex, sexual health and sexual relationships. Participant 9 noted how she valued the advice she received from friends:

> I think there's also a relationship between friends… try and talk to your friends, [to gain advice] or try and find someone who can [offer advice about how you can] change your way in your relationship. (P9, aged 21 FGD)

Partners had the greatest influence over young women's comfort of discussing sex and sexual relationships. Unlike the previously mentioned partners who hampered sexual health communication, some partners fostered open dialogue, deep friendship and pleasure in sexual relationships, reducing shame and taboo (Figure 2). Young women in long-term relationships reported feeling valued as equals, and deserving of care, trust, and fidelity, which helped support talk about their expectations. Participant 9's long-term relationship had grown to become one of mutual support and respectful communication.

> …now I'm like more 'this is what I want from a relationship', like I want someone who's here to support me, love me… 50/50 of doing things…grow together'. It has changed a lot…'(from earlier in her relationship). (P9, 21 years IDI)

Many young women reported growing confidence to talk about sex and sexual health. They attributed this to a deeper understanding of themselves, which they recognised grew into agency. They also recognised the importance of communication for their own well-being:

> This thing of me being quiet didn't help me, so I've learned to talk …so you [the partner] can't just decide what you want and not to think what do I want. So, we have to be in this together…. Not for you to just decide what you want to do. (P1, aged 25 IDI)

The above young woman's self-awareness and confidence proved beneficial for her satisfaction in her relationship and sexual health service access. It was notable that participation in the Stories from the Edge experience helped young women to know themselves better, and with group sharing, grow their confidence and experience emotional relief:

> … there was some emotions that I didn't understand but I feel like now that I actually do understand … I feel like most important for me it has been growth and understanding who I am and what I want in life… For me it [the painting] was kind of a form of a relief because… it's just a way of opening up to yourself… (P8, aged 25 IDI)

While barriers to communication were prominent in young women's accounts in this study, the findings also revealed important facilitators: family members, though sometimes motivated by fear of negative consequences, did provide guidance; peers and partners emerged as accessible and receptive sources of information; and as young women matured, their growing sense of agency and confidence enabled increasingly open conversations, particularly within intimate relationships.

Figure 2. Art-based representation of a satisfying sexual relationship created by P8 (aged 25 years), in painting session 3, captured her satisfying long-term sexual relationship.

Communication barriers and facilitators in accessing sexual health care

General discussions about sex, sexual health and sexual relationships are important to both gain access to information to make informed and safe decisions, but also to negotiate safe sex and healthy relationships. However, communication about issues related to specific aspects of sexual health, and communication to facilitate sexual health care, is a more specific and is an important type of communication that needs to be addressed.

Young women who felt comfortable talking about sex with their partners reported help from them to access sexual health care. Participant 1 said her partner had infected her with an STI. After she confronted him about this, he arranged counselling, treatment and care.

> It was him…and I was fussy about it … I was like 'now you want us to talk our things out there [in a counselling session]'…for the appointment at the clinic to get to be cleaned [STI treatment]…we go together. No, we didn't go to the hospital for him because he is working, so we go to Clicks [Pharmacy]. So, when we get to Clicks … they explained 'if…it's him that made you to get this, this thing [STI], you need to sit down and talk'. (P1, aged 25 IDI)

Here, clear communication facilitated treatment and the health care provider recommended sexual health counselling, supplying the contact details of the local government hospital to make the counselling more affordable. The health care provider, the young woman and her partner were clear in their communication to resolve the problems the young couple were experiencing.

While in the example above the couple sought care at private pharmacy clinic, the majority of people in the study communities receive sexual and reproductive health services through government provided health facilities. This included access to contraception, as well as HIV and STI testing and counselling. For many of the young women in this study, government health services, specifically those providing sexual and reproductive health care, were associated with judgement, breaches of confidentiality, long waiting times, and little open communication.

Some participants described positive encounters with doctors and male nurses, while female nurses were perceived as more rushed, dismissive, or shaming. In an informal discussion the young women shared their experiences, confirming the negative attitudes of the nurses. Participant 9, aged 21, described it as 'horrifying, like you can't confide in them', while Participant 8, aged 25, said that the nurses go around the clinics, shouting 'Hey, make some time there, you see that one is 123-4567', publicly describing the patient's reason for attending the clinic, where 'you sit and wait for hours'.

There were, however, also experiences of more positive treatment and communication with health care providers in government settings. Participant 3, aged 21, said that 'being in the hospital is like the best…nobody knows you', ensuring that her personal information remained confidential. Unrushed staff who explained treatment options and test results were experienced by Participant 1, aged 25,

> … even after you update for your test for the STI you still get someone that you talk to, 'you know… the STI leads you to this and this and this…' they talk to you like a normal human being.

Beyond general discussions about sex and relationships, the ability to communicate specifically about sexual health, to navigate care-seeking, and engage meaningfully with providers, represents a distinct and critical competency that warrants particular attention.

Discussion

Sexual health communication among young women is not a skill that develops linearly with age, but a socially patterned practice developed and shaped across multiple intersecting contexts. The findings from this study extend existing literature (Bastien, Kajula, and Muhwezi 2011; Zuma et al. 2020) by mapping these patterns across the levels of the socio-ecological model, revealing how individual confidence, interpersonal relationships, community norms, and institutional practices collectively shape young women's ability to communicate openly about sex and sexual health.

Individual level: agency, confidence and personal beliefs

At the individual level, young women's capacity to communicate about sex and sexual health was deeply shaped by their personal beliefs, confidence, and a developing sense of agency. Early understandings of sex and sexuality were formed within broader gendered, moral, and socio-cultural environments that framed sex as taboo, dangerous, or morally prohibited, and many of these beliefs persisted into adulthood. Existing evidence supports this finding. For some young women participating in the Stories from the Edge study, painting sessions prompted recognition and recall of both formative communication barriers and sexual health-promoting experiences (Hartley et al. 2023). Age, maturity and possibly participation in shared process may have contributed to greater self-awareness, agency and confidence in communication (Abrams et al. 2022; Duby, Bunce, et al. 2022). However, many participants still found sex and sexual health communication challenging, underscoring how deeply embedded these difficulties are and that individual-level interventions alone are insufficient to disrupt them (Tsakani, Davhana-Maselesele, and Obi 2011; Glasier et al. 2006).

Interpersonal level: family, peers and partners

Participants' earliest and most formative communication experiences took place within the family. Caregivers frequently communicated through silence, fear-based messaging, or deliberate vagueness,

framing sex as shameful or dangerous. Participants often recognised these interactions as inadequate in retrospect. In contrast, participants who had experience of more open family discussions, most often with female family members, described earlier and more supportive engagement with sexual health services, particularly in relation to contraception at puberty. Similar findings have been reported in other South African studies (Frederico et al. 2019; Zuma et al. 2020), reinforcing the role of familial relationships in shaping not only sexual knowledge but pathways to care.

As young women aged, influence shifted from family to peers and partners (Abrams et al. 2022) who played an important role in shaping sexual attitudes and service use. Peers provided a more accessible and reciprocal space in which to discuss sex and sexual health, shaped by shared assumptions and lived experience, a finding noted in other research (Fearon et al. 2015; Govender, Naidoo, and Taylor 2019).

Partners emerged as a particularly significant interpersonal influence. Consistent with existing literature, entrenched power asymmetries and the persistent association of condoms with HIV, mistrust, and infidelity contributed to young women's reluctance to initiate discussion about safer sex (Gevers et al. 2013; Jewkes and Morrell 2012; Jonas et al. 2020). Several participants described strategically avoiding condom negotiation in early or emotionally fragile relationships to preserve intimacy and relational stability, illustrating how risk is often weighed against emotional security and revealing the relational and moral dimensions of condom use beyond biomedical framings of prevention (Svanemyr et al. 2015). However, participants' accounts also complicate dominant narratives that positioned partners as barriers to women's sexual health decision-making. Several young women described supportive sexual relationships in which partners respected boundaries, engaged in open discussion, and actively supported access to sexual health services, highlighting the relational complexity of young women's sexual lives where constraint and support coexist. Recognising this ambivalence is important for understanding sexual agency as negotiated within relationships, rather than determined by fixed gender roles.

Community level: socio-cultural norms

At the community level and in alignment with prior research in this and similar contexts, conservative, patriarchal, and religious norms frequently positioned sexual knowledge as morally risky, reinforcing silence and limiting young women's sexual agency (Duby, Verwoerd, et al. 2022; Zuma et al. 2020). Community attitudes towards sex and relationships affected young women's willingness to discuss sexual health openly, with fear of gossip, judgement, and stigma discouraging disclosure and service-seeking.

Organisational level: health care access and providers

At the organisational level, experiences of accessing sexual health care were significantly shaped by the nature and quality of communication with healthcare providers. As identified by other research in this and similar contexts, government-funded health care facilities were commonly perceived as judgemental, indiscreet, and difficult to navigate, deterring young women from attending and seeking services (Jonas et al. 2020; Nkosi et al. 2019; Zuma et al. 2020). Concerns about confidentiality were particularly salient when healthcare providers lived in the same communities as service users (Jonas et al. 2018).

Limitations

The findings from this study should be interpreted within the context in which they were generated. Participation required a substantial time commitment, including travel for some participants, likely shaping the sample and limiting the transferability of findings to other settings. Participants were young adults in tertiary education and largely in stable relationships, contexts typically associated with greater social and informational resources, yet they still reported significant barriers to sexual health communication, suggesting these challenges may be even more pronounced in less well resourced populations. The highly individual and reflexive nature of the creative process meant that the accounts could not be independently verified, and it remains difficult to identify the specific contribution of the Stories from

the Edge to the quality of the data analysed. While the small sample size limits broader applicability, the in-depth, longitudinal methodology provided rich, contextualised data enabling detailed exploration of communication processes over time (Boddy, 2016). The close relationship between participants and the facilitator likely facilitated openness and depth of reflection, although this relational dynamic may be difficult to replicate in other contexts, despite efforts to enhance credibility through peer checking during focus group discussions.

Conclusion

Collectively, these findings highlight how sexual health communication for young women is shaped by intersecting individual, familial, relational, community, and institutional factors. Barriers to communication emerge early and persist across adolescence and young adulthood, reflecting deeply embedded gendered norms and moral expectations rather than individual knowledge deficits alone. Understanding sexual health communication as a relational and culturally situated practice draws attention to the importance of supportive social environments, safe spaces for dialogue, and equitable sexual relationships in shaping young women's agency. Future research should continue to explore how young women navigate these intersecting contexts and how culturally responsive, youth-centred approaches can support more open and affirming conversations about sex, relationships, and wellbeing.

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Author contributions

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