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ORIGINAL RESEARCH

Provision of contraception to adolescents in primary healthcare clinics in South Africa: Perspectives of primary healthcare practitioners

Thabile J. Ketye[1*], Gbotemi B. Babatunde[1,2], Solange Z. Mianda[1], Olagoke Akintola[1]

[1]School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape, Cape Town 7535, South Africa
[2]Graduate School of Professional Psychology, University of Denver, Denver, CO 80208, United States of America

***Corresponding author:** tketye@yahoo.com

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ABSTRACT

Introduction: The provision of contraception to adolescents is a fundamental public health strategy for preventing adolescent pregnancies and realising universal access to sexual and reproductive health. In the South African context, and as informed by national and provincial policy guidelines, this strategy is delivered at primary healthcare clinics. In this study, we sought to explore the barriers and enablers of providing contraception to adolescents in primary healthcare clinics from the perspectives of healthcare practitioners.

Methods: We employed a qualitative research design. Using purposive sampling, we recruited senior managers and nurses involved in primary healthcare and sexual and reproductive health programmes in South Africa. We conducted semi-structured interviews with twenty-nine participants working in an urban or rural district. Subsequently, we transcribed the interviews, verifying for errors. Guided by Braun and Clarke's model of thematic analysis, we grouped the data into four themes derived from the healthcare access frameworks. Each of the four themes has sub-themes describing both enablers and barriers to providing contraception to adolescents.

Results: The study revealed that practitioners' knowledge of policy guidelines enabled them to provide contraception to adolescents effectively. However, the differences between what is stated in policy documents and practical limitations could impede the extent to which services reach adolescents. Other barriers to providing contraception to adolescents included language differences between healthcare practitioners and users, time constraints, and lack of privacy during consultations. Participants noted that appropriate nurse training and ensuring an accepting environment for adolescents facilitated the provision of contraception to this age group.

Conclusion: Our study offers valuable insights into the perspectives of primary healthcare practitioners about the barriers and enablers in providing contraception to adolescents. Our results indicate that policy development and future research should focus on strengthening the delivery of contraception services for adolescents.

Keywords: Adolescents; contraception; healthcare practitioners; primary healthcare clinics; perspectives; South Africa.

Abstract in Español at the end of the article

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INTRODUCTION

Globally, the importance of providing sexual and reproductive health (SRH) services, including contraception to adolescents is well recognised amongst policymakers, researchers, and healthcare service practitioners [1,2]. The 1994 International Conference on Population and Development (ICPD) emphasised the need to offer comprehensive SRH services to adolescents. According to the ICPD, policies and programmes should ensure that adolescents are provided with information and the broadest possible range of safe and effective contraceptive methods to enable them to exercise free and informed choice [3]. In 2015, this theme was reaffirmed by the United Nations (UN) Sustainable Development Goal (SDGs) 3, which aims to ensure universal access to SRH services by 2030 [4]. Thus, policymakers and implementers should integrate contraception, education, and reproductive health into national strategies and programmes. However, most low- and middle-income countries (LMICs) are far from realising the SDG target and have inadequate policies to address the health needs of adolescents [5,6].

Adolescents aged 10 to 19 make up one-sixth of the world's population, with 90% living in LMICs [5]. This is a crucial period of transition from childhood to adulthood, characterised by rapid physical, cognitive, social, emotional, and sexual development [7]. It is common for young people to initiate sexual intercourse during this stage of life [1]. However, early sexual debut is more likely to lead to unintended pregnancy and sexually transmitted infections (STIs) [8]. In 2019, an estimated 21 million adolescent girls from LMICs became pregnant, with around half of those pregnancies being unintended. Notably, approximately 2.5 million of those pregnancies occurred in girls below the age of 16 years [5]. Unintended pregnancies pose significant risks to the physical health and social well-being of adolescents [1]. These young girls are more likely to develop pregnancy-related complications and illnesses, including puerperal endometriosis and systemic infections, which could result in maternal and perinatal mortality [9,10]. In South Africa, only about a third of sexually active girls aged 15 to 19 use a contraceptive method [11].

Inclusive SRH policies have been developed to address the unmet need for contraception among adolescents in South Africa. According to the guidelines, contraception should be provided at primary healthcare (PHC) clinics, which is the main point of entry into the health system [2,12,13]. These clinics offer a range of preventive, promotive, rehabilitative, and basic curative services, including effective contraceptive methods that are available upon request to individuals aged 12 years and above [14–20]. Public PHC clinics operate as nurse-led structures supported by doctors and other health practitioners [16,21,22]. In the structure, senior managers oversee policy development and provide overall governance to support operations [23]. Clinic managers are professional nurses who are responsible for the administration of PHC clinics and supervise other nurses [23]. Nurses implement policies, providing safe and effective patient care, including contraception services to adolescents [24]. Despite these efforts, gaps remain in the implementation of contraception policies and the provision of contraception to adolescents [25].

Various studies identified factors that either enable or hinder adolescents from accessing and using contraception services [9,26–29]. For instance, Fataar et al. found that long waiting times, limited consultation time, and health practitioners' negative attitudes impeded access to contraception [30]. To increase contraceptive uptake among adolescents, it is crucial to provide high-quality, adolescent and youth-friendly services (AYFS) that are tailored to their specific needs [31]. Adolescent and youth-friendly services are characterised by the accessibility, acceptability, and appropriateness of SRH services for young people. They offer a welcoming environment that ensures privacy, confidentiality, and respect for adolescents. These services are designed to be equitable, effective, and inclusive, addressing adolescents' unique developmental, psychological, and social needs [26]. The South African National Adolescent and Youth Health Policy emphasises the importance of these being AYFS [19]. However, Davids et al. note that many healthcare services fail to meet the AYFS standards [25]. Lack of health practitioner sensitivity, reluctance to offer contraceptives to adolescents, gender biases, lack of privacy and confidentiality, and contraceptive unavailability have been found to hinder the provision of contraception [12,27]. This failure highlights a persistent gap in contraception provision and a need for improved SRH training, resources and policy implementation to meet the needs of adolescents.

Much of the existing research in South Africa has addressed contraception or SRH-related issues by examining the perspectives of healthcare practitioners (usually nurses) and/or community members (including adolescents) [27]. While those perspectives are critical, these studies have only been conducted in urban settings, focusing on adolescent girls and young women or sexually active women of reproductive age [28,29]. For example, Fataar et al. interviewed nurses in Cape Town, a city in South Africa, focusing on approaches to contraceptive service provision for women attending public sector clinics [28]. Abrahams et al. surveyed nursing practitioners in a Cape Town peri-urban area to understand their knowledge, beliefs, and practices regarding long-acting reversible contraceptives (LARC) [30]. Because of the particularities of rural settings, existing studies could only provide partial insights about contraceptive service delivery that could be used to design comprehensive multi-level interventions for adolescents. To address this knowledge gap, this study was designed to explore the barriers and enablers to providing contraception to adolescents. This was achieved by exploring the perspectives of healthcare practitioners working in PHC clinics in urban and rural settings. Exploring the provision of

contraception from the perspective of senior managers and nurses could help bridge the gap between policy and practice and guide the development of an effective contraception service delivery system for adolescents.

Conceptual Framework

In this study we used Baroudi's conceptual framework on access to healthcare to explore the provision of contraception to adolescents. Central to the provision of healthcare including contraception is access. According to Levesque, at each stage of the process of accessing healthcare a person interacts with dimensions or constructs that either hinder or enable access [31]. This is supported by Baroudi, who believes that barriers to access are influenced by various factors including a person's previous encounters to the healthcare system including public health policies [32].

Drawing on Levesque et al. and Baroudi's conceptual frameworks on healthcare access, we applied four interrelated constructs that influence the provision of contraception to adolescents: approachability, acceptability, adequacy and quality. **Approachability** is related to how easily adolescents potentially access contraception services based on knowledge of contraception policies and procedures among healthcare practitioners [31,32]. **Acceptability** involves social norms and standards and the attitudes and training of healthcare practitioners that are applied to meet the needs of users [31,32]. **Adequacy** covers organisational factors such as the resources and time available for consultations [(32]. **Quality** encompasses the overall environment and process of care [32]. These constructs are interrelated and reflect the relationship between the healthcare user and practitioner.

METHODS

Study Design

In this study, we used an exploratory qualitative research design. We sought to explore the perspectives of senior managers and nurses about the barriers and enablers of providing contraception to adolescents in urban and rural PHC clinics in South Africa. These are healthcare professionals with experience in policymaking and implementation of SRH policies in PHC clinics. Qualitative methodologies are well suited for gaining a deep understanding of participants' lived experiences [33–35]. It was, therefore, appropriate for exploring the nuanced perspectives of senior managers and nurses regarding the provision of contraception to adolescents in South Africa [35,36].

Study Settings

The study was conducted in two of the six health districts of the Western Cape province in South Africa. We selected the City of Cape Town Metropolitan Municipality and the West Coast District Municipality to capture insights from both rural and urban settings. The City of Cape Town, which has about 66% of the population, is the largest district in the Western Cape province. Conversely, the West Coast is among the smallest districts, with approximately 7% of the total population.

At the time of the study, Provincial Health (provincial government) and City Health (local government) managed clinics in the City of Cape Town Metropolitan Municipality and the West Coast District Municipality. In addition, a few clinics had joint authority in the city. However, only Provincial Health managed clinics in the West Coast District Municipality. Table 1 provides a description of the study site.

Table 1. Profile of study setting.

Health district	City of Cape Town Metro	West Coast District
Population size	4 748 976	476 020
Geography	Urban	Rural
Number of sub-districts	8	5
Public health authority	Western Cape Department of Health (Provincial Government) and City of Cape Town Health (Local Government)	Western Cape Department of Health (Provincial Government)

Sources: [37-39]

Study participants

This study included 29 purposively selected key informants chosen for their roles and responsibilities in the PHC system [35]. This approach facilitated the identification of individuals with relevant expertise and experiences related to the study's objectives [34,40]. The sample included five senior managers from the Western Cape and national Health Departments, five clinic managers, and nineteen nurses from various PHC clinics, as shown in Table 2. Inclusion criteria were established to ensure that participants were actively involved in the provision of contraceptive services to adolescents and young people and in policymaking, planning, monitoring, or reporting within the PHC system in both rural and urban settings.

Data Collection

Data collection commenced in December 2019 to January 2020 and was subsequently halted because of the coronavirus pandemic and delays in getting authorisations from the provincial Department of Health. Data collection continued in April 2022 until June 2022, and

September 2023. We conducted one telephonic and twenty-eight face-to-face semi-structured interviews. We developed the interview guides in consultation with experts and based on four constructs from Baroudi's conceptual framework on access. The interview guides comprised open-ended questions that focused on participant characteristics, views about adolescent SRH policies, provision of contraceptive and STI prevention methods to adolescents, challenges experienced with the provision of contraception to adolescents, and perceived solutions to those challenges. Interviews were conducted in English and lasted 30 to 60 minutes. Participants provided written informed consent, and interviews were audio-recorded with their consent. Interviews were held in a private office or room where participants worked and at a time allocated by each participant. Field notes were taken during and after interviews to ensure accuracy.

Table 2. Participant characteristics.

Participant characteristics	Frequency	Percent (%)
Gender		
Male	0	0
Female	29	100
Racial group		
African	13	45
Coloured	7	24
Indian	1	3
White	8	28
Position at the time of the study		
Senior Manager (office-based)	5	17
Clinic Manager	5	17
Professional Nurse	13	45
Enrolled Nurse	6	21
Health Authority		
National Health	1	3
Provincial Health	17	59
City Health	11	38
Locality (District)		
Urban (Cape Town Metro)	18	62
Rural (West Coast)	11	38
Total	**29**	**100**

Data Analysis

Interviews were transcribed verbatim and subjected to reflexive thematic analysis, following the stages outlined by Braun and Clarke [41]. Reflexive thematic analysis emphasises our role as researchers in the process of identifying, analysing, and interpreting patterns or themes within data, acknowledging that our subjectivity and reflexivity shape how themes are developed. This involved familiarising ourselves with the data by reading and re-reading the transcripts and making initial notes. Next, we coded the data manually and grouped the codes into potential themes that represented important patterns. Although the conceptual framework guided the analysis, we identified themes from the results that either enable or hinder the provision of contraception to adolescents. Then, we reviewed and refined the themes through iterative discussions, checking them against the coded data and the entire dataset to ensure they accurately reflected the data. Data analysis was conducted using Atlas.ti 22 for data management, with codes and themes generated manually.

Trustworthiness

To ensure the trustworthiness of the study, we adhered to the criteria of **credibility** achieved through prolonged engagement with the data [36]. In addition, we held regular discussions and iteratively refined the themes. **Transferability** was achieved through detailed descriptions of the research context, participants and processes to allow the reader to determine the applicability of the findings to other contexts. **Dependability** was addressed by maintaining an audit trail of the research process and data collection and analysis documentation, including detailed field notes and a research journal. **Confirmability** was achieved by ensuring that the data accurately reflects the views and experiences of participants. Therefore, ensuring that the findings are the product of the focus of inquiry and are free from bias by reporting only the perspectives of participants [35,36]. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) guidelines provided a comprehensive framework for transparency, rigour, and credibility [42].

Ethical considerations

This article is partially based on TJK's thesis entitled *"The provision of contraception and STI prevention methods within the public sector to young people in the Western Cape"* which received ethical approval from the Biomedical Research Ethics Committee of the University of the Western Cape (Ref. BM19/1/24), the Western Cape Health Department (Ref. WC_201905_040) and City of Cape Town Health (Ref. 9563). This was followed by engagement with area, district, and subdistrict managers to inform them about the study and obtain necessary approvals. Clinic managers were then contacted to seek permission to recruit nurses from selected clinics. Potential participants were provided with study information and a research approval letter. All the participants provided written informed consent. The data were encrypted and stored in password-protected computers accessible only to the research team. Anonymity and confidentiality were ensured by replacing the names of participants with interview codes.

RESULTS

We grouped the data into four broad themes: barriers and enablers to approachability, enablers to acceptability, barriers and enablers to adequacy and barriers to quality, as shown in Table 3. Illustrative quotations from the interviews that support the results are included. In the quotations, the symbol (…) means the participant paused.

Table 3. Themes and sub-themes.

Themes	Sub-themes (Enablers)	Sub-themes (Barriers)
Approachability	• Practitioners' knowledge of policy guidelines	• Policy and reality differ
Acceptability	• Appropriate nurse training • Ensuring an accepting environment	
Adequacy	• Ease of access to contraception • Adolescent-friendly clinics	• Time constraints
Quality		• Lack of privacy • Language differences

The participants (senior managers and nurses) described a range of factors that enable or support the provision (or access and use) of contraception among adolescents. They also identified barriers that hinder the provision (access and use) of contraception for young people.

Barriers and Enablers to Approachability

Policy and reality differ

Senior managers and nurses were concerned that school policies prohibited the provision of contraception to school-going adolescents (or learners) on school premises despite national policies that promote this. Therefore, highlighting a difference between national policy guidelines and the realities of their implementation. They also reported that they could only provide contraception to learners after receiving approval from members of the school governing bodies (SGBs). Thus, potentially making it challenging for sexually active adolescents to access contraception and inhibiting healthcare practitioners from providing comprehensive SRH services in school settings.

> *"…so, one of the strategies was for us to give contraceptives at the schools, but they serve a lot of backlash depending on the [area]. So, the majority of them do not open their doors to us. They say yes, you can come to do health education, you can come and talk about contraceptives. At some of the facilities (clinics) that allow us to come and talk but not give the method itself at the school, which is quite a challenge."* (Interview 0040; Senior Manager)

> *"We cannot give contraceptives at schools because they are not allowed. Our nurses are not allowed to give contraceptives at schools…I want you to understand this. School nurses are not allowed by the SGBs and Department to give out contraceptives at school."* (Interview 0120; Clinic Manager)

Senior managers and nurses also reported that SGB members had conflicting views and beliefs about the provision of contraception to adolescents in schools. At times those views and beliefs are rooted in myths and misconceptions about contraception or information that adolescents will acquire about sex. Further, healthcare practitioners reported that it could be challenging for adolescents to approach teachers or school health practitioners when the Department of Education does not clearly demonstrate its commitment to providing comprehensive SRH services to adolescents who need them.

> *"We approach the Department of Education to say this is the challenge. We'd really like to go into the schools, and can you give something to the principal to say, allow them to give contraceptives at their schools, but then you also then get the parents. They're clashing at the teachers to say… the cultural beliefs, if you give a child contraception or a condom, you are encouraging them. So yeah…."* (Interview 0040; Senior Manager)

Some senior managers expressed concern that the size of some policy documents was very lengthy and therefore hindered people's ability to contribute to policy development and stay informed about services offered. They also expressed concern about the limited accessibility of the policy documents to a wide range of people. Thus, suggesting that the complexity of the policies created a barrier to service provision, particularly for healthcare practitioners who struggled to comprehend their applicability. Consequently, adolescents, the intended beneficiaries, were unlikely to seek out services they were unaware of.

> *"The one thing that I sometimes think, which is a bit frustrating, is that some of the policies [documents] are sometimes very large, and you get it, and you don't look through it. Even the drafts... Yeah, so... it's difficult to sit and interrogate each policy...."* (Interview 0050; Senior Manager)

Some senior managers and nurses highlighted the importance of ensuring that policies speak to the day-to-day realities of those who are meant to benefit from them (or use them), and the inclusion of the voices of policy implementers (and users) in the policymaking process. They were of the view that this would make it easier for adolescents to approach healthcare services, and for healthcare practitioners to provide contraception to adolescents.

> *"And (when) then everybody else has given his or her input, and now the policy comes, and it must be implemented. Now you look at it, and you say, but now, who thought of this? Why didn't they think of that? So, there are things that you miss, but unfortunately, once it's there for implementation, you now have to see to that."* (Interview 0050; Senior Manager)

We could not ascertain from senior managers and nurses the role young people played in the development of policies. Senior managers and nurses were of the view that exposing young people to policy-making would enable them to know where and how to seek or approach healthcare including contraception.

> *"I'm not sure if they get an opportunity to comment to say into that policy. I would hope that at the national level, when they discuss it, but at the operational level, we have a patient experience of care or a client satisfaction survey, and we do a waiting time survey. And a percentage of that is targeted at the youth so that we can get their input and their opinions and what changes they would like to see and things like."* (Interview 0050; Senior Manager)

Practitioners' knowledge of policy guidelines

Senior managers and nurses reported that knowledge of policy guidelines enabled them to provide contraception to adolescents as it guided their clinical procedures. They mentioned that they use policy documents from the World Health Organization and the Department of Health, including the Practical Approach to Care Kit (PACK) manual [43]. This equips them to reach out to potential users of contraception and make them aware about healthcare options so that their needs as adolescents can be met.

> *"So, we use all national guidelines. PACK is a short version of what the national guidelines are. So, it's a simplified version for the staff so that it's easier for them to be able to refer and package."* (Interview 0040; Senior Manager)

> *"There are policies and guidelines...we have our own PACK guidelines that we refer to. This little book that we refer to has all the general guidelines for us."* (Interview 009; Professional Nurse)

Senior managers also discussed their role in reviewing policy guidelines, demonstrating their knowledge of these policies. Participants were of the view that staying informed about policy developments was essential for ensuring access to contraception services for young people.

> *"...now we have a policy document that talks to sexual and reproductive health, and then we have related guidelines. There are about six of them. So that they cover different components of sexual and reproductive health... for young people there is already the published one specifically for young people. It's called the Adolescent Sexual and Reproductive Health Policy, which was published some time ago."* (Interview 0010; Senior Manager)

Enablers to Acceptability

Appropriate nurse training

Senior managers and nurses discussed the importance of ensuring that healthcare practitioners meet the service needs of adolescents (or users) through nurse training. They mentioned that the PACK guidelines included a contraception module, and that PACK training was mandatory for nurses. They also highlighted that there was specialised training for administering long-acting reversible contraceptives, such as implants. A few nurses indicated they attended SRH training, which was covered periodically for over six months.

> *"...there is the training on policy ...on the PACK guidelines that we use at the facility (clinic).... We did different chapters, so they would include it (family planning). So, it would depend if the trainer would do a lot. But it didn't take a long time. It is a short course ."* (Interview 020; Professional Nurse)

> *"I went for family planning training and the training for STIs. It is all included in one course... Maybe in 2015 or 2016. I cannot remember... It was six months. You go there once a week. At first, I think the first two months you attend class and then the other months you do the practical. They place you in different clinics, where you can treat STIs or initiate FP ."* (Interview 023; Professional Nurse)

Nurses acknowledged that they needed continuous training that was streamlined and focused on their areas of work in order to provide an acceptable service to adolescents. They emphasised that it is inadequate to only rely on their formal qualifications. Further, they mentioned that it is important for them to be equipped to provide relevant information to young people.

"The nurse's skillset are important. Nurses also need to be knowledgeable in the current times and not try to use the information that they learned a long time ago, which may not be useful in the here and now. Because some people trust nurses, and they will take their word ." (Interview 0070; Enrolled Nurse)

Ensuring an accepting environment

Nurses highlighted the importance of upholding a positive mindset and strong work ethic when engaging with young people. They indicated that most adolescents were reluctant to broach the topic of contraception or sex with an adult. Nurses stated that it was their duty to foster a comfortable environment during consultations and promote open dialogue.

"… they do not just get in and start warming up immediately... They are young. They are shy. They cannot just say sex. You know you have to figure out how you are going to present sex to this child. You have to find ways of speaking to them ." (Interview 0060; Professional Nurse)

Senior managers and nurses emphasised the importance of clear communication. The nurses mentioned that they avoided using jargon while communicating with clients. They also discouraged using a harsh tone that could make adolescents uncomfortable or intimidated. According to the nurses, communicating in a friendly and approachable manner during consultations enabled the provision of contraception to adolescents.

"You have to find ways of speaking to them… One thing you never want to do is to offend a young person because then they will get into a shell, and you will never be able to get them out of it." (Interview 0060; Professional Nurse)

The nurses stressed the importance of maintaining an open-minded, objective, and non-judgmental approach when working with young people. They acknowledged that establishing trust with adolescent clients is a gradual process, yet essential. Some nurses mentioned that sharing personal or relatable experiences when engaging with adolescent clients helped build trust and a good rapport with young people.

"You try to stay as unbiased as possible. Basically, you are supposed to be guided by your ethics because, at the end of the day, you are the care provider for the patients. You are not the Counsellor but the advocate for the patient. So, you need to put your patient's interest first them ." (Interview 009; Professional Nurse)

"I think it is about being open and non-judgmental. Being polite – not being harsh. Explaining. Answering questions. Being patient and interacting well...We cannot force people. We can only give them options; otherwise, they will default. Usage is a personal issue. But they must be informed. It is better to be informed them ." (Interview 007; Enrolled Nurse)

Barriers and Enablers to Adequacy

Time constraints

Nurses indicated that one of the challenges they experienced was limited contact time to meet the health needs of adolescents, specifically on their first visit. A few of the nurses attributed time constraints to staff shortages.

"... We have 5 minutes or 10 minutes to convey a message. So that is a challenge…so on a busy day, I think we don't get enough time to reinforce condom use to explain exactly how it is used. To reinforce that it is not just a contraceptive for pregnancy, but it is for all other STI stuff. I think, especially for the first visit, we need to sit down with a patient and talk to answer questions. We don't always have time." (Interview 011; Professional Nurse)

"The only thing sometimes is that the clinic gets too busy, and you don't have the time really to have a nice talk because it really gets too busy. There is not enough staff, and it is just… and everything must just be quick and quick." (Interview 015; Clinic Manager)

Ease of access to contraception

Participants reported that ease of access to contraception facilitated the provision of contraception to adolescents. According to them, this entailed making contraceptive methods that were preferred by young people available. Participants were of the view that the needs of adolescents are not met when they do not receive their preferred contraceptive method. As such, the participants indicated that PHC clinics offered a variety of contraceptive and STI prevention methods to adolescents who seek them as per the Essential Medicines List [17]. Further, participants described how the methods were made available, distinguishing between condoms and other contraceptive methods. Participants indicated that condoms were readily available to adolescents without the need for nurse consultation, in contrast to other contraceptive methods, such as injectables, that involved a clinical examination by a nurse.

"There are guidelines, and so condoms are available in every room, so if you walk into a consulting room, there should be male and female condoms. Some clinicians have them on their desks. Some have them in their drawers. We have condom dispensers in the bathrooms and at some places in the facility (clinic), OK. And it is freely available. You will find on the health promotion

tables at some of the facilities (clinics) you will find boxes of condoms displayed. And yeah, in the bathrooms, you will find access ." (Interview 0040; Senior Manager)

"*We keep them [condoms]in the waiting area. There's a table there. We keep them there by the door, and all the rooms have condoms.*" (Interview 023; Professional Nurse)

However, some nurses made value judgements by promoting certain contraceptive methods to adolescents. They argued that injectables and implants were more suitable for adolescents although senior managers indicated that nurses were not permitted to select contraception methods for users. Therefore, some of the nurses restricted adolescents' choice and access to contraceptives, possibly viewing them as less responsible than older contraception users.

"*The implant is the one we are really advocating for because they forget and not honour their appointments for oral. Whereas the implant is for three years, and after three years, you can take it out. We try to minimise teenage pregnancy. So that is the is the most favourable one....*" (Interview 0120; Clinic Manager)

"*But mostly, we promote the injection just for them to remember, for the client's part.*" (Interview 008; Clinic Manager)

"*We are not very fond of using tablets [oral contraceptive pill] for the young girls, especially those in school [adolescents]. Once they are at the college or start working then we start treating them with a better option. But there are few teenagers that feel like she wants the pill then we give her the pill, but you must understand that she will take a responsibility for that.*" (Interview 008; Clinic Manager)

Adolescent-friendly clinics

Participants described the importance of having youth and adolescent-friendly clinics. They described this as adhering to the Ideal Clinic framework, minimising waiting times, and providing health services in a welcoming and professional environment for adolescents. Therefore, reducing barriers to healthcare and showing young people that their healthcare is a priority.

"*It started there because Ideal Clinic [initiative] demanded that we focus on adolescents. We are doing an ideal clinic assessment, we want to know if they've got posters of adolescents and youth, if they've got a special window where they go to, do they know that is their window, do they know that that sister in room 24 is there? I'm saying now they know that if they go to the clinic, they are treated like VIPs [very important people], even if it's not a youth clinic. And as a result, other clinics are even putting like two to four for them.*" (Interview 0030; Senior Manager)

Participants mentioned strategies that they use to improve young people's access to contraception at clinics. These include offering contraception to learners after school hours and partnering with organisations for educational activities. Thus, ensuring that adolescents interact with their peers or people they can relate to.

"*I don't know if I remember correctly, but I think about a quarter of the facilities (clinics) have a special time for providing services to young people. This is mainly for young people who come (to the clinics) outside the normal time. But remember that at any time, at any of the hours, they access the services.*" (Interview 0010; Senior Manager)

Participants noted that having specialised clinics and designated areas within clinics allowed adolescents to receive assistance separately from other contraceptive users and potentially judgmental adults. They believed that this approach helped them meet the contraception needs of young people while also minimising the need for them to travel long distances or wait in long queues at clinics.

"*I think the fact that there is a youth clinic is a better step because if they go to the general clinic, the clinic that attends everybody... they don't feel comfortable. Now, with the youth clinic, it is only them. It is very convenient for them. So, I see it as a very good step.*" (Interview 0606; Professional Nurse)

"*There could be a section or room for children [adolescents] within the clinic.*" (Interview 005; Professional Nurse)

Barriers to Quality

Lack of privacy

Some nurses emphasised the importance of upholding privacy and confidentiality for adolescents from the moment they enter the clinic premises. They indicated that not all rural PHC clinics possessed the necessary infrastructure to guarantee privacy.

"*There is no special place for them (teens) to go. We have a lot and lot of teenagers [adolescents] in the clinic, and they are 14, or you have a girl of 13.*" (Interview 013; Enrolled nurse)

Some nurses mentioned cases of guardians who insisted on being present during the consultation session, which is supposed to be between the nurse and adolescent, and how that invaded the client's privacy.

> *"About the parents who insist on being part of the consultation, normally we ask them to stand outside if they don't have a problem, but even if they still want to be part of the consultation, they can be here… So, if the patient is comfortable with them in the room, we let it be, and I'm still going to give my health education. I always advise them to come back to me privately if they like or if they have any questions that you have because normally they would be too shy to talk in front of their parents..."* (Interview 009; Professional Nurse)

> *"I usually ask the adults to leave so that I can talk to the patient themselves, but sometimes the mother does not want to leave. So, I feel that they don't disclose as much confidential information as the mother stands here"* (Interview 011; Professional Nurse)

Language differences

Participants discussed the importance of language in the nurse-client relationship and how language differences could hinder communication and service provision when the nurse and adolescent were proficient in different languages. Nurses indicated that adolescents need to express themselves during a consultation or counselling session and that it is essential that they also understand the nurse. However, when there are language differences between a healthcare practitioner and a user, the quality of healthcare provision is compromised.

> *"We have a bit of a language barrier. Even if they speak English, and we understand, it is very difficult."* (Interview 012; Enrolled nurse)

> *"Language is also important...It is also a barrier to use big jargon with them because they won't understand."* (Interview 0060; Professional Nurse)

A nurse who worked in a rural area supported this and highlighted that PHC clinics served anyone who required healthcare. This included farm workers, migrant workers, refugees, asylum seekers, tourists, and people experiencing homelessness.

> *"We assume that people understand English...All over, we just assume that everybody needs to understand English, but it is not working. And it is not only like Afrikaans people (but) also people from Eastern Cape and then up from Africa..."* (Interview 013; Enrolled nurse)

DISCUSSION

In this study, we explored the barriers and enablers of providing contraception to adolescents in primary healthcare clinics from the perspectives of healthcare practitioners. This study was guided by the constructs of Levesque et al. and Baroudi's conceptual frameworks on healthcare access [31,32].

An enabler to approachability was highlighted through the knowledge of policy guidelines, which promote that nurses reach out to potential service users. Senior managers and nurses noted that practitioners' knowledge of policy guidelines, such as the PACK manual, was crucial to ensure that adolescents' needs were adequately met [19,43]. Existing literature also highlights the importance of frontline healthcare practitioners being familiar with policy guidelines for the effective implementation thereof [24,44,45].

Barriers to approachability related to the inaccessibility of lengthy and complex policy documents. Senior managers expressed frustration over the large size and complexity of some policy documents and missing information in some policy documents. This underscores the need for clear, concise, and accessible policy documents to ensure that adolescents' needs are adequately met. Although the policymaking process advocates for continuous collaboration with multiple stakeholders, including adolescents, senior managers highlighted their limited participation and that of young people. Therefore, this suggests the need for a more inclusive, transparent, and collaborative approach to policy development and implementation [44,46].

Senior managers and nurses reported the distinction between national policy documents and school policies as a barrier. Despite national policies promoting contraception provision in schools [15,25], many school policies prohibited this practice. Consequently, contraception provision required approval from SGB members; however, approval was frequently not granted. This scenario reflects conflicting views and beliefs held by SGB members and parents. Studies show that a lack of parental support contributes to low self-esteem and risky sexual behaviour in adolescents [47,48]. Therefore, it is crucial for SRH policies and services to reflect the social and cultural norms and needs of adolescents. In addition, it underscores the need for improved coordination and communication between national policies and school governing bodies [49].

Enablers to acceptability were nurse training and ensuring an accepting environment for adolescents seeking contraception. Participants stressed the importance of specialised training for nurses as a crucial factor in providing effective contraception. However, many nurses did not recall receiving specific training related to SRH or contraception, attributing their knowledge to their formal qualifications and work experience. Studies report that continuous professional development is necessary to enhance nurses' skills and confidence [27,29]. In contrast, inadequately trained nurses struggled to provide

appropriate care, often due to stereotypes and judgmental attitudes that could discourage adolescents from seeking services [22,28]. Nurses emphasised the importance of effective communication, characterised by clarity, empathy, and mutual respect, as essential for building trust and ensuring adolescents feel comfortable discussing sensitive topics [50,51]. Research highlighting the role of good communication in achieving satisfactory health outcomes and sustained contraceptive use further supports this finding [52,53].

Enablers to adequacy were emphasised through ease of access to contraception and adolescent-friendly clinics. Senior managers and nurses stressed the importance of making contraception accessible within PHC clinics, offering a variety of contraceptive methods to prevent unintended pregnancies and combat poverty. However, healthcare practitioners seemed to advocate for certain contraceptives, such as injectables and implants, without giving adolescents the freedom to make their own choices [11,28,51]. This reinforces the need for continuous training to enhance nurses' skills in providing adolescent-friendly services, thus ensuring the SRH rights and justice for adolescents [6,54]. The importance of adolescent-friendly clinics was discussed, emphasising adherence to the Ideal Clinic framework, which stresses reduced waiting times and a welcoming environment to promote adolescents' access to contraception services [1,7,16]. However, time constraints and staff shortages inhibited nurses' ability to address adolescents' health needs during their visits thoroughly. There is a need for strategies to minimise adolescent waiting time and address staff shortages to promote access to contraception services.

Senior managers and nurses reported barriers to quality. Quality of care includes both the structure and process of contraception service delivery, with significant issues identified in privacy and language differences. Nurses stressed the importance of maintaining confidentiality for adolescents from the moment they enter the clinics. However, not all clinics had the necessary infrastructure to maintain it, especially in rural areas. Additionally, guardians often compromised adolescents' privacy by insisting on being present during consultations, hindering open communication with healthcare providers [12,27]. Language differences between providers and adolescents were a barrier to effective service delivery. Language barriers hinder effective and empathetic care [52,53]. Therefore, underscoring the need for strategies to overcome communication challenges in diverse settings to improve the quality of contraception service and promote service use [55].

Implications for Research, Practice, and Policy

Our findings have several implications for research, practice, and policy. Firstly, future research should explore SRH service provision across different provinces in South Africa to understand regional variations and barriers comprehensively. Including perspectives from policymakers, decision-makers, nurses, and adolescents in future studies could provide a holistic view of the factors influencing contraception provision.

In practice, enhancing nurse training and promoting positive attitudes could foster a more welcoming environment for adolescents and encourage their use of SRH services. Ongoing training programmes for nurses on adolescent contraception services should be prioritised to ensure they are equipped with current knowledge and skills to provide AYFS. Emphasising non-judgmental, respectful, and empathetic care is crucial for improving nurse-patient relationships and encouraging adolescents to seek SRH services.

From a policy perspective, the Departments of Health and Basic Education should work together to improve access to SRH services for school-going adolescents. This could be achieved by addressing the barriers that hinder their access to contraception. Initiatives may include information sessions at schools and in local communities to explain relevant policies such as the Integrated School Health Policy. In addition, stakeholder workshops could be organised to discuss and explore the social and cultural norms that may restrict access to these services. Further, the Department of Health and relevant stakeholders should enhance the physical infrastructure of PHC clinics to ensure privacy and confidentiality during consultations. This is vital for creating a supportive environment for adolescents.

Limitations of the study

Despite its contributions, this study has limitations. The sample was restricted to urban and rural districts in the Western Cape province; thus, its transferability could be limited to areas with similar socio-economic profiles and health system challenges. Other healthcare practitioners who did not form part of the sample could have different views. Conducting interviews in English could have affected participants' responses. Additionally, we did not return transcripts to participants for validation, although we asked them questions to clarify and confirm information during data collection.

Conclusion

This study offers valuable insights into the perspectives of PHC practitioners in providing contraception to adolescents. While national and provincial policy guidelines are usually adhered to by PHC practitioners, a range of facilitators and barriers to effective implementation remain. Addressing the identified barriers and leveraging facilitators to contraception provision could improve the accessibility, adequacy, and quality of contraception services. This could enhance universal access to SRH services, ensuring equitable access for all adolescents and ultimately achieving SDG targets related to SRH.

DECLARATIONS

Publication Consent

Not applicable.

Competing interests

The authors have declared no conflict of interest.

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Author contributions

Conceptualisation of the study: TJK. Methodology: TJK, GBB and OA. Writing—original draft preparation: TJK. Writing—review and editing: TJK, SZM and OA. Supervision: GBB and OA. Funding acquisition: TJK. All authors read and agreed to the published version of the manuscript.

Data availability

The de-identifiable data supporting this study's findings are available from the corresponding author upon reasonable request.

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ORCIDs

Thabile J. Ketye 0000-0002-0655-2864
Gbotemi B. Babatunde 0000-0002-9147-8637
Solange Z. Mianda 0000-0002-4353-3929
Olagoke Akintola 0000-0002-2137-1906

Provisión de anticonceptivos a adolescentes en clínicas de atención primaria en Sudáfrica: Perspectivas de los profesionales de atención primaria

RESUMEN

Introducción: La provisión de anticonceptivos a adolescentes constituye una estrategia de salud pública esencial para prevenir los embarazos no planificados en este grupo etario y garantizar el acceso universal a la salud sexual y reproductiva. En el marco de las directrices políticas nacionales y provinciales de Sudáfrica, esta intervención se implementa en las clínicas de atención primaria. Este estudio se propuso explorar las barreras y los facilitadores que influyen en la provisión de anticonceptivos a adolescentes en dichas clínicas desde la perspectiva de los profesionales de la salud.
Métodos: Adoptamos un enfoque cualitativo para la investigación. A través de un muestreo intencionado, seleccionamos a directivos y enfermeras implicadas en programas de atención primaria y salud sexual y reproductiva en Sudáfrica. Realizamos entrevistas semiestructuradas a veintinueve participantes en contextos urbanos y rurales. Tras transcribir las entrevistas y verificar su precisión, empleamos el modelo de análisis temático de Braun y Clarke para organizar los datos siguiendo marcos teóricos de acceso a los servicios de salud. Identificamos cuatro temas principales, cada uno con subtemas que detallan tanto los facilitadores como las barreras en la provisión de anticonceptivos a los adolescentes.
Resultados: Los resultados indican que el conocimiento adecuado de las directrices políticas por parte de los profesionales sanitarios facilita la provisión efectiva de anticonceptivos a los adolescentes. No obstante, las discrepancias entre las políticas escritas y las limitaciones prácticas pueden obstaculizar la adecuada prestación de estos servicios. Entre otros impedimentos destacan las barreras lingüísticas entre los proveedores de salud y los adolescentes, las restricciones de tiempo y la falta de privacidad durante las consultas. Se observó que una formación robusta del personal de enfermería y la creación de un entorno acogedor para los adolescentes son factores que contribuyen significativamente a mejorar la provisión de anticonceptivos.
Conclusiones: Este estudio aporta una perspectiva valiosa sobre las barreras y facilitadores que enfrentan los profesionales de atención primaria en la provisión de anticonceptivos a adolescentes. Los hallazgos sugieren que las políticas futuras y las investigaciones deberían enfocarse en fortalecer la prestación de servicios anticonceptivos dirigidos a adolescentes, abordando tanto las barreras identificadas como las oportunidades de mejora.

Palabras clave: Adolescentes; anticoncepción; profesionales sanitarios; clínicas de atención primaria; perspectivas; Sudáfrica.

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