EXPERIENCES OF FEMALE ADOLESCENTS ATTENDING COMMUNITY HEALTH CENTRES REGARDING THE USE OF CONTRACEPTIVES IN BUFFALO CITY HEALTH DISTRICT

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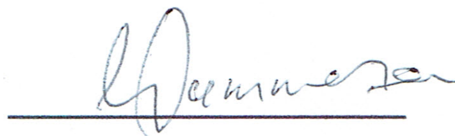
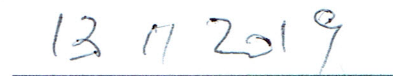
DECLARATION: In accordance with Rule G5.6.3, I hereby declare that the above-mentioned treatise is my own work and that it has not previously been submitted for assessment to another University or for another qualification.





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ABSTRACT

Family planning is a broad term that encompasses the provision of contraceptive methods to sexually active women or girls and includes fertility planning. Despite the widespread availability of knowledge about modern contraception, many young people do not use contraception or use it inconsistently and incorrectly.

The purpose of the study was to explore and describe the experiences of female adolescents attending community health centres regarding contraceptive usage. The study also intended to provide recommendations to the district health office and facility managers at community health centres regarding care and support of adolescents concerning their use of contraceptives.

The study utilised a qualitative, exploratory, descriptive, and contextual research design. The target group comprised of female adolescents attending community health centres in Buffalo City Health District, for contraceptive and adolescent-friendly services. A purposeful sampling technique was used to select the community health centres in the study and the researcher used convenience sampling to select participants at each community health centre. The researcher used semi-structured interviews to interview the participants regarding their experiences of using contraceptives. Tesch's thematic method of data analysis was used to analyse the data. The researcher adhered to all the ethical principles of the Belmont Report while conducting the study.

The analysed data indicated the issue of access to contraceptives and their usage as a challenge to many female adolescents attending the community health centres in Buffalo City Municipality. Adolescents expressed a range of negative emotions regarding the consequences of not using contraceptives and some also complained about the side effects of using contraception. Some adolescents felt that nurses did not always provide them with quality care, while others experienced receiving patient-centred, holistic care from clinic nurses, as well as health education

regarding contraceptive usage from nurses and life orientation teachers. However, female adolescents called for an increase in reproductive health education at clinics and hospitals. They also expressed the need for regular school involvement regarding the education of adolescents on the various aspects of contraceptive usage. Hence, it is hoped that the recommendations from this study will assist the DoH to better assist adolescent females with contraceptive usage.

Keywords: community health centres, family planning, adolescent pregnancy, primary health care, contraceptive services

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CHAPTER ONE

BACKGROUND AND OVERVIEW

1.1 INTRODUCTION

In 2010, the United Nations Population Fund (UNFP) estimated the total number of adolescents in the world at 1.8 billion, with an estimated 900 million representing female adolescents (UNPF, 2013:1). Adolescence is defined as a transitional period moving from childhood to adulthood. These transitions occur on a biological, cognitive, social, and emotional level. This age is sometimes referred to as teenage years or puberty and occurs roughly between the ages of 10 and 20.

The World Health Organisation (WHO) broadly categorise adolescence into three stages (WHO, 2014:1). Firstly, early adolescence ranges from 12 to 14 years and at this stage, physical changes take place. Secondly, middle adolescence, which ranges from 14 to 17 years marks changes on the emotional, cognitive, and mental maturity levels. Many individuals in this age group routinely have sex; subgroups often engage in unprotected sex where their survival depends on the social exchange of sex which is often characterised by uneven power dynamics (Kurth, Lally, Choko, Inwani and Fortenberry 2015:25). Finally, late adolescence, ranging from 17 to 19 years just prior to adulthood. Characteristics of this stage include the development of a secure identity and more stable interests. According to Hashmi (2013:3), adolescents are more distrustful of security, safety, and independence. Adolescence is a period during which attitudes about sex, love, marriage, gender roles, and other important life issues are formed and become part of the individual's identity (Hashmi 2013:3).

The Second National Youth Risk Behaviour Survey of Learners in Grades eight (8) to 11 attending public sector schools across the nine provinces, found that 37.5% of adolescents were sexually active, of which 17.9% indicated that they do not use contraception (Department of Health, 2012:18). The WHO indicated that adolescents confront a multitude of sexual and reproductive health risks stemming

from early, unprotected and often unwanted sexual activity (WHO, 2012a:2). The responsibility to provide sexual education forms part of the promotive, and preventative educational responsibility of Primary Health Care (PHC) practitioners as many adolescents are unable to rely on parental figures for information and guidance about responsible sexual behaviour (WHO, 2014:1).

Findings in an Ethiopian study (Taffa, Haimanot, Desalegn, Tesfaye and Mohammed, 2017:1) suggested that young people's knowledge of aspects of their sexuality is incomplete and not enough to avoid risk-taking. Taffa *et al*. (2017:1) cite a number of studies that indicate that more than half of adolescents believed that it is unacceptable to discuss growth changes and sexual issues with parents during adolescence. It is worth noting that parents only had a partial knowledge about adolescent sexual maturation and behaviour. The study by Taffa *et al.* (2017:5), concluded that higher educational levels of parents and smaller family sizes positively associate with an open discussion on sexual matters between parents and their adolescent children. It is, therefore, vital for countries to invest in comprehensive sexual education focusing on female adolescent sexual and reproductive health care issues. The focus areas of sexual health education should also make provision for comprehensive life skills education, which should include skills to negotiate for safer sex (Taffa, 2017:7). Reddy, Sewpaul and Jonas (2016:2) contributed to the discussion by suggesting that education on the awareness of responsible womanhood and the negative impact of early pregnancy is imperative.

Comprehensive sexual education provides young people with information according to their age level regarding human development, gender, healthy relationships, and sexual and reproductive health and rights (Population Reference Bureau, 2017:2). Loaiza and Liang (2013:11) suggest that one of the most effective interventions to empower adolescents with the most basic skills to function and contribute to society is to obtain comprehensive sexual education. This includes the ability to know and recognise options to negotiate better reproductive desires, including when and how many children to have; and the ability to demand quality services for sexual and reproductive health.

In 2006, the South African Government embarked on various programmes and initiatives to help adolescents to achieve these goals, through the National Adolescent Friendly Clinic Initiative (NAFCI) and managed through the LoveLife initiative. The initiative is a component of the national HIV prevention campaign which combined a sustained, multi-media HIV awareness and education campaign with outreach services. In 2006, the Department of Health (DoH) agreed to take over the management of NAFCI under their Youth Friendly Services (YFS) programme. NAFCI recognised that the PHC clinics were best positioned to provide quality health services to adolescents (Geary, Gómez-Olivé, F.X., Kahn, K., Tollman, S. & Norris, 2014:1) because PHC is the first entry point to the healthcare system with its core function of providing preventative healthcare.

The mission of the DoH is to improve the health status of adolescents by promoting healthy lifestyles, early detection, the prevention of illness, and the improvement of the healthcare delivery system by focusing on the accessibility of services (National Adolescent and Youth Policy 2017:1). One of the indicators for the success of NAFCI was to increase the utilisation of public sector clinics by adolescents (Geary et al., 2014:1).

The National Adolescent and Youth Policy of the DoH (2017:4) identified eight (8) priority areas. This research study will analyse and discuss two (2) priority areas of interest, namely adolescent and youth-friendly services and sexual and reproductive health.

- **Youth-Friendly Services**

In South Africa, the Youth Friendly Services (YFS) was conceptualised and implemented between 1999 and 2005. In January 2001, the YFS was rolled out in all nine provinces in South Africa (MietAfrica, 2011:14). The YFS is elaborated upon in Chapter 2.

- **Sexual and Reproductive Health**

Denno, Hoopes and Chandra-Mouli (2015: S23) define, reproductive healthcare as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems''. There is a global trend to prioritise Sexual and Reproductive Healthcare (SRH) for adolescent girls' needs and in particular their right to access and utilise SRH services (Jonas, Crutzen, Krumeich, Roman, van den Borne and Reddy, 2018:1). In sub-Saharan Africa countries, however, statistics suggest that SRH services are still under-utilised by adolescents. Many factors, such as the attitude and behaviour of healthcare workers, contribute to the under-utilisation of SRH services by adolescents (Jonas *et al*., 2018:1). Sexual and Reproductive Health and Rights are discussed in detail in Chapter 2.

FACTORS THAT INFLUENCE THE EFFECTIVE USE OF CONTRACEPTIVES

The DoH identified factors that influence the effective use of contraceptives by adolescents (DoH, 2012:15). Firstly, the socio-economic status of the adolescent plays a critical role in the decision-making process. Secondly, by improving women's levels of education allows them to gain more information and knowledge on contraception. The limited knowledge of the range of contraceptive methods hampers the adolescents' ability to make informed choices about methods most suitable for them. Finally, access to contraceptive services and PHC providers play a critical role in influencing women's uptake of contraceptive services. There is evidence to show that disapproving healthcare providers may discourage young women from accessing contraceptives. Many adolescents attending contraceptive services do not obtain enough information and counselling on the expected side effects of injectable contraceptive methods (DoH, 2012:15).

Studies conducted in South Africa reported on factors associated with adolescent pregnancy and other sexual risk behaviours such as the poor use of contraceptives and poor knowledge of contraceptives. These studies illustrate the general ignorance among young people about sexual and reproductive health. Many adolescents could not comprehend the relationship between unsafe sexual

intercourse and pregnancy. Unsafe sex is common among South African adolescents and is known to result in many unpleasant health and social consequences. In South Africa, adolescent pregnancy is reported as the most common consequence of unsafe sex, followed by HIV/AIDS, and other STIs (Jonas, Crutzen, van den Borne, Sewpaul and Reddy, 2016:2).

ACCESS TO HEALTH CARE

Key findings from a review study conducted by Chilinda, Hourahane, Pindani, Chitsulo and Maluwa (2014:1711), indicated that the unprofessional attitude of healthcare professionals and lack of youth-friendly reproductive health services inhibits adolescents from utilising the benefits of sexual and reproductive health services in developing countries. Poor access to contraceptives is caused by factors such as school health services being prevented from providing family planning service at schools, negative attitudes on the part of some PHC staff members towards adolescents, thus deterring adolescents from returning to facilities to access contraceptives, and the lack of fast queues for family planning clients (Massyn *et al.*, 2014:143).

Mushwana, Monareng, Richter and Muller (2015), reported on the experiences of adolescents regarding clinic nurse services in the Limpopo Province and found that there is a strained nursing staff-adolescent relationship, whereby adolescents are reluctant to approach professional nurses for assistance. These findings suggest that improved relationships between healthcare providers and adolescents might improve accessibility to healthcare services and thus contraceptive usage. In the same study, the respondents were distrustful of whether nurses would maintain confidentiality and only 46.2% of the participants indicated that the nurses provided information on contraceptives (Mushwana *et al.*, 2015). A study conducted by Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Myani and Blanchard (2012) in a semi-rural area of South Africa examined young women's experiences with nurses. Results revealed that nurses stigmatised adolescent sexuality and harshly treated adolescent girls seeking contraceptive services.

The UNFP (2014:1) indicated that one of the main challenges in the accessibility of contraceptive services for youth nationally is due to PHC facilities operating only during office hours, resulting in poor access for school going youths. Dlamini (2016) agreed that accessibility to contraceptives for adolescents is often affected by operational hours of health facilities and negative attitudes displayed by nurses when approached for contraceptives services. Jonas *et al*. (2018:9) support this notion that operating clinic hours are not suitable for many adolescents and proposes an extension of at least 30 minutes to an hour to accommodate the adolescents that finish school at 15:00 and must travel to the clinic.

MATERNAL AND CHILD CARE

Globally the adolescent birth rate in 2015 was 44 per 1000 women aged 15 to 19 years (Cavazos-Rehg, Krauss, Spitznagel, Bommarito, Madden, Olsen, Subramaniam, Peipert and Bierut, 2015:1). The adolescent birth rate in low-income countries was 97 per 1000 women aged 15 to 19 years. This rate was five times higher compared to high-income countries where the birth rate was 19 per 1000 women aged 15 to 19 years. Early childbearing poses increased health risks to adolescent mothers. According to Cavazos-Rehg *et al*. (2015:1), pregnant women between the ages of 15 and 19 years old had higher likelihoods for severe preeclampsia, eclampsia, postpartum haemorrhage, poor foetal growth, and foetal distress. Denno *et al.* (2015: S23) support the notion that adolescents aged 10 to 19 years face particular health risks, especially concerning reproduction and sexuality. Eleven per cent of all births and 14% of maternal deaths worldwide are among 15 to 19-year-old females, with 95% of adolescent births taking place in developing countries.

Maternal mortality and morbidity in South Africa remain exceedingly high, and research findings suggest that about 40% of all maternal deaths are avoidable (DoH, 2012). The South African National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) states that these deaths are related to community, administrative and clinical factors (DoH, 2012a). The Saving Mothers Report identified five (5) major causes of maternal deaths

which included non-pregnancy related infections, as: mainly AIDS (50%); obstetric haemorrhaging (14%); complications relating to hypertension (14%); pregnancy-related infections (5%) and complications relating to pre-existing medical conditions such as diabetes (9%) (Gumede, 2015:14).

The Minister of Basic Education expressed concern about the rate of pregnancies in South African schools. The 2015 Annual School Survey reported that over 15,000 pupils fell pregnant during the academic year. The minister indicated that the rate of pregnancies at schools had become a major social challenge not only for the education sector but more importantly for the national development of South Africa (Makhubele, 2015:1).

The Eastern Cape had the second highest number of adolescent pregnancies in the country with 3,898 reported cases. The Gauteng Province is leading with 5,209 adolescent pregnancies for the financial year 2013/2014 (Boshoff, 2015:3). Adolescent pregnancy is a result of non-usage of contraceptives or poor contraceptive usage and adolescent pregnancy often results in severe consequences such as maternal deaths, stillborn births, premature births, increased school dropout rates and an increased financial burden on society (Martin, Hamilton, Ventura, Osterman, Kirmeyer and Mathews, 2011:1).

Pregnant teenagers often neglect to attend antenatal care sessions, and potential complications in their pregnancy or delivery may be missed until it is too late to refer them to specialist units (Reddy *et al.*, 2016:2). Maternal mortality is the leading cause of death among girls aged 15 to 19 years (WHO, 2016:68). The DoH (2014) had identified four (4) leading causes for the 71.7% reported maternal deaths among South African pregnant teenagers. These are (1) hypertension accounted for 22.8%; (2) non-pregnancy-related infections (HIV/AIDS-related, such as TB or pneumonia) accounted for 21.1%; (3) obstetric haemorrhage 14.2%; and (4) medical and surgical disorders (13.6%) (Reddy *et al.*, 2016:2). Consequently, preventing teenage pregnancy could contribute significantly to limit maternal deaths and to

achieve the millennium development goals of maternal and child survival (Dulitha, Nalika, Upul, Chrishantha, De Alwis, Hemantha and Chithramalee, 2013:1).

BARRIERS

A series of multifaceted barriers currently prohibits good sexual and reproductive health for adolescents. Various societal, cultural, and religious factors create an inhibitive environment for the discussion of adolescent sexual and reproductive health. Many societies hold a deeply embedded sense of disapproval of adolescent sexual activity. This is often demonstrated through the stigmatisation of sexual health concerns, in particular, STIs such as HIV. Judgemental attitudes about sexual activity abound, especially for unmarried women and sexually active girls (Morris & Rushwan, 2015:541).

- **Socio-Cultural Barriers**

Another major obstacle which prevents adolescent girls from accessing contraceptive services in South Africa is rooted in social-cultural and beliefs which entrench patriarchy and encourage gender inequality. Cultural beliefs prevent young women from accessing information about sexual reproductive health from their parents and adults since it is believed that discussions relating to sexuality are offensive and culturally inappropriate (Greene, Rasekh and Amen, 2002:1).

- **Religious Barriers**

The religious beliefs of adolescents influence their uptake of contraception (Mutumba, Wekesa and Stephenson, 2018:2). Religion may be helpful and assist in educating adolescents on the benefits of delaying sexual activities. However, the adverse effects of religion as a barrier to contraceptive use can occur, as many religions associate the use of condoms and contraceptives as immoral and sinful behaviour. Therefore, religion could contribute to unfounded beliefs that the use of family planning methods could result in future infertility, thereby scaring away adolescent girls from using them.

- **Economic Barriers**

Adolescent girls who live in poverty not only tend to be more susceptible in engaging in sexual behaviour than their wealthier counterparts but, as a result of their lack of economic empowerment, these girls are unable to negotiate safer sex such as condom use. The 2009 National HIV Prevalence, Incidence, Behaviour and Communication Survey found an increase in inter-generational sex as a factor which significantly contributes to adolescent girls' risk of contracting HIV. This increase is because older men in relationships with young girls give the girls gifts in exchange for sex, causing girls in such relationships to be unable to control or dictate safe sexual practices (Savage-Oyekunle and Nienaber, 2015:550-552).

SUSTAINABLE DEVELOPMENT GOALS

The UN General Assembly adopted the Sustainable Development Goals (SDGs) in September 2015. They set the global direction for 17 development goals, one of which focuses on health (SDG 3). The SDGs substantially broaden the development agenda beyond the MDGs, with an emphasis on country-level ownership and multi-sectoral investments and a focus on leaving no one behind (Stenberg, Hanssen, Tan-Edejer, Bertram, Brindley, Meshreky, Rosen, Stover, Verboom, Sanders and Soucat, 2017:1).

SDG target 3.7 was set to ensure universal access to sexual and reproductive healthcare services, which is accessible for all people and communities to services that they need without financial hardship. These were to be monitored by two proposed indicators; (1) the adolescent birth rate; and (2) coverage of modern family planning services. Both were also previously part of the MDGs (WHO: 2016). Women and children's health remain a central concern in the SDGs, as evidenced by the strong commitment to ending preventable new-born, child and maternal deaths by 2030, to ensure universal access to sexual and reproductive health-care services, and to promote early child development and adolescents' health (WHO, 2015:79).

1.2 PROBLEM STATEMENT

The researcher is working at a community health centre in Buffalo City. The centre provides Youth-Friendly Services, where adolescents receive various health services such as antenatal care, STIs, termination of pregnancy, and HIV care. The researcher was concerned that many of these adolescents had not been using contraceptives or at least had not been utilising them effectively.

The researcher observed that contraceptive services were not offered consistently and routinely during consultations with adolescents. For example, adolescents were offered and given contraceptives at post terminations and post-delivery services, while contraceptive services were not offered in the HIV, acute or chronic sections of the clinic. The monthly data verification meetings corroborated an increase in the number of adolescent deliveries, requests for termination of pregnancies and pregnant adolescents attending the facility.

Statistics supplied by the Deputy Director of the District Health Information System of the Buffalo City Metropolitan Municipality, on delivery and termination of pregnancy under 19 years, reported four (4) deliveries for age group 10 to 14 years, 314 deliveries for age group 15 to 19 years, and 55 termination of pregnancy (age 10 to 19) from June 2017 to May 2018.

According to research done by Jonas *et al*. (2016:9) education on teenage pregnancy appears to be inadequate and poses a severe public health threat, as the enormity of the problem is relatively hidden for consideration into intervention programs that aim to reduce adolescent pregnancy. Furthermore, the lack of information may affect programme outcomes aimed at reducing adolescent pregnancy and improving maternal and child health.

According to the 2015 annual school survey, over 15,000 pupils fell pregnant during the academic year. The minister indicated that the rate of pregnancies at schools had become a major social challenge. Massyn, Padarath, Peer and Day (2017:54)

indicated that the Eastern Cape is one of three rural provinces which had the highest deliveries of under 18 years (8.6%), of which Buffalo City represented at 5%.

The research question for this study was:

What are the experiences of female adolescents regarding contraceptive usage?

1.3 AIM OF THE STUDY

The study aimed to explore and describe the experiences of adolescents attending community health centres in Buffalo City Health District regarding their use of contraceptives. The findings of the study will be used to make recommendations to the district health office and facility managers at community health centres in the Buffalo City Health District regarding care and support of adolescents concerning their use of contraceptives.

1.4 OBJECTIVE OF THE STUDY

The objective of the study was to:

- Explore and describe the experiences of adolescents regarding their use of contraceptives

1.5 CONCEPT CLARIFICATION

The following concepts were discussed and described in relation to the study.

- **Female adolescent**

Waite, Laumann, Das and Schumm (2009:i56) define a female as the sex that can bear offspring or produce eggs, distinguished biologically by the production of gametes which can be fertilised by male gametes. An adolescent refers to a young person who is developing from a child into an adult (Hornby, Turnbull, Lea, Parkinson and Phillips, 2010:16). The research population for this study was female adolescents, between the age of 13 and 19 years.

- **Adolescent-friendly services**

The term adolescent-friendly services refer to health services rendered to adolescents aimed at providing health services within the framework of national policies and strategies on adolescent health, reproductive health or HIV (WHO, 2012a:18). Adolescents are a heterogeneous group. The expectations and preferences of adolescents vary, but two common characteristics of this group are that they want to be treated with respect and want to be sure that their confidentiality is respected (WHO, 2012a:4). In this study, adolescent-friendly services consist of services dedicated to the youth in PHC settings.

- **Experiences**

Experiences refer to the process by which information about the world, as received by the senses, is analysed, and made meaningful (Hornby *et al.*, 2010). In this study, participants shared their personal experiences regarding their use of contraceptives.

- **Contraceptives**

Hubacher and Trussell (2015:1) propose a new definition of a modern contraceptive method as a product or medical procedure that interferes with the reproduction resulting from acts of sexual intercourse. In this study, contraceptives are family planning methods that are issued to adolescents to prevent unwanted pregnancies.

- **Community Health Centre**

A community health centre is defined as a facility that, in addition to a range of other PHC services, usually provides 24-hour maternity and accident and emergency services and contains up to 30 beds where patients can be observed for a maximum of 48 hours (Cullinan, 2006:7). The PHC services offered include preventative, promotional, curative, and rehabilitative care, immunisations, family planning, treatment of STIs, minor trauma, and care for those with chronic illness (Cullinan, 2006:7).

1.6 RESEARCH METHOD

According to Silverman (2015:454), a research method refers to the choice made with regard to the methodology about appropriate models, cases to study, methods of data gathering, forms of data analysis, in planning and executing a research study. Research method includes describing the process of selecting the research population, sampling, data collection and data analysis. A detailed discussion of the research method will follow in Chapter Two.

- **Population**

Gray, Grove and Sutherland (2017:687) describe a population as a particular group of individuals or elements who are the focus of the research. The target population for this study included all females between the ages of 13 and 19 years and of all socioeconomic backgrounds and attending community health centres in the Buffalo City Health District. Female adolescents requesting sexual and reproductive health services at community health centres in the Buffalo City Health District were identified as the population for the study.

- **Sampling**

Sampling refers to strategies that allow generalisation from the sample to the population because the sample is representative of the population (Flick, 2015:106). The researcher incorporated both purposive and convenience sampling in this study.

- **Data Collection**

According to Houser (2015:219), the choice of the data collection method should be based upon the aims and objectives, as well as the research question of the study. Semi-structured interviews were conducted to collect data in the current study.

- **Data Analysis**

Data analysis is the application of techniques in the treatment of generated and collected data to achieve research outcomes (Mills and Birks, 2014:257). In this study, the researcher developed categories according to Tesch's eight-step method. The identified themes and sub-themes were grouped, coded, and sent to an independent coder for review.

1.7 RESEARCH DESIGN

Research design refers to the overall plan for obtaining answers to the research questions, including specifications for enhancing the study's integrity (Polit and Beck, 2012:58). The research design used in this study was qualitative, explorative, descriptive, and contextual and was conducted on female adolescents at Community Health Centres in the Buffalo City Health District. In Chapter Three, the researcher will discuss the research design in more detail.

1.8 TRUSTWORTHINESS OF THE STUDY

Grove, Burns, and Gray (2015:513) indicate that the strength and trustworthiness of a qualitative study should be determined by evaluating its: Credibility, Dependability, Transferability and Confirmability. These concepts were applied throughout this study and will be discussed in more detail in Chapter Three.

1.9 ETHICAL CONSIDERATIONS

Researchers have a responsibility to conduct research ethically. According to the Belmont Report, there are three fundamental ethical principles relevant to the research of human subjects. These are the principles of respect for persons, beneficence and justice guided the researcher throughout this study (Houser, 2015:52), and will be discussed in Chapter Three.

1.10 CHAPTER OUTLINE

Chapter 1: Background and Overview

Chapter 2: Literature Review

Chapter 3: Research Methodology

Chapter 4: Data Analysis and Findings

Chapter 5: Conclusion, Limitations and Recommendations

1.11 CHAPTER SUMMARY

In this chapter, the researcher identified the topic to be researched and provided a background on the topic. The aim of the study was highlighted, and an indication of the research methodology and design to be followed was given.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The researcher's intention in the previous chapter was to provide background; problem statement; aim; and objectives to the study. The objective of this chapter is to explore the literature as it refers to adolescents regarding their use of contraceptives by undertaking a comprehensive traditional literature review. Burns and Grove (2011:189) indicate that a literature review provides a background for the identified problem and includes a description of the current knowledge of the topic; identifies gaps in the knowledge and indicates what further studies can contribute to understanding the problem.

The literature review will focus on adolescents, contraception, factors influencing adolescent sexual behaviour, access to health care services for adolescents, youth-friendly policy, reproductive health services, barriers in obtaining contraceptives, negative attitudes of health care providers, lack of knowledge of adolescents about contraceptives, description of the parent-adolescent relationships and improving access to contraceptives for adolescents.

2.2 ADOLESCENTS

The World Health Organization (WHO) defines an adolescent as a person aged 10 to 19 years (WHO, 2014:1). Adolescence is a progression from the initial physical appearance of sexual characteristics to sexual and reproductive maturity. It is a transition from total socio-economic dependence to relative independence. Thus, it is exceptionally critical to provide them with reliable and accurate information about sexuality for adolescents to make informed decisions regarding their sexuality. According to a Polish study by Skrzeczkowska, Heimrath, Surdyka and Zalewski (2015:146) found that 42% of sexually active adolescents admit to using contraceptives all the time and 9% of participants admitted to occasionally using contraceptives while 3% responded to not using contraceptives at all.

Skrzeczkowska *et al.* (2015:146) recommends that classes on sexual reproductive health education should be included in the primary school curriculum, to educate adolescents before their very first sexual encounter.

Indulging in sexual activity at school is becoming a widespread practice and adolescents are not shocked about such behaviour. The Cape Times (2010:3) quoted Wasserman, then Director at LoveLife, as saying that "sex at schools was happening all the time, children of school-going age were having sex and were starting to have sex at an increasingly younger age". Studies indicate that adolescents become sexually active during early puberty. Pregnancies among learners of school-going age in South Africa reportedly numbered 20,000 in 2014, while pregnancies among primary school learners accounted for 223 of the total number (Masemola-Yende and Mataboge, 2015:2). Makhitha and Botha (2017:511) reported that sexual activities of learners at school in South Africa occur during school hours, in the morning before class, during break periods, after school or on their way home while waiting to use transport. Access to a cell phone made planning dates easier during school hours, as adolescents could chat with their boyfriend or girlfriend via various social media networks or forums using SMS, Twitter, Facebook, and WhatsApp. All the participants in Makhitha and Botha's (2017:511) study had engaged in consensual sex while at school, and only two participants had used condoms. The authors further indicated that the highest number of pregnancies occurred in Gauteng (5,209) and the Eastern Cape (3,898), with KT Twala Primary School in Mpumalanga recording 13 pregnancies. An Australian study suggested that pregnancy may occur among children as young as 10 or 12, which is even before their adolescent years (Marino, Skinner, Doherty, Rosenthal, Robbins and Cannon, 2013:1029).

The South African government and various stakeholders have expressed concern about the increasing rate of sexual activity among schoolchildren (Department of Health, 2012:12). Although various intervention strategies, for example, the integrated health programme and life skills, have been introduced at schools, the

problem of adolescent sexual activity on school grounds persists and has resulted in a high rate of adolescent pregnancies (Braine, 2009:411).

In an article titled “Gauteng education needs ideas on curbing teenage pregnancy”, Makhubele (2015:1) reports that Gauteng’s Education MEC, Panyaza Lesufi, admitted that the department had run out of ideas on how to deal with the problem of adolescent pregnancy (Makhitha and Botha, 2017:496). The National Adolescent and Youth Health Policy led to the development of programmes such as the Integrated School Health Programme to promote learners’ health and well-being and to enable accessibility of health services to adolescents (South Africa, 2017:4).

2.3 ADOLESCENT AND YOUTH HEALTH POLICY

Health promotion and management is a priority of the DoH, and it strives towards a pro-active and preventative focus (DoH, 2017:1). The growing recognition of the behavioural and structural causes of health and disease is a growing concern as is the associated commitment to adopting programmes that will positively impact on the social and structural demands of health. There is an array of opportunities for increasing effective health programmes for adolescents and for implementing these programmes on a national scale. According to the DoH, the national conceptions of effective health promotion among adolescents and youth in South Africa can be changed and achieved through the Adolescent and Youth Health Policy which will aid the DoH, together with other key partners in government. This policy provides an opportunity for government and communities to integrate and streamline their programmes and objectives to promote health among adolescents and youth (DoH, 2017:1).

The aim of the National Adolescent and Youth Health Policy is to promote the health and wellbeing of young people between the ages of 10 and 24 and to ensure effective implementation of adolescent-friendly services in the public health sector (DoH, 2017:1). The policy targeted adolescents who are out of school, orphans, and child-headed homes, abandoned and abused or neglected adolescents including those with special needs such as lesbian, gay, bisexual, transgender and intersex

groups as well as adolescents living with chronic conditions such as HIV/AIDS and mental disorders (DoH, 2010:18).

Over the past two decades, the public health service in South Africa has been transformed through a focus on the equitable distribution of health resources and the expansion of service delivery (DoH, 2010:18). There has been a significant increase in the understanding of needs and responses, as well as an improvement of health care provision and awareness programmes (DoH, 2010:18). Nevertheless, adolescents and youth still face significant risks. Rates of HIV transmission (particularly among young black women), tuberculosis, unintended and unsupported pregnancy, sexually transmitted infections, and substance abuse are still persistently high (Amathole District Municipality, 2012:29). These are the significant challenges faced by adolescents and for the health sector (DoH, 2010:18).

In South Africa, the Youth Friendly Services (YFS) was conceptualised and implemented between 1999 and 2005 and is present in all nine South African provinces (MietAfrica, 2011:14). Youth Friendly Services target youth in general; pregnant and parenting adolescents; gay and lesbian adolescents; and HIV positive adolescents (DoH, 2012:18). Youth Friendly Services seek to deliver special attention to adolescents' unique needs linked to their physiological vulnerability, especially there susceptibility to peer pressure. Adolescents tend to engage in high-risk behaviour and are unable to negotiate safer sex. Sometimes adolescents experience challenges in accessing reproductive health information and services (WHO, 2014:1).

2.4 ADOLESCENT STATISTICS

Approximately 1.2 billion adolescents (10 to 19 years old) make up 16% of the world's population, and nearly 90% of this adolescent population lives in developing countries (Statistics South Africa, 2018a:14).

In 2016, the majority of South African adolescents were found among the black African (19,3%) and coloured (18%) population groups. Adolescents were more likely to reside in rural areas (22,5%) compared to the 16,2% in urban areas (16,2%). Between 1996 and 2001, there were slightly more female than male adolescents; however, in 2011 and 2016, the percentage of male and female adolescents appeared to be almost the same (Statistics South Africa, 2018b:18).

2.5 CONTRACEPTION

Bafana (2010:3) defines contraception as the prevention of pregnancy through temporary or permanent means, and it is a fundamental element of family planning. Contraceptives help and protect women from unwanted pregnancies. Contraceptives can be divided into modern and traditional contraceptive methods. These include the pill, IUD, injections, diaphragm used with contraceptive foam or jelly, condom, female sterilisation, male sterilisation as the modern forms and periodic abstinence, withdrawal, and herbs as the traditional methods (Mnyanda, 2013:1). Adolescents should be well-informed about the range of contraceptives methods that is accessible to them (Skrzeczkowska *et al*., 2015:144) so that they can make an informed choice.

There has been a noticeable increase in the use of contraceptives worldwide, although at a much slower pace in sub-Saharan Africa (Chersich, Wabiri, Risher, Shisana, Celentano, Rehle, Evans and Rees, 2017:307). Approximately a quarter of women in sub-Saharan Africa currently use modern contraceptive methods, with levels highest in Southern Africa. In South Africa (SA), estimates of the proportion of women of reproductive age who are protected against unplanned pregnancies, using modern contraceptive methods, have increased steadily from 26.3% in 2002/2003 to 37.3% in 2013/2014 (Chersich *et al*., 2017:307).

According to a South African study conducted by De Klerk (2015:3), whose study focused on factors that influenced contraceptive usage by adolescents, the average age of sexual debut was 15 years, with 42% using contraception at the time of the study. Thirty-three per cent (33%) of the sexually active respondents were not using

contraception. Statistics supplied by the Deputy Director of the District Health Information System of the Buffalo City Metropolitan Municipality on the delivery and termination of pregnancy in girls under the age of 19 years from June 2017 to May 2018, indicated four (4) deliveries for girls between the age of 10 and 14, and 314 deliveries for girls between the ages of 15 and 19. During the same period, the DoH reported 55 terminations of pregnancies for the age group of 10 to 19 years. Therefore, it is clear that many adolescents do not use contraceptives or do not use them effectively.

According to De Klerk (2015:3), adolescent's knowledge about contraception was reasonably good, with school, home and friends playing pivotal roles. Furthermore, De Klerk (2015:16) indicated that condoms were perceived to be easiest available by the sexually active and non-active respondents, while injectable contraception was perceived as readily available by the sexually active youth, but not by the sexually inactive young people. Most of the adolescents were instructed by their parents to use contraceptives, but peer pressure played a role here too, as indicated by 20% of the respondents. The most popular reasons for not using contraception while being sexually active included sensation loss with condoms and partner pressure. The study by De Klerk (2015:16) also showed that more adolescents heard about contraception for the first time at school (37%) rather than at home (25%). This is a result of effective educational programmes in the district. Females pay more attention to their parents (35%) than males (23%). Surprisingly, the results showed that friends were a major source of information (26%). The study concluded that peer education could be a tool that can be utilised when planning new intervention programmes regarding sexual education to adolescents (De Klerk, 2015:16).

2.6 REPRODUCTIVE HEALTH SERVICES

In South Africa, all citizens have a legal right to health services, particularly sexual and reproductive health services. In the constitution of the Republic of South Africa, Children's Act 108 of 1996, Section 27, it states that all South Africans have the right to "access health care services, including sexual and reproductive health care

services" (DoH, 2012:13). It is the government's legal responsibility to provide these services to all South Africans. Furthermore, the Children's Act 38 of 2005 intends to protect the health of children, giving children over the age of 12 the ability to give consent for medical treatment and surgical operations. This further extends to access to contraception, testing for HIV and access to condoms (DoH, 2012). With an ever-increasing population of adolescents who are engaging in sexual activities from an early age, the government has identified the need for sexual and reproductive services to be freely available to adolescents as young as 12 years old.

The DoH (2011) established a policy on Sexual and Reproductive Health and Rights, from which an essential service package for adolescents based on PHC services was developed. The package includes information and education on sexual reproductive health, violence/abuse counselling, contraceptive information and counselling, pregnancy testing and counselling, pre- and post-termination of pregnancy counselling and information on sexually transmitted infections (STIs).

However, despite government supplying free contraceptive services and ensuring the availability of contraception, many South African adolescents are at risk of falling pregnant or contracting HIV and STIs (Massyn, Day, Peer, Padarath, Barron and English, 2014:144). The study of Massyn *et al.* (2014:144), concluded that adolescents have an inadequate understanding of sexual and reproductive health and discussion on sexual matters remains a cultural taboo for both the adolescents and parents. Adolescents prefer peers to be the primary source of information on matters of reproductive health.

2.7 FACTORS INFLUENCING ADOLESCENT SEXUAL BEHAVIOUR

The sexual behaviour of adolescents is of importance because during the period of adolescence, they are at risk of early pregnancy due to the increasing number of sexually active adolescents globally (WHO, 2012b:1). Adolescents and young adults may face many sexual and reproductive health risks stemming from early, unprotected, or unwanted sexual activity (WHO, 2012b:4). Sexual behaviour is

influenced by many physiological factors. In addition to this, the cultural and social pressures can change rapidly from one generation to the next. Understanding the physiological influences that drive adolescent sexual activity, such as hormonal, chemical, and neurological reactions and changes, can help inform interventions to support adolescents in making appropriate choices regarding their sexual behaviour. In order to design effective responses to meet the sexual and reproductive health needs of adolescents, it is essential that the nature of these physiological processes and associated consequences be explored (WHO, 2012b:4). This may help to protect the rights of adolescents in relation to their choices.

Mnyanda (2013:17) conducted a quantitative study on adolescents and contraceptives in the Eastern Cape, and the findings revealed four main factors that influenced adolescent pregnancies. These factors were: (1) a lack of contraceptive knowledge, (2) unclear opinions about contraception and pregnancy, (3) contradictory messages about the reproductive role of young women, and (4) the interaction of young, inexperienced girls with experienced, older male partners. Adolescents are misguided by their peers about the long-term side effects of family planning methods, believing that their health will be affected and that may result in them not conceiving in the future. Speizer, Tambashe and Tegang (2001) as cited by Chandra-Mouli *et al.* (2014:4) state that adolescents consider natural methods such as withdrawal and traditional methods as more acceptable (Chandra-Mouli *et al.*, 2014:4).

A study conducted by Aji, Aji, Ifeadike, Emelumadu, Ubajaka, Nwabueze, Ebenebe and Azuike (2013:13) in Nigeria, revealed the following factors influencing adolescent sexual behaviour as described below.

- **Socio-economic Factors**

Adolescents with low parental income were more sexually active than those who reported high or medium parental income. This is consistent with arguments and reports that economic hardship encourages girls to become sexually active at an

early age for financial reasons. Rewards, both financial and material, are also temptations to be involved in early sex. Poverty is one of the factors that is found to influence adolescent pregnancy, intergenerational relationships, and transactional relationships. Substance abuse, particularly alcohol, was found to be a critical influence. It concluded that adolescents' understanding of contraceptives and reproductive health was generally poor. A study that was conducted by Sodi (2009:19) in Limpopo, indicated that socio-economic factors may influence early sexual behaviour, which results in early pregnancy and found that underprivileged adolescents with low education background were more likely to become adolescent mothers compared to their high-achieving peers as cited by (Lacasa, Araneta, Apilado, Lacaba and Pelobello, 2016: 43243).

- **Peer Pressure and Influence**

Male adolescents, more often than females identify peer pressure as one of the reasons for having sex. Nearly all participants in a study by Muanda, Gahungu, Wood and Bertrand (2018:9) mentioned the pressure to conform. The pressure ranged from subtle name-calling to physical harassment. Male adolescents were in favour of sex mostly for the experience and due to pressure from their counterparts. Risk factors that influence early sexual activities in girls are different from those influenced by boys. Results for boys were analysed and compared with girls, and it was found that girls were 1.56 times more likely to become sexually active at an early age compared to boys (Lacasa *et al.*, 2016:43244).

- **Gender Norms and Values**

Many cultures in Nigeria showed a preference for the male child and rendered him certain privileges often to the exclusion of the female child. This leaves the female with little or no education and at a low socio-economic stratum with sex as the only bargaining tool. According to the study by Syanemyr, Amin, Robles and Green (2015:9), a culture of silence is created particularly for adolescent girls where social norms and taboos related to gender sexuality and SRH issues, especially in obtaining information or expressing their worries about SRH issues. Many adolescents are faced with challenges and are unable to express themselves freely

without being judged and know very few people and places to seek information and support.

- **Parental influence**

According to a study by Ankomah, Mamman-Daura, Omoregie, and Anyanti (2011:7), parents could have either a negative or positive influence on the sexual activity of their children. However, some parents shy away from educating their adolescents regarding sex due to fear that such communication may encourage their interest in sex. While other parents see sex education as immoral due to their religious beliefs and do not discuss issues around sex in order to discourage their adolescent children from initiating sex at a young age (Oluyemi, Yinusa, Abdullateef, Kehinde, and Adejoke, 2017:38).

- **Media**

The research found that exposure to television as a crucial link to the onset of early sex. Locally produced movies, as well as foreign films, were identified, as a critical catalyst for engagement in early sexual initiation. The results of a study by Asekun-Olarinmoye, Asekun-Olarinmoye, Adebimpe and Omisore (2014:22) indicated that most of the adolescents were aware of numerous forms of mass media and the internet, although only a few of them had easy access to these. Most of them spent 3-5 hours a day watching television and most frequently used the internet. The researchers found a relationship between sexual activities and time spent watching television, and the frequency of internet use. It is presumed that those adolescents who spent more time watching television and used the internet frequently were more likely to be sexually active. In a study that was conducted by Oladeji and Ayangunna (2017:195), it was confirmed that spending considerable time with the media, whether watching adult movies, viewing sexual messages online, watching television with sexual content or listening to sexually loaded lyrics, contributed to an increase in adolescents' risky sexual behaviour.

- **Unrestrained Curiosity**

Unrestrained curiosity was another factor influencing adolescent sexual behaviour, which Aji *et al.* (2013:10) found was closely related to the media. A study conducted by Envuladu (2016:20) revealed reasons why adolescents were having sex or being sexually active. These included watching pornography or nude activities, an uncontrolled urge for sex and curiosity. Watching films with some nude activities are also a trigger to sexual activity. Oladeji and Ayangunna (2017:194) found that exposure to pornography foresees sexual insecurity, casual sexual exploration, earlier intercourse, sex mediation and transmitted diseases. The internet allows adolescents to satisfy their curiosity by providing them with a relatively safe space to explore and define themselves as sexual beings (Oladeji and Ayangunna, 2017:194).

- **Coercive Factors**

Sexual coercion can be defined as "the act of forcing another individual to have sex against his or her will through the use of violence, threats, verbal insistence, deception, cultural expectations or economic circumstances" (van Decraen, Michielsen, Herbots, van Rossem and Temmerman, 2012:139). Poor sexual and reproductive health, including HIV and other sexually transmitted infections and accidental pregnancy, is directly related to sexual coercion. Studies have shown that female victims of forced sex are probably not even using condoms or any form of contraceptives, there could be a history of having multiple sex partners and transactional sex (van Decraen *et al.*, 2012:140). Forced sex experienced by adolescents with their first sexual partner is a risk factor for adolescents' sexual and reproductive behaviour (Syanemyr *et al.*, 2015:9).

From the above discussion, it is clear that multiple factors influence the sexual behaviour of adolescents. Hence, professional nurses have to deal with many challenges when providing PHC to adolescents who attend public health clinics.

2.8 ACCESS TO HEALTH CARE SERVICES

Ralph and Brindin (2012) as cited by Mason-Jones, Crisp, Momberg, Koech, de Koker, and Mathews (2012:49) state that accesses to healthcare is of great importance concerning policy objectives in many countries as adolescents particularly require access to sexual and reproductive health and mental healthcare. The WHO (2011:1) estimates that worldwide, 11% of adolescents give birth each year. These findings are a clear directive that the barriers to sexual and reproductive health services need to be overcome and access to these services made more easily accessible to adolescents (Mason-Jones *et al.,* 2012:49).

In South Africa, the Constitution provides for the right of access to healthcare services and other health-related rights (South Africa, 1996). In addition to the Constitution, the National Development Plan (NDP) 2030, highlights plan to build a better future for the young people of South Africa. The NDP prioritises policies that will improve the capabilities and life chances of the country's youthful population (South Africa, 2015:2).

One of the goals of DoH is to improve the health status of adolescents by promoting healthy lifestyles, early detection of disease, the prevention of illness, and the improvement of the health care delivery system by focusing on the accessibility of services (South Africa, 2015:13). Indeed, one of the indicators for the success of NAFCI was the increased access and utilisation of public sector clinics by adolescents (Geary et al., 2014:1).

The National Adolescent and Youth Health Policy 2017 aims for a genuine, hands-on approach to health programming. The DOH is obliged to see to the well-being of the youth and recognises all role-players in the advancement of this process. All the various government departments and agencies have a critical role in supporting and contributing to the successful implementation of healthcare programmes. Among the priorities: are adolescent and youth-friendly services; elimination of drug and substance abuse; HIV/AIDS and TB prevention; mental health and illness; sexual and reproductive health, and violence prevention" (Department of Health, 2017).

This policy is essential, as it addresses the needs of adolescents seeking to increase their access to health care services.

According to an Eastern Cape study conducted in Mdantsane by Ndlebe (2011:42), adolescents complained of overcrowding and a lack of privacy at the clinics. The respondents complained that one consulting room was being used by more than two (2) nurses consulting more than one (1) client. Ndlebe (2011:45) found that adolescents were dissatisfied with adolescent reproductive services at Mdantsane clinics, due to inadequate family planning services. The study by Ndlebe (2011:45) furthermore concluded that research data indicated that adolescents were not aware of their reproductive health rights and could not judge whether the services and care they received was of an acceptable standard.

Chandra-Mouli, McCarraher, Phillips, Williamson and Hainsworth (2014:4) suggested there are barriers to obtaining contraceptives, and in some countries, unmarried adolescents may not access contraceptives due to legal restrictions. Even when contraceptive methods are available, certain countries have laws and policies that prevent their provision to unmarried adolescents or those under a certain age, even if there is no restriction. In such countries, health providers may refuse to provide contraceptive information and contraceptive methods to adolescents due to non-approval of premarital sexual activity. Healthcare services supply condoms to adolescents, with the belief that hormonal methods are not suitable for nulliparous women. However, in South Africa, the National Contraception and Fertility Planning policy regard adolescents' contraceptive usage as important concerning the consequences of early childbearing (DoH, 2012:18) and seeks to provide contraceptive services to adolescents.

However, in practice, the study by Mnyanda (2013:17) revealed that existing family planning programs fail to address the needs of the sexually active school-age population. Furthermore, adolescents in the study revealed that adolescents believe that schools are the most convenient place for them to receive contraceptives than clinics, followed by youth centres. Over 50% of research participants felt that the

clinics were not youth-friendly. Furthermore, participants accused clinic staff of being judgmental and cruel and complained about long lines and clinic hours that were not flexible to their times and needs.

Nursing staff should treat all adolescents with equal care and respect, regardless of sex or status. According to a study conducted by Mayeye, Lewis and Oguntibeju (2010:32), more females than males (98% females and 2% of males) visited the clinics to access reproductive health services. The considerable difference between the two gender groups shows that South African society still considers that contraceptive and reproductive services are the sole responsibility of females. Health services traditionally have concentrated on women, and the majority of health-workers are found to be females.

Mayeye, Lewis and Oguntibeju (2010:278) state that health services should be available to all adolescents during the times of the day that is convenient for them. Some adolescents find it difficult to obtain health services if operational hours coincide with times when they are at school, study or work. The results of Mayeye, Lewis and Oguntibeju (2010:278) indicated that adolescents were dissatisfied with accessibility to reproductive health services, for example, “opening hours” were not suitable for adolescents and scored the lowest percentage. Dlamini (2016:32) agreed that accessibility to contraceptives for adolescents is often affected by operational hours of health facilities.

2.9 BARRIERS TO OBTAINING CONTRACEPTIVE METHODS

STIGMATISATION OF ADOLESCENT SEXUALITY

Stigma and discrimination of adolescent sexual reproductive health remain a hindrance for adolescents to access sexual reproductive health care. In some countries, stigma regarding contraceptive usage by adolescents is sometimes frowned upon by adults because adolescents are still young and not having a stable relationship (Chandra-Mouli *et al*., 2014:4). In addition, stigmatisation by health

professionals regarding adolescents’ sexuality causes reluctance in adolescents to use reproductive health services (Branson and Byker, 2018:3). A study by Smith, Marais, Bennie, Nkala, Nchabeleng, Latka, Gray, Wallace and Bekker (2018:677) found that adolescents avoid healthcare services because of both real and perceived barriers which include avoiding interaction with healthcare workers out of fear of being stigmatised.

LACK OF PRIVACY AND CONFIDENTIALITY

Adolescents regard privacy and confidentiality as highly sensitive matters and become reluctant to request contraceptives from health care services if there are concerns about lack of privacy and confidentiality. Results from the study that was done by Mayeye *et al*. (2010:278) also showed that adolescents felt the least satisfaction with confidentiality at the clinics. These negative responses are in line with a study by Smith *et al.* (2018:677) regarding barriers preventing adolescents from accessing reproductive health services which include the lack of privacy, and lack of confidentiality are cited as elements of service delivery that serve to dissuade young people from making use of the clinic services.

NEGATIVE ATTITUDE OF HEALTHCARE WORKERS

The study conducted by Mnyanda (2013:9) concluded that nurses' attitudes could frighten and prevent adolescents from seeking contraceptives. The nurses were uncomfortable about providing teenagers with contraception, as they felt they should not be having sex. Adolescents felt intimidated by the responses of the nurses when requesting contraception; they regarded the reactions of nurses as critical. In a study done in Malawi by Chilinda, Hourahane, Pindani, Chitsulo and Maluwa (2014:1711), it was evident that negative attitudes by healthcare professionals toward adolescents, such as being shouted at, was a barrier to accessing sexual and reproductive health services. Consequences, such as falling pregnant or seeking abortion services by adolescents who were turned away at the healthcare facilities by the health care professionals as a result of unprofessional behaviour (Chilinda *et al*., 2014:1711).

The adolescents' access to SRH is also adversely affected by the negative attitude of healthcare providers when attending to adolescents' sexual reproductive health needs. Therefore, health care providers need to be trained to provide integrated youth-friendly sexual and reproductive health services. The healthcare providers working in youth-friendly services should be approachable, friendly, non-judgemental, and welcoming. Thus, the staff should be specially trained to meet the sexual and reproductive health needs of the youth (Chilinda *et al.*, 2014: 1712).

According to Chilinda *et al.* (2014:1712), healthcare providers, could not fulfil their role in providing sexual and reproductive health care to adolescents as they experienced discomfort in providing the adolescent with contraceptives. The nurses displayed an inability to separate their cultural beliefs from their professional role as a healthcare worker. Adolescents seek health care services that accept adolescent sexuality (Chilinda *et al.*, 2014:1712).

Dlamini (2016:32) agreed that accessibility to contraceptives for adolescents is often affected by the negative attitudes displayed by nurses when adolescents request contraceptives services from the nurses. According to the WHO (2015:1), adolescents often find PHC services as unacceptable because of the perceived lack of respect (WHO, 2015:1).

2.10 ADOLESCENTS' LACK OF KNOWLEDGE OF CONTRACEPTIVES

In a study by Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Myani and Blanchard (2012:283), healthcare providers highlighted that some of the adolescents' levels of knowledge were insufficient as young women do not have enough information about the consequences of sex and the importance on how to prevent pregnancy. Holt *et al.* (2012:288) highlighted poor communication between adolescent girls and their mothers. Therefore, it is necessary that healthcare centres should provide comprehensive sexual education to young people with information according to their age level (Population Reference Bureau, 2017:2).

A Nigerian study found that students' knowledge of the use of condoms was reasonably high (67.5%) while the knowledge of the uses and timing for contraceptive methods was generally poor (Chimah, Lawoyin, Ilika and Nnebue, 2016:186). The above results suggest that these respondents lacked the necessary factual information, particularly from reliable sources, on contraceptive devices. This lack of knowledge might have influenced their use of contraceptives while simple measures such as mobile phones and social media if censored by proper authorities were promising means of increasing contraceptive use among adolescents (Chimah, *et al.*, 2016:186).

Chandra-Mouli *et al.* (2014:4) suggest that the irregular use of contraceptives by adolescents is a result of a lack of understanding of how contraceptives work. Furthermore, adolescents are misguided by their peers about the long-term side effects of family planning methods, believing that their health will be affected and that may result in them not conceiving in the future. A study conducted by Muanda *et al.* (2018:5), in the Democratic Republic of Congo, revealed that although both males and females had some knowledge about contraceptive methods the lack of information and misinformation about contraceptive methods were indicated as barriers to contraceptive usage.

A South African study conducted, in Taung, by Kanku and Mash (2010:569), revealed that adolescents had inadequate knowledge about contraceptives and reproductive health. The study suggested that peer education should be prioritised in rural areas as adolescents in these areas cannot easily access information through the internet and many times solely rely on parents, schools, initiation schools and healthcare workers for information on sexual and reproductive health.

Chersich, Wabiri, Risher, Shisana, Celentano, Rehle, Evans, and Rees (2017:312) conducted a research study in South Africa and findings revealed that their peers wrongly informed adolescents regarding contraception especially among the age group of 15-19 years old. The great concern was whether the integrated school health policy was implemented effectively in schools. Legally, anyone aged ≥12

years has the right to receive contraception without parental consent. The provision of contraceptives at school is essential, and according to the Department of Basic Education, the implementation of the HIV, STI and TB policy does not reside with the school governing body (Department of Basic Education, 2017: xi). Skrzeczkowska *et al.* (2015:148) found that adolescents consider both the internet and their peers the primary sources of information about sexuality, family planning or birth control methods.

2.11 PARENT ADOLESCENT RELATIONSHIP

Branje (2018:171) states that the parent-child relationship becomes strained during adolescence. Leading to conflict as adolescents seek independence from parents. Parents believe that they are “protecting young people from information that they believe may lead to sexual experimentation” (Mudhovozi *et al.*, 2012:121). However, rather than showing that sexual communication between parents and children encourages sexual activities, research has shown how “young people who openly communicate about sexuality with their parents, especially mothers, are less likely to be sexually active, or girls, become less likely to fall pregnant before marriage” (Mudhovozi *et al.*, 2012:122).

A study by Makhitha *et al.* (2017:511) revealed a breakdown in communication and support between parents and their adolescent children on sexual topics. Furthermore, adolescents did not even trust or believe in their teacher's ability to prevent or intervene in sexual activities at school. The adolescents only believed in the social workers and felt that they were more equipped than the teachers to deal with sexual issues. Therefore, they preferred that a social worker should support them immediately after their sexual transgression.

According to De Klerk (2015:8), sex outside of marriage has become standard behaviour of adolescents rather than the exception. Adults and especially parents, maintain the idea that increased availability and increased knowledge of contraceptives will influence adolescents to engage in riskier sexual behaviour or inspire them to initiate sex. However, evidence shows a link between the availability

of family planning and better contraceptive usage behaviour. School-based clinics seem to increase the use of contraception. Sexually active school-going women are 1.7 times more inclined to use contraceptives than their same-aged peers.

Yadeta, Bedane and Tura (2014:102579) indicated that the consequence of uninformed adolescent sexual conduct could be detrimental to both the adolescent and for society. The problem is not that adolescents are sexually active but rather that they are inadequately prepared and guided in developing responsible sexual behaviours. The family, as the important protector factor of other behaviours, is not powerful in determining adolescents' sexual behaviour because of the socio-cultural, religious beliefs and sense of morality obstacles affecting discussion of sexual and reproductive health issues with their adolescent children.

2.12 IMPROVING ACCESS TO CONTRACEPTIVES

Research conducted by Cooper, Morroni, Orner, Moodley, Harries, Cullingworth and Hoffman (2004:70) indicated, that ten years after the inception of democracy in South Africa, that South Africa has a high contraceptive usage compared to other African countries in the region. Cooper *et al.* (2004:70) conceded that despite all the advances that South Africa struggles with the optimal implementation of services. A more recent study conducted by Savage-Oyekunle and Nienaber (2015:548) state that a disconnect arose between sexual and reproductive policies and the implementation thereof. The study further concludes that especially adolescents do not receive adequate information or services. Willan (2013:55) in her study expressed the importance of staff, facilities, and the availability of contraceptives to be acceptable, accessible, and suitable for adolescents. Furthermore, the study recommends that healthcare providers should receive frequent training in order to provide current and comprehensive information and services. Willan (2013:55) suggests that healthcare staff should treat adolescents confidentially and respectfully irrespective of their religion or cultural beliefs. A study conducted in Nepal found that many adolescents in rural areas exclusively relied on government health service to provide sexual health information and through creating a youth-

friendly environment at healthcare facilities it encouraged adolescents to utilise the services (Regmi, van Teijlingen, Simkhada and Acharya, 2010:624).

2.13 CHAPTER SUMMARY

The discussion in this chapter provides an overview of the main objectives of the study as stipulated in section 1.3. The chapter is divided into the section dealing with the different aspects of adolescent contraceptive usage and provided a comprehensive investigation of actual and perceived barriers in obtaining contraceptives. This chapter concludes by stating that the experiences of contraceptive usage by adolescents are similar across the world.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter, the researcher explored the literature as it refers to adolescents regarding their use of contraceptives by undertaking a comprehensive traditional literature review. Chapter three is concerned with the discussion of the research design and research methodology. According to Mills and Birks (2014:259), the methodology is a set of principles and ideas that inform the design of a research study of practical procedures, strategies and processes used to generate and analyse data. Silverman (2015:454) states that methodology refers to the choices we make about appropriate models, cases to study, methods of data gathering, forms of data analysis in planning and executing a research study. The study aimed to explore and describe the experiences of adolescents attending community health centres in Buffalo City Health District regarding their use of contraceptives. The findings of the study will be used to make recommendations to the district health office and facility managers at community health centres in the Buffalo City Health District regarding care and support of adolescents concerning their use of contraceptives.

3.2 RESEARCH DESIGN

Research design refers to the overall plan for obtaining answers to the research questions, including specifications for enhancing the study's integrity (Polit and Beck, 2012:58). According to Grove *et al*. (2015:211), a research design is a blueprint for conducting a study. Gray *et al*. (2017:676) state that research design is the choice of the researcher to best answer a research question, concerning several considerations, including the number of subject groups, the timing of data collection, and research interventions. The following section describes the research design used in the study. The researcher conducted a qualitative, explorative, descriptive, and contextual study on female adolescents at three (3) community health centres in the Buffalo City Health District.

3.2.1 Qualitative research

Qualitative research is a scholarly and rigorous approach used to describe life experiences, cultures, and social processes from the perspective of the persons involved (Gray *et al.,* 2017:689). De Vos, Strydom, Fouché and Delport (2011:308) state that qualitative research is concerned with understanding rather than explanation and seeks to explore reality from the perspective of an insider. Denzin and Lincoln (2011:3) define qualitative research as the study of things in their natural settings, and it focuses on the experience of an individual and their interpretation and understanding of the experience. Grove *et al*. (2015:20) state that qualitative research evolved from the behavioural and social sciences as a method of understanding humans. The qualitative researcher believes that there are many different interpretations of reality, and these interpretations lie within each individual (Houser, 2015:36); therefore, experiences of a phenomenon differ from person to person. The researcher aimed to generate an understanding of the subjective experiences of female adolescents on contraceptive use. Qualitative researchers also argue that there are many different experiences of reality and that all of them are right (Houser, 2015:33).

The research focused on the experiences of adolescents who attend public community health centres regarding their use of contraceptives. The researcher explored and described their experiences in order to understand the phenomenon of interest better.

3.2.2 Explorative research

Gray *et al*. (2017:678) state that explorative research strives to increase the knowledge of a field of study and is not intended for generalisations too large populations; it provides the basis for confirmatory studies. This design is, therefore, appropriate when a topic is studied where no theory exists or when a researcher does not know what constructs are appropriate or how to measure essential variables (Maree, 2016:317). The research was conducted using an exploratory

design in order to understand the experiences of adolescents regarding their use of contraceptives.

3.2.3 Descriptive research

A descriptive research design was used, as the researcher wanted to describe the variables of interest as they naturally occurred (Botma, Greeff, Mulaudzi, and Wright, 2010:110). The purpose of a descriptive research design is to paint a picture of situations as they happen in their natural environment. Gray *et al*. (2017:200) state that descriptive research is conducted in a natural setting to answer a research question related to an incident, the prevalence of a phenomenon of interest and its characteristics. A descriptive design was used to describe in detail the experiences of selected participants regarding the use of contraceptives (Houser, 2015:138). This design was appropriate to the study as the researcher sought to describe the experiences of adolescents in order to make recommendations to the relevant stakeholders.

3.2.4 Contextual research

Holloway and Wheeler (2010:41) referred to context as the environment and conditions in which the study took place as well as the culture of the participants and location. Awareness of context contributed to the meaningful and appropriate interpretation of data and to understand the relationship between structure and process (Bazeley, 2013:81). According to Ritchie, Lewis, Nicholls and Ormston (2014:31) contextual research is concerned with identifying what exists in the social world and the way it manifests itself. The researcher looked to investigate and capture interpretations of the phenomenon of contraceptive usage, as experienced and understood by participants in a natural setting where the event of interest took place.

The study used a contextual design and conducted at three community health centres in the Buffalo City Health District. The Buffalo City Metropolitan Health District consists of five community health centres, of which three community health centres render youth-friendly services. The researcher interviewed a selection of

adolescents attending these three (3) centres. These health centres are located in East London and Mdantsane areas, which serve a predominantly Xhosa and Afrikaans speaking community.

3.3 POPULATION

Brink and van Rensburg (2012:123) define a population in research as the entire group of persons or objects that are of interest to the researcher, or that meet the criteria the researcher was interested in studying. The population is, according to Gray *et al*. (2017:687), a particular group of individuals or elements who are the focus of the research. The researcher defined the population in this study as all female adolescents using contraceptives.

The target population for this study included all females between the ages of 13 and 19 years and of all socioeconomic backgrounds and attending community health centres in the Buffalo City Health District. Female adolescents requesting sexual and reproductive health services at community health centres in the Buffalo City Health District were identified as the population for the study.

The inclusion criteria were:

- All female adolescents in the age group of 13 to 19 years attending community health centres and who requested PHC services.

The exclusion criteria were:

- All pregnant female adolescents who were requesting antenatal care and termination of pregnancy services.

3.4 RESEARCH SETTING

The study was carried out in the Buffalo City Metropolitan Municipality situated on the east coast of the Eastern Cape Province, South Africa. This area includes the towns of East London, Bhisho and King William’s Town, as well as the large townships of Mdantsane and Zwelitsha. Buffalo City Municipality contains one tertiary hospital, one regional hospital, three district hospitals, four community health-care centres and 101 clinics. The researcher chose Buffalo City Metropolitan

Municipality because it comprises urban and rural areas. This study was carried out at three community health care centres.

3.5 SAMPLING

Sampling is the process of selecting elements from the population to be studied (Gray *et al*., 2017:44). Flick (2015:106) states that sampling refers to strategies that allow generalisation from the sample to the population because the sample is representative of the population. Silverman (2015:455) states that sampling is a statistical procedure for finding cases to study; it allows the researcher to estimate the representatives of the case studied and thereby the degree of confidence in any inferences you draw from them. The researcher incorporated both purposive and convenience sampling in this study. Purposive sampling was used to select the community health centres, and convenience sampling was used to select the participants.

According to McBride (2012:114), the purpose of sampling is usually to study a representative subsection of a precisely defined population in order to make inferences about the whole population. The researcher did purposive sampling to select community health centres because she wanted to include community health facilities that specifically offer adolescent-friendly services. Purposive sampling was used to especially select the community health centres that met particular research goals of the research study (Bazeley, 2014:49). Gray *et al*. (2017:689) state that purposive sampling involves the conscious selection of particular subjects or elements to include in a study; it is a type of non-probability or non-random sampling.

Convenience sampling was used to select adolescents because adolescents who used contraceptives are a difficult population to access. Convenience sampling is a non-probability sampling procedure that involves the selection of the most readily available people or objects for the study (Brink, van der Walt and van Rensburg, 2015:210). Gray *et al*. (2017:343) state that when incorporating convenience study, subjects are included in the study because they happen to be in the right place at the right time. This refers to an approach in which selection is made purely based

on who was available. Sampling size refers to the number of people who participate in a study (Polit and Beck, 2012:742). The size depended on how soon data collected was saturated. Altogether, 14 participants took part in the study.

3.6 INTERVIEW GUIDE

Instrumentation is a component of measurement in which specific rules are applied to develop a measuring device or instrument (Burns & Grove, 2009:539). Speziale and Carpenter (2007:22) indicate that "the researcher as instrument is another characteristic of qualitative research". The researcher has a very important role to play as an observer, interviewer or interpreter. There is a belief that the researcher's contribution to the investigation has the potential to add to the richness of data collection and analysis. In this study, a semi-structured interview guide was used to guide the researcher in conducting the interviews (see Annexure 1).

3.7 PILOT STUDY

The researcher conducted a pilot study before data collection. The purpose was to test the methods and procedures of the study before actual implementation (Houser, 2012:306). A pilot study is a smaller version of a proposed study that was conducted with the same research population, setting, interventions, and plan for data collection and analysis, to determine the effectiveness of methods in locating and consenting subjects (Gray *et al*., 2017:686). The researcher was able to test the feasibility of the proposed study, as well as determining whether questions asked provided appropriate responses from participants.

The pilot study was conducted on one participant, no problems were identified, the participant understood the questions and gave relevant information regarding the experiences of adolescents regarding their use of contraceptives. This interview was not included in the main study. More importantly, the pilot study provided the researcher with an understanding of the meaning that the phenomena had for the people involved, and the perspectives that informed their actions (Maxwell, 2013:67). The researcher provided the research study supervisors with a copy of

the transcribed interview for comments on the quality of the interview and the interview skills of the researcher.

3.8 DATA COLLECTION

According to Gray *et al*. (2017:256), data collection is complex because it coincides with data analysis, it is a precise, systematic gathering of information that is relevant to the purpose, objective and research question. The choice of a data collection method is in relation to the aims and objectives of the study and the research question (Houser, 2015:219). Data collection is a process of gathering data in which the researcher has limited influence on the data source, such as occurs when data is extracted from static materials such as documents and literature (Mills *et al*., 2014:257). Prior to data collection, the researcher submitted her proposal to the Department of Nursing Science's Research Committee (DRC) followed by the Faculty of Health Science's Post-Graduate Studies Committee (FPGSC) for ethical approval and thereafter the Research Ethics Committee (Human). Ethical approval was granted by the Research Ethics Committee (Human) to obtain ethical clearance. The researcher also obtained permission from the Department of Health before conducting the study. Thereafter, she requested permission from the facility managers of the identified healthcare centres, and after that, the professional nurses allocated to provide adolescent-friendly services were approached to act as gatekeepers to obtain access the adolescents. Quiet rooms in the community health centres were identified as suitable venues for the interviews.

Adolescents over the age of 18 years did complete a consent form while those under 18 needed to complete an assent form. Consent was not obtained from the parents because many adolescents attended community health centres without their parents' knowledge. According to the Children's Act no 38 of 2005, which came into effect on 1 July 2007 states that females over 12 may legally acquire contraceptives without parental consent (South Africa, 2005). The researcher was of the opinion that if the adolescent has to obtain parental consent, they would refuse and not return given the sensitive nature of the interview topic. Hence, the gatekeeper had to ensure that the potential participants were fully informed. A gatekeeper, according

to Silverman (2015:453) is someone who can grant or deny access to participants in the field. Once the participants had agreed to participate, they completed the consent and assent form (Annexure 2). Participants were accessed at the community health centre. Next, the researcher scheduled appointments for interviews with the participants. The sampling size was 14 participants, and sampling continued until data saturation was reached. Probing was done according to the responses of the participants.

Semi-structured interviews were used in this study to allow participants time and scope to obtain information regarding the researched phenomenon. The researcher posed specific open-ended questions to participants and followed this step by further probing and clarification (Maree 2016:93). Grove *et al.* (2015:512) state that semi-structured interviews have a fixed set of questions and no fixed responses. These were used to obtain a clear idea of the participants' experiences of, or beliefs about a particular topic. A semi-structured interview has a set of predetermined questions, which did not dictate but rather guided the interview process (De Vos, *et al.* 2011:351-352). The researcher designed an interview schedule in order for the researcher to allow time for participants to talk during and after interviews. The researcher used the schedule to prepare for the interviews.

Using an interview schedule assisted the researcher in considering the degree of mental concentration that was required for both researcher and participant. Before the commencement of interviews, each participant was requested to sign an informed consent. The researcher assured participants that their participation was voluntary, and they could withdraw at any stage they wished. Voluntary consent also implied that participation was done out of free will and without coercion or any undue influence (Gray *et al.*, 2017:696). Brinkmann and Kvale (2015:365) state that informed consent implies informing research participants about the overall purpose and design of an investigation and obtaining their consent to participate. Participants received information regarding the research study in writing, and this was followed up by a verbal explanation. The use of digital recorders for information storage was explained to the participants. The researcher obtained consent from participants to

record the interviews. During interviews, the digital recorder was placed in an unobtrusive position. The researcher posed the interview questions to participants in their everyday language (Brinkmann and Kvale, 2015:365). Confidentiality was mantained throughout the interviews. The information and identities of all participants contained in this research study were dealt with in the strictest of confidence. Anonymity was maintained by using codes not by names to prevent possible maleficience to the participants.

The interview questions for the study were as follows:

a. Tell me how it has been for you to use contraceptives?

b. Tell me how you have experienced the services at the community health centre regarding contraceptive advice and support?

The interviews took place at the community health centres immediately after PHC services had been rendered to the participant. The interviews were conducted in privacy and where participants felt secure in the environment (Grove, Burns and Gray, 2013:83). Throughout the interview, the researcher took descriptive field notes. After the interviews, the researcher documented what she saw, heard, experienced and thought throughout the interviews (De Vos *et al*., 2011:359).

3.9 DATA ANALYSIS

The aim of data analysis, according to Streubert and Carpenter (2011:47), is to highlight the experiences of the participants by sharing the richness of their experiences. It was the researcher's responsibility to describe and analyse the raw material presented to them and bring to life the phenomenon under investigation (Streubert and Carpenter, 2011:47). Data analysis usually involved a process of labelling, organising and interpreting data concerning a set of codes, concepts, categories, or themes (Ritchie *et al*., 2014). According to Gray *et al.* (2017:675), qualitative research is the reduction and organisation of data, and revelation of meaning. Creativity and deep thoughts may produce innovative views to analyse the data, but the process requires discipline to develop data analysis plans consistent with the specific philosophical method of the study (Grove *et al.,* 2015:88). Data analysis is the application of techniques in the treatment of generated and collected data to achieve research outcomes (Mills *et al*., 2014:257).

Generally, qualitative data analysis is not a distinct step in qualitative research studies process but rather is done concurrently with data collection (Brink *et al.*, 2015:193). In this study, data analysis was done, and the researcher developed categories according to Tesch's eight-step method, that is:

- A careful reading of data and jotting down ideas coming to mind.
- Picking the most interesting/ shortest interview to sense its underlying meaning. Thoughts may be written on the margin.
- Topics can be coded next to appropriate segments of the text.
- Grouping the topics, turning them into categories that relate to each other.
- A final decision is made on the abbreviation of these codes for each category.
- Data material belonging to each category is assembled in one place.
- A preliminary assessment is done.
- Lastly, the recording of existing data (Creswell, 2014:198).

Data analysis started with the transcribing of the interviews by the researcher. The researcher then familiarised herself with the raw data that was transcribed by reading through it a number of times as well as listening to the tape-recorded interviews. The researcher took field notes in addition to the transcribed data, to capture contextual issues and nonverbal responses (Houser, 2015:412). From the raw data, the researcher then identified common themes, while the newly collected data were compared to the existing data to determine which themes were supported or not supported by the emerging information. This constant comparison enabled the identification of saturation when it occurred (Houser, 2015:412-413). The identified themes and sub-themes were grouped, coded, and sent to an independent coder for review.

3.10 TRUSTWORTHINESS OF THE STUDY

Trustworthiness refers to the employment of procedures to ensure the accuracy and authenticity of findings (Brink *et al.*, 2015:171). Grove *et al.* (2015:513) state that the strength of a qualitative study should be determined by evaluating all study aspects. The following section determined the trustworthiness of this study.

3.10.1 Credibility

Grove *et al.* (2015:502) suggest that credibility is the confidence of the reader about the extent to which the researcher had produced results that reflected the views of the participants. The credibility of a research project is achieved when those that read the study findings believe that the presented data is an accurate reflection of the participants' perceptions, experiences or beliefs. Credibility talks about the confidence in the truth of the data and the interpretation thereof. The investigation must be done in such a way that the findings demonstrate credibility; in other words, that the reader will believe them (Brink *et al.*, 2015:172). Confidence in this study was established through peer review, whereby the researcher sought colleagues who were experts, in either the method or the phenomenon under investigation (Brink *et al.*, 2015:172).

3.10.2 Dependability

According to Streubert and Carpenter (2011:49), dependability cannot be achieved before achieving credibility. De Vos *et al.* (2011:420) state that with dependability the researcher attempts to account for the changing conditions in the chosen phenomenon as well as changes in the design that is a result of a refined understanding of the setting. Dependability also refers to documentation of the steps taken and decisions that were made during qualitative analysis (Grove *et al.*, 2015:502). The researcher reviewed other literature in order to identify other studies that supported the findings of the research.

3.10.3 Transferability

Transferability refers to the probability that the research findings have meaning to others in similar situations. Maree (2016:124) states that unlike generalisability, transferability does not invite generalised claims, but invites readers of research to make the connection between elements of a study and their own experience or research. If a study adheres to the concept of transferability, other researchers will be able to adapt the study findings to suit their context (Streubert and Carpenter, 2011:48). The researcher enhanced the transferability of the study by carefully maintaining all data transcripts, analysed data records, audio recordings and the independent coder's analysis.

3.10.4 Confirmability

According to Houser (2015:393-395), confirmability occurred when the researcher strived to increase objectivity by eliminating bias. The researcher maintained the conformability of the study by taking notes throughout the research process, by bracketing, reflexivity and triangulation (Houser, 2015:394) and by using field notes, interviews and literature. Confirmability is concerned with establishing whether the data represented the information provided by the participants and that the interpretations were not fueled by the researcher's imagination or own understanding thereof. Multiple experiences from the various participants were used to collect and interpret data regarding the phenomenon to converge on an accurate representation of reality (Brink *et al.*, 2015:218). The researcher achieved confirmability by maintaining field notes, utilising bracketing and continually reflecting on the research process through reflexivity.

3.11 ETHICAL CONSIDERATIONS

The Faculty of Health Science's Post-Graduate Studies Committee (FPGSC) granted ethical approval. The researcher obtained ethical approval from committee, reference number [H16-HEA-NUR-013]. The DoH, district manager for Buffalo City and facility managers, also granted permission to conduct the study before the study commenced.

Researchers have a responsibility to conduct research ethically. Therefore, state, and national regulations, as well as international and professional codes, have been developed for regulation (Bazeley, 2013:51). Ethics is concerned with matters of right or wrong. The possible impact on people participating in the research study, their roles and responsibilities as a researcher are brought into focus (Bazeley, 2013:51). Therefore, three fundamental ethical principles relevant to the ethics of human subjects was considered by the researcher and implemented throughout the research process. The principles of respect for persons, beneficence and justice guided the researcher throughout this study (Houser, 2015:52).

3.11.1 Respect for persons

Respect is an ethical principle that indicates that persons have the right to self-determination and the freedom to participate or not participate in research (Gray *et al.*, 2017:691). Respect for persons incorporates two ethical convictions. Firstly, individuals should be treated as autonomous beings capable of making their own decisions and secondly, that persons with diminished autonomy should be protected (Houser, 2015:52). Autonomy means that these individuals will have the freedom to make choices, and their rights will be respected (Green and Thorogood, 2011:76).

The participants in this study, namely female adolescents, were shown respect throughout the study, beginning with the provision of an information letter and a consent form (Brink *et al.*, 2012:38). It was made clear to them that they were free to withdraw from the study at any time and without any repercussions. They were given opportunities to ask questions for clarity. The researcher explained the goal and the procedure of the research to the participants verbally, as well as in writing. After the researcher obtained consent and assent for the interviews, the researcher re-explained the goals and procedures of the research to the participants as well as what type of information the researcher required from the participants. The consent form used by the researcher can be viewed in Annexure 2.

3.11.2 Beneficence

Beneficence requires that researcher to do good and no harm physically or emotionally. In order to ensure the principle of "doing good" and not inflicting any harm, the researcher will seek to respect the participants' decisions and to ensure their well-being (Houser, 2015:53). Gray *et al.* (2017:672) state that this ethical principle compels the researcher to actively strive to do good and confer a benefit, concerning the participants and do no harm.

The researcher ensured that participants were not subjected to fear; their decisions to participate or to withdraw at any stage was respected. Any risks of economic constraints (such as transport costs) were addressed timeously to avoid possible stressors for the participants. For instance, as far as possible, the participants were interviewed when they attended the community health care centre for their health needs. The researcher reminded participants that they might experience emotional upset when reliving earlier experiences and assurance was given of the availability of counselling by either the psychologist or mental health practitioners at the community health centre.

3.11.3 Justice

The third principle of justice incorporated the participants' right to fair treatment and fairness in the distribution of benefit and burden (Houser, 2015:53). The researcher may not take advantage of underprivileged persons in order to benefit those who are privileged. Thus, the selection of participants should be fair and unbiased (Houser, 2015:52). Gray *et al.* (2017:682) state that human subjects should be treated fairly, as groups and as individuals. None of the study participants was excluded from participating in the study based on race, language, age and socio-economic status. All the participants were interviewed using the same interview questions.

3.12 DISSEMINATION OF RESULTS

A well-conducted and well-analysed research project is meaningless if no one never hears about it. Thus, proper communication that informs the selected audience as clearly and as accurately as possible about the research project is vital (Brink 2012:198). A research report was compiled to communicate the process that the researcher followed, and the findings that emerged from the research. A summary of the research report will be communicated to the provincial DoH, the Buffalo City Health District Manager and Nurse Managers at the community health centres where the study was conducted. The researcher will submit an article to a journal for publication.

3.13 CHAPTER SUMMARY

This chapter provided a detailed description of the research design and the research methods used in this study. Measures were taken to ensure the trustworthiness of the study and the researcher discussed the various ethical standards of data collection. Chapter Four will present data analysis and literature control.

CHAPTER FOUR

DATA ANALYSIS AND FINDINGS

4.1 INTRODUCTION

In Chapter Three, the researcher described the research design and methods of the study. In this chapter, the researcher will discuss the data collection and analysis processes, followed by the characteristics of the participants and a discussion on the identified themes which addressed the research question. The themes identified will be discussed separately with an in-depth explanation of the relevant identified sub-themes. Each theme and sub-theme discussed will be supported with relevant quotations from the participants during the data collection process. In addition, a literature control was used to substantiate the themes and sub-themes of the study. All findings presented served to answer the following research question for this study: What are the experiences of female adolescents regarding contraceptive usage?

4.2 OPERATIONALISING OF DATA ANALYSIS AND LITERATURE CONTROL

The following section will discuss the operationalising of data analysis and the implementation of the literature control.

4.2.1 Interviews

The researcher conducted semi-structured interviews with 14 voluntary participants. The 14 participants interviewed all met the inclusion criteria for this research as described in chapter three, namely that all participants had to be female adolescents in the age group 13 to 19 years attending community health centres and who requested primary health care contraceptives.

4.2.2 Literature Control

Literature control entails researchers comparing their findings with those of published findings (De Vos *et al.*, 2011:298; Polit and Beck, 2008:106). Literature control is the procedure whereby the researcher uses literature during data analysis to build a structure related to the outcomes of similar studies done previously, before interpreting the findings of their study (De Vos *et al.*, 2011:238). A literature review provides the researcher with current theoretical and scientific knowledge about the event of interest, assisting the researcher in identifying what is known and what is unfamiliar about the event in order to understand the need for conducting such research thoroughly (Burns and Grove, 2011:189).

4.2.3 Demographic profile of the participants

Fourteen (14) participants who took part in the study. Their ages ranged between 16 and 19 years. Altogether seven (7) participants were African and seven (7) participants Coloured. The educational status of the participants ranged from Grade 8 to Grade 12. Table 4.1 presents the demographic background of the participants.

Table 4.1: Demographic profile of participants

Participant	Age	Population	Educational Status
1	19 years	Coloured	Grade 11
2	18 years	Coloured	Grade 9
3	16 years	African	Grade 8
4	17 years	African	Grade 10
5	18 years	African	Grade 11
6	17 years	Coloured	Grade 11
7	19 years	African	Grade 11
8	19 years	Coloured	Grade 10
9	17 years	Coloured	Grade 10
10	18 years	Coloured	Grade 10
11	19 years	African	Grade 11
12	19 years	Coloured	Grade 12
13	18 years	African	Grade 12
14	18 years	African	Grade 12

The researcher conducted individual interviews with adolescents who were willing to participate in face-to-face interviews. The researcher used a tape recorder during the interviews and transcribed the tapes verbatim and conducted semi-structured interviews with 14 voluntary participants. The data collection stopped when the researcher achieved saturation of information about the experiences of female adolescents' contraceptive usage. The researcher performed data analysis in accordance with Tesch's (1990) approach through the open coding method, as cited in Creswell (2014:186).

4.3 DISCUSSION OF THEMES

Following data analysis, three main themes emerged. Table 4.2 shows the three themes and the accompanying sub-themes. The three themes were: female adolescents encountered barriers to accessing contraceptive services, female adolescents experienced clinical, and community support regarding contraceptive usage and female adolescents provided recommendations regarding the optimisation of contraceptive usage.

Table 4.2.: Identified themes and sub-themes

THEMES	SUB-THEMES
1. Female adolescents encountered barriers to accessing contraceptive services	1.1. Female adolescents highlighted challenges related to accessing contraceptives at clinics.
	1.2. Some female adolescents described a lack of family support regarding contraceptive usage.
	1.3. Female adolescents expressed a range of negative emotions regarding the consequences of not using contraceptives.
	1.4. Some female adolescents experienced side effects using contraception.
	1.5. Female adolescents felt that nurses do not always provide quality care.
2. Female adolescents experienced clinical and community support regarding contraceptive usage.	2.1. Some female adolescents experienced receiving patient-centered, holistic care from clinic nurses
	2.2. Some female adolescents received health education regarding contraceptive usage from nurses and life orientation teachers.
	2.3. Some female adolescents experienced a degree of family support regarding contraceptive usage.
3. Female adolescents provided recommendations regarding the optimisation of contraceptive usage	3.1. Female adolescents called for an increase in reproductive health education at clinics/hospital.
	3.2. Female adolescents expressed the need for regular school involvement regarding contraceptive usage.

4.3.1 THEME 1: FEMALE ADOLESCENTS ENCOUNTERED BARRIERS TO ACCESSING CONTRACEPTIVE SERVICES

Female adolescents highlighted challenges related to accessing contraceptives at clinics. Some healthcare providers do not supply adolescents with contraceptives and contraception information. According to Chandra-Mouli *et al*. (2014:4), some healthcare providers do not support premarital sexual activities.

Some female adolescents described a lack of family support regarding contraceptive usage. The family is the main socialiser in households, is not influential enough in shaping adolescents' sexual behaviour because the socialisation is influenced by socio-cultural, religious beliefs and sense of morality barriers which affects discussion of sexual and reproductive health issues with their adolescents (Yadeta, Bedane and Tura, 2014:1). A study conducted by Makhitha and Botha (2017:511) revealed that teenagers cited lack of communication, lack of support and information from parents on sexual issues and that teachers were not competent to prevent or intervene in sexual activities at school.

The study identified the negative attitudes of some healthcare providers as one of the barriers to accessing sexual reproductive health services. When healthcare providers display negative attitudes towards adolescents, it may have severe consequences for the life of adolescents. As evidence from the study conducted by Hung (2010:102-110) indicated that many adolescents were driven away from the health facilities when they requested contraceptives, and the consequences thereof resulted in pregnancy which sometimes leads to them utilising unsafe abortion services (Chilinda, Hourahane, Pindani, Chitsulo, and Maluwa, 2014:1711).

4.3.1.1 Sub-theme 1.1: Female adolescents highlighted challenges related to accessing contraceptives at clinics

Many of the participants indicated that they often encountered long queues when they were attending the clinics. The long queues were said to cause long waiting

times, which sometimes led to the adolescents becoming impatient and walking away before having a consultation with the clinic nurse. The responses from participants regarding long queues were as follows:

"Queues are very long at times and makes us feel disappointed some of us end up leaving without getting seen because we did not want to wait" (Participant 2, page 8, line 246).

"*Because when learners come out of school, they wait and wait and wait in queues because the nurses must see other patients also."* (Participant 11, page 1, line 937)

The research supports the findings in the study by Masango-Makgobela *et al*. (2013:2) who indicated that long queues and long waiting times are a problem in most public-sector PHC services. Therefore, according to the National Core Standards, waiting times and queues should be managed to improve patient satisfaction and care (Department of Health, 2011:18). Among the recommendations made by the WHO (2012:33) was the rendering of accessible adolescent-friendly health services to the youth, as adolescents, in general, find it difficult to obtain health services during regular working hours. Therefore, it is recommended that healthcare services should be made available at times that are more convenient for adolescents. In this study adolescents raised their concerns regarding the long queues and long waiting times especially attending clinics after school, resulting in some of those adolescents who came specifically for family planning leaving the clinic without being attended to. A study conducted by Godia, Olenja, Lavussa, Quinney, Hofman, and van den Broek (2013:9) revealed that the impatience of adolescents was the reason why they did it wait at healthcare facilities. Long waiting times is one of the main barriers perceived by adolescents and may be a contributing factor for adolescents defaulting on contraceptives.

Participants were also unhappy that there was only one queue that was serving family planning clients and sick patients. They felt that there should separate queues for family planning clients and sick patients.

"All young people there were sick and were coming for treatment, others were HIV positive, and we were all together even those that wanted family planning (Participant 6, page 16, line 489)

"The line can be very long because there are sick people, and others come for their HIV pills." (Participant 4, page 13, line 378)

"In the line, it is not only family planning people; there are sick people and sick children." (Participant 7, page 19, line 589)

Some adolescents were attending the clinic for contraceptive methods only and were unhappy to wait in lines with other sick patients. They felt that facilities should not restrict adolescents from accessing reproductive health care services by combining sick patients with adolescents who were seeking contraceptives. However, Chandra-Mouli *et al.* (2014:5) support the integration services since it could be the first appropriate moment for adolescents to obtain information on contraceptive methods from health professionals. The integration of services is supported Matzos (2016:1) who disagreed with the idea of separate queues as voiced by the female adolescents because the critical focus of PHC is to deliver integrated care to patients with chronic and acute diseases or whoever comes for preventative services. The adolescents observed sick patients queuing with the adolescents who were only attending to receive contraceptives. Hence, the adolescents felt this was one of the reasons why the queues were long. However, it appears that regardless of the circumstances of long queues and long waiting times, some authors disagree with separate queues, as they feel that integrated services are required. The National Adolescent and Youth Health Policy revealed that the sexual and reproductive health services had previously attended to sexuality issues

exclusively. The needs of youth with disabilities, chronic or acute illnesses and adolescents exposed to risky sexual relationships were not met; hence integration enables recognition of all challenge's adolescents encounter, strengthening referrals to social workers and could include sexual partners in counselling sessions (DoH, 2017).

Many participants stated they found the clinic times to be inconvenient. Most adolescents are learners based at secondary schools, so it is difficult for them to attend clinics in the mornings. The participants suggested that the clinic opening times sometimes caused them to miss classes if they were permitted to attend the clinic during the morning session because the waiting times were so long. The only suitable time for them to visit clinics for contraceptives was in the afternoon, as the participants were at school in the mornings. However, they argue that there is limited time for them to receive attention during the afternoon because the clinics close at 16:30. It has been argued that healthcare services should be accessible at a time that is suitable for young people, such as late afternoons, evenings, and weekends (MietAfrica, 2011:13). Participants expressed the problem as follows:

"So even if we ask permission at school to get our injection, we cannot get back to school on time. (Participant 7, page 20, line 599)

"…it is always full, especially in the afternoon because one doesn't get a chance to go during the day to the clinic as young students…" (Participant 2, page 7, line 232).

Dlamini (2016:32) agreed that accessibility to contraceptives for adolescents is often affected by operational hours of health facilities. Jonas *et al.* (2018:9) found that clinic hours are not suitable for adolescents; it needs to be extended by at least 30 minutes to an hour to provide for adolescents who finish school at 15:00 and have to travel to the clinic. In Jonas *et al.*'s study adolescents also found that accessibility to contraceptives was affected by operational hours, they also experienced

challenges attending the clinic in the mornings since school-going adolescents are attending classes during the morning. Short and rigid clinic hours that are from Monday to Friday, 07:30 or 08:00 to 16:00 or 16:30 reduces the availability of health care services especially to school-going adolescents who attend health care services after school hours. Due to the numbers of adolescents visiting healthcare centres during the afternoon, waiting times increase, and not all adolescents can receive service. However, it could be argued that adolescents might use the opening hours simply as an excuse for their non-attendance at the clinics.

Participants observed that the clinics often only have one (1) sister who is attending to the adolescents, despite the clinics being very busy. Hence, the adolescents concluded that staff shortages were evident. Therefore, adolescents felt the queues were long due to staff shortages, and they would often leave the clinic because they did not have the patience to wait. Responses from participants:

"It does happen at times that we leave without being helped, that's when there is one nurse sometimes, you get one nurse having to attend to everybody, and I am sure that it is also a lot for that nurse" (Participant 2, page 7, line 236).

"It is a busy clinic, but it has only one nurse which creates a problem…" (Participant 9, page 25, line 744)

"The nurses sometimes come and explain to us that there is only one nurse that will be doing the family planning. They are a bit slow at the clinic; I wish they can speed up the process." (Participant 5, page 14, line 439).

According to Masango-Makgobela *et al*. (2013:2), the shortage of healthcare providers is one of the causes of long waiting times in South Africa. A study exploring the work experiences of PHC nursing managers stated that some of the causes for the shortage of resources were due to the moratorium on filling vacant posts, as well as the problem of absenteeism among nurses (Munyewende &

Rispel, 2014:7). A major concern is the DoH's inability to fill vacant positions, especially by nursing staff. The vacant funded posts are frozen, so the posts are not advertised. According to Rispel and Padarath (2018), the findings revealed that the shortage of health professionals and inadequate resources has a negative impact on the provision of quality patient care. In this study, adolescents felt that the shortages of staff at the clinics were one of the causes of long waiting times and most of the clinics were busy resulting in compromising quality care as well as waiting times which is one of DoH quality care priorities.

Another barrier experienced by the participants was the fear of older nurses. Some participants perceived the nurses as being strict and that some nurses shouted at them. Many participants viewed older nurses in the same way as they viewed their parents and did not feel comfortable conversing with them or asking them questions regarding personal or sexuality-related problems.

"Another problem the nurses are old like our parents, now we are scared of them they like to shout. We can't open up even if you have a boyfriend problem." (Participant 7, page 20, line 615)

"Most of the time, we don't feel free to ask questions to the older nurses, because they look strict." (Participant 3, page 11, line 331)

"The nurses are not always friendly, worse, the ones that are older. We take them as our elders and do not want to ask them questions about personal stuff like sex issues." (Participant 5, page 13, line 180)

Participants stated that nurses are old, like their parents and participants are scared of them because they shout like their parents. Also, participants felt that they could not even talk about their boyfriends to the older nurses. Therefore, Chilinda *et al.*, (2014:1712) argue that healthcare providers should accept and understand adolescent sexuality as a reality and assist them without parenting the adolescents.

Godia *et al*. (2013:10) agree that health personnel could be more inclined to fulfil a parental role when dealing with adolescents. According to a United Kingdom study, health professionals' negative attitudes toward adolescents were evident in many studies as a hindrance to accessing sexual and reproductive health services. Displaying negativity towards adolescents by nurses could cause reluctance of adolescents to utilise sexual and reproductive health services (Chilinda *et al*., 2014:1711). In this study, adolescents felt that older nurses were unfriendly, and they felt that they were not free to talk to them because they had witnessed the nurses shouting at patients and thus were afraid to ask them questions regarding their sexual lives. The research findings accentuated the need for healthcare services and staff to provide youth-friendly services in a non-judgemental manner. Furthermore, healthcare providers should build a more constructive professional relationship with youth and treat them with respect.

4.3.1.2 Sub-theme 1.2: Some female adolescents described a lack of family support regarding contraceptive usage

Some of the participants revealed that they received no support from their parents regarding contraceptive usage. They described their experiences as follows:

"I didn't know much about family planning; my mother didn't tell me anything about family planning" (Participant 3, page 9, line 260).

"Most of our parents don't feel comfortable talking about sex and family planning, because we are still at school and should concentrate in our education than boys" (Participant 12, page 38, line 1168).

Some parents, due to their cultural background, may avoid discussing contraceptive use with their adolescent children. Msutwana and de Lange (2017:228) found that in the Xhosa culture, adults are restricted from discussing sex with adolescents. Ramathuba, Khoza and Netshikwera (2012:1) indicated that traditional customs sometimes deter parents from providing sexual information to adolescents, thus

preventing adolescents from gaining more facts about their sexuality. In a South African study conducted in 2008 concerning sexuality and reproductive health, it was found that parents are reluctant to discuss sex with their children (Panday Makiwane, Ranchod & Letsoala, 2009:21). The study focused on adolescents who indicated that they obtained most of their information about sexuality and reproduction from their friends at school. It was, however, also established that friends very seldom provided the correct or complete information. In this study, some of the adolescents experienced similar problems where their parents were reluctant to discuss sexual issues with them. One participant also felt that her parents did not talk because they believed that talking about sexual matters to adolescents would encourage risky sexual behaviour.

"My mother thinks that if she talks to me about these things, she is sending me to have sex" (Participant 9, page 26, line 756).

Mudhovozi *et al*. (2012) state that adults do not always see adolescent sexuality as a natural phase of development, and therefore view it as something that needs to be controlled. A study conducted by Lebese, Maputle, Ramathuba and Khoza (2013:4) found that when parents have open communication with their adolescents about family planning, parents perceive it as promoting promiscuity. Similarly, one participant in this study revealed that she received no information from her mother regarding sexuality because her mother feared that discussing such issues would encourage her to become promiscuous. Indeed, and Lebese *et al*. (2013:4) concurred that some parents do avoid such topics for fear of encouraging early sexual behaviour by adolescents. Some participants felt that their parents needed to be educated about adolescents' sexuality to enable them to instruct their adolescent children adequately.

"Our parents must also be educated about these things so that they can also help and teach us at home" (Participant 8, Page 24, Line 707)

"*… my friends' parents they don't talk about these things, they think sex is not a topic for discussion, sometimes I think they are scared to talk to their children*" (Participant 6, Page 16, Line 471)

Parents of adolescents often lacked knowledge about sex education and contraception according to Lebese *et al*. (2013:4), the parents also indicated various reasons why they do not discuss reproductive health issues with their children. Most parents claimed lack of awareness regarding sexual and reproductive health issues of adolescents and had difficulty initiating discussion thereof due to fear and shyness (Yadeta, Bedane and Tura, 2014:6). Responses from the abovementioned adolescents revealed the same sentiments regarding their parents who lacked knowledge about adolescent sexuality and family planning. Parents' lack of confidence to discuss sexual activity and lack of education about sexual activity may result in adolescents lacking awareness regarding their responsibility towards their sexual behaviour. The research indicated that some of the study participants expressed a sense of frustration as parents refused to acknowledge adolescent sexuality and the importance of discussing reproductive health with their adolescent children.

4.3.1.3 Sub-theme 1.3: Female adolescents expressed a range of negative emotions regarding the consequences of not using contraceptives

Negative emotions as displayed by the adolescents who had fallen pregnant due to either missed appointments for their injection or who stayed away from the clinic due to the attitudes portrayed by the healthcare providers. Adolescents experience the consequences of falling pregnant at an early age as a highly emotional period. Participants articulated that their pregnancies were a challenge because it interfered with their educational aspirations, while some participants indicated how caring for their babies impacted negatively on their academic activities.

"I don't feel good about myself right now; I am the only one in my circle that is pregnant at the moment." (Participant 3, Page 10, Line 292)

"I was 17 years old; I was pregnant and had a baby. It was sad for me because those were not my dreams to drop out at school and to have a baby at that age." (Participant 10, Page 27, Line 781)

Pregnant adolescents are affected psychologically, socially, and emotionally. Hence, they drop out of school, suffer loneliness, depression, stigma, and poor education (Vin, Muhammad, Sun, Meng, Tohid & Omar, 2014:1). A study conducted by Singh and Hamid (2016:286) has shown that stigmatising attitudes of parents and teachers can reinforce the conservative norms that position sexuality as shameful. In this study, adolescents were affected emotionally by falling pregnant at such an early age, especially when they were still attending school. It was clear that they were not ready to become mothers, and to drop out of school was not their dream. The importance of education for adolescents on the use of contraceptives is once again highlighted in the abovementioned studies to prevent adolescents from engaging in unprotected sex that could lead to the above repercussions.

One participant went to the clinic for the injection but unfortunately discovered that she was already pregnant but did not have the courage to reveal the pregnancy to her parents and opted to terminate her pregnancy.

"I decided to have an abortion because I was scared for my parents" (Participant 5, page 14, line 14)

"*I had a miscarriage. How I got pregnant, me and my friends were at a party, I got forced to drink, my drink got spiked. I was basically, sexually raped, that's how I fell pregnant."* (Participant 11, page 31, Line 901)

In a study performed among South African adolescents by Howard (2010:48), results showed that there was confirmation that adolescents suffer severe

emotional trauma that is caused by the abortion procedure. Consequently, education on the dangers of unsafe abortions is vital. Information should be freely available so that adolescents could develop life skills to improve their links to social networks. Furthermore, unplanned pregnancies, as well as the trauma experienced by the participants as mentioned earlier, could have been prevented had they used contraceptives. Sexual abuse could cause female adolescents to experience sexual activity and becoming pregnant before they intended (Darroch, Woog, Bankole and Ashford, 2016:11).

Those participants who had fallen pregnant in the past expressed sadness, shame, and embarrassment because they were unable to continue participating in the usual activities with their peers. They dropped out of school because they were shy to attend school because they were worried about what people will think about them. The participants described their experiences as follows:

"Sometimes, I feel embarrassed because I can't even go out with my friends. I am really ashamed for my behaviour." (Participant 1, page 2, line 44)

"*Feeling sadness and ashamed of what people are going to think about me."* (Participant 2, page 6, line 163)

Findings from a study conducted by Bhana, Morrell, Shefer and Ngabaza (2010:873), revealed that some pregnant teenagers might show feelings of shame, embarrassment, humiliation, and fear of losing the respect of their parents, peers, and communities. A study conducted by Singh and Hamid (2016:286), showed that negative attitudes of parents and teachers could reinforce cultural norms that position sexuality as shameful. A comprehensive intervention strategy should be put in place to address all the factors that will enhance healthy behaviour about sex education and sexual engagements. In this study, adolescents expressed feelings of shame and embarrassment; hence, they

were concerned about what people would say about them being pregnant while they were still at school.

Participants also expressed how isolated they felt since they felt that they were unable to socialise with their friends anymore. In some cases, boyfriends abandoned pregnant participants, and some participants indicated that they were not young anymore because they had babies. Another participant expressed feeling alone during pregnancy because she did not see much of her friends anymore. They discovered that peers continue with their academic and other extra-mural activities and thus not include them in activities. Here are some of their responses:

"I do feel alone because I don't get to see my school friends that much anymore because they busy with school stuff" (Participant 3, page 10, line 293)

"My friends were far away from me. I couldn't go out at night with my friends." (Participant 2, page 6, line 170)

"My boyfriend ran away and denied the pregnancy. I am struggling now. I am embarrassed." (Participant 7, page 18, line 562)

In this study, pregnant adolescents experienced loneliness and isolation because they were unable to socialise with their peers, and according to Bulmer-Smith (2013:15) many teenage mothers undergo feelings of loneliness, fear, and isolation. Literature also indicates that pregnant adolescents often feel excluded from their peers, friends and educators (Chauke, 2013:34; Weed, Nicholson and Farris, 2015:58). In a study by Julie (2013:20), some of the adolescents experienced a sense of abandonment from their boyfriends and their peers blamed them for their pregnancy (Julie, 2013:20).

Participants expressed feeling a sense of loss and disappointment. They felt that they had lost their dreams for their future. One participant admitted not listening to her parents. The adolescents stated that their parents instructed them to stay away from boys. Many had a fear for the future and were concerned about how they were going to cope financially to support their families.

"My mother was very disappointed because she said that I must not sleep with boys" (Participant 1, page 1, line 10)

"*I am really disappointed with myself because I could have stayed away from boyfriends and waited until I am older and ready for a baby"* (Participant 3, page 9, line 264)

"Feeling bad and disappointed with myself, this thing that we as young people don't want to listen to our parents is really a problem because my education is in a mess" (Participant 2, page 6, line 162)

Participants were remorseful for not listening to their parents. Participants realised achieving their dreams was somewhat unattainable now that they had babies in their lives to take care of. Sriyasak, Almqvist and Sridawruang (2018:44) revealed that parents experienced mixed emotions when they found out about their teenagers' pregnancies and expressed both positive and negative reactions to their future parenthood. Karra and Lee (2012:15) found that adolescents perceived falling pregnant while still at school as a negative event with consequences such as difficulty at school or dropped out, unemployment, guilty feelings, alienation from family members and friends and some of the participants' boyfriends deserted them. It is clear in this study that participants' sexuality was incomplete and not enough to early unplanned pregnancies. According to Reddy, Sewpaul, and Jonas (2016:2), healthcare centres should prioritise education that focuses on awareness of responsible womanhood and the negative impact of early pregnancy. The participants expressed shame and disgrace as they realised that their actions of

falling pregnant had adverse consequences. Some also expressed that the entire direction of their lives had changed after they fell pregnant; often regretting not having listened to their parents.

4.3.1.4 Sub-theme 1.4. Some female adolescents experienced side effects using contraceptives

Some participants complained that they encountered various side effects while using contraceptive methods. In some instances, the adolescents stopped using the contraceptives because of the side effects experienced by participants. Here are their responses:

"It never worked, so I went onto the three (3) month injection, and after that, I started getting the spotting, and it was a bad smell." (Participant 1, page one, line 24)

"That worked well for me in the beginning, and then I started getting headaches, and my period was irregular, then I started two (2)-month injection." (Participant 12, page 33, line 991)

"*And after using Petogen, I stopped getting to my periods, and I got a little bit fat. And the nurses said that I must not stop using it, because if I stop, I will get pregnant. I stopped using it because I wanted to control my weight, then again I went back using it because I did not want to fall pregnant."* (Participant 13, page 40, line 1236)

Tabane and Peu (2015:5) showed that adolescents experienced minor side effects and expressed unhappiness, especially when they experienced irregular menstrual patterns and weight gain while using contraceptives. They were under the impression that 'dirty' or infected blood was accumulating in their uterus. Therefore, it is considered essential to provide information about possible side effects that may arise from the use of various contraceptive methods (Tsikouras, Deuteraiou, Bothou, Anthoulaki, Chalkidou, Chatzimichael, Gaitatzi, Manav, Koukoul, Trypsianis

and Galazios, 2018:7). In this study, some of the participants complained about minor side-effects, such as spotting, headaches, and weight gain.

4.3.1.5 Sub-theme 1.5: Female adolescents felt that the care received at the clinic was not always adequate.

Not all the participants were satisfied with the care provided to them at the clinics. They felt that some nurses were not respectful towards them. They also felt that there was a lack of privacy in the clinics. For instance, a number of participants indicated that they were not provided with adequate privacy when consulting with the nurses, which prevented them from discussing specific personal issues with the nurses. This lack of privacy was due to some facilities requiring that nurses share consultation rooms while accessing more than one (1) client. Two (2) nurses are allocated to one (1) consulting room, and then two (2) adolescents would be seen in the same consulting room at the same time.

"No privacy at all. At times we are two (2) or three (3) in the room" (Participant 7, page 18, line 612)

"So, I remembered what she said, but the only thing that I didn't like was the long queue, and there was no privacy." (Participant 6, page 16, line 488)

"We young people don't want our friends to see us at these clinics, because if they see us, they talk bad about us". (Participant 8, page 23, line 684)

Participants were concerned about the lack of privacy during consultation, especially when attending the healthcare facilities, and they also feared being seen by the other adolescents. Kim and White (2017:8) cited a number of sources that highlighted that adolescents' anxiety regarding privacy stemmed from their apprehension of being judged by parents or nurses as well as the accompanying embarrassment. The National Health Act requires the maintenance of patient privacy and confidentiality

except in situations where it will be impossible to do so (Section 26), especially for female adolescents who suffer humiliation at the hands of health providers when seeking to access sexual reproductive health care services (Savage-Oyekunle, 2018:482). Lebese *et al*. (2013:5) found that it was clear that there was a lack of privacy in clinics and healthcare centres, which is a violation of participants' rights.

Some participants indicated that they did not always receive adequate information about contraceptives at the clinics. Any patient who attends a family planning clinic should receive a full medical examination where a complete medical history is taken up by a registered nurse. The adolescent should always receive information and supplied with pamphlets or information booklets. Inadequate knowledge about contraception results in the incorrect use thereof and the result is often unwanted pregnancy. The participants responded as follows:

"They never asked me if it is my first time coming for a contraceptive nothing, didn't explain to me what it is." (Participant 1, page 2, line 71)

"The services are not of the best, because when you go to the clinic, they give you the injection then you must leave, nobody tell you nothing". (Participant 3, page 10, line 308)

"They don't tell us about the disadvantages of using family planning they just tell you it protects you from this and that they don't tell you about the long-term effects of it". (Participant 4, page 12, line 370)

Participants indicated that sufficient contraception information was not always available at the clinics. These sentiments were supported by the adolescents in the Lebese *et al.*'s (2013:5) study, who indicated that poor healthcare education was an element that contributed to the poor uptake of family planning and argued that this related to healthcare staff being too busy to spend quality time with adolescent patients. According to the participant's communication between nursing staff and

participants was poor, and the participants stated that they rarely received education regarding contraceptive methods.

This theme demonstrated that the adolescent participants perceived a range of challenges regarding accessing contraceptives at clinics. They felt that there was a lack of family support regarding contraceptive usage. A number of participants experienced a range of negative emotions as a consequence of not using contraceptives. Some participants described their experiences with the side effects of using contraceptives. Many of the participants also felt that the nurses at the clinics did not always provide quality care.

4.3.2 THEME 2: FEMALE ADOLESCENTS EXPERIENCED CLINICAL AND COMMUNITY SUPPORT REGARDING CONTRACEPTIVE USAGE

In contrast to the previous theme and the negative experiences of some participants, participants in this section experienced the opposite, as they reported high levels of support by staff in the PHC centres that they attended, plus their families were positive regarding contraceptive usage. The following three sub-themes underpinned Theme 2, and these are presented below.

4.3.2.1 Sub-theme 2.1: Some female adolescents experienced receiving patient-centered, holistic care from clinic nurses.

Some of the participants expressed positive views regarding their treatment at the youth-friendly services that they attended. Participants reported that nursing staff treated them with respect, especially the friendliness and caring attitude that was shown by the nurses, which had a positive impact on the adolescents. The adolescents felt that the nursing staff ensured privacy and essential information was explained to them as required. Participants described their positive experiences as follows:

"I was lucky because when I go to the clinic, I always get a nice sister who is willing to help us". (Participant 6, page 17, line 504).

"With the new youth-friendly clinic, the fact that you get more lessons there, it is actually very nice regarding the support and advice you get from the nurses, just for all they are doing there also it is nice to be treated privately". (Participant 2, page 7, line 204).

"They would always advise you to continue using condoms to prevent not only HIV/AIDS but STIs also". (Participant 2, page 7, line 208).

"Nurses are very nice because they help us through the process and talking to us and giving us advice of how to stay safe". (Participant 11, page 30, line 940)

Some of the participants found that the nursing staff were friendly and approachable. The adolescents perceived the care they received to be holistic, especially at the youth-friendly centres. The DoH agreed to take over the management of NAFCI under their Youth-Friendly Services (YFS) programme. NAFCI recognised that the PHC clinics were best positioned to provide quality health services to adolescents (Geary et al., 2014:1).

Many of the participants reported receiving a full medical check-up from nursing staff, in the form of individual support and care in a safe environment. They described what they perceived to be full check-ups before they received their contraceptives. The responses from the participants were as follows:

"I told the nurse, and she checked everything about me, and she also gave me a birth control tablet. She advised me to take the tablet every day at the same time." (Participant 12, page 37, line 1135).

“Nurses are very nice because they help us through the process and talking to us and giving us advice of how to stay safe. They do full check-ups before they give you contraceptives.” (Participant 11, page 30 Line 940)

“I always get checked, my breasts gets checked. My weight, blood pressure and urine as well.” (Participant 6, page 17, line 503).

Several participants expressed that the nurses were helpful and performed full medical checks. Tilahun, Mengistie, Egata and Reda (2012:1) indicated that many of the healthcare providers generally had positive attitudes toward sexual and reproductive health to adolescents in Ethiopia. In this study, some of the adolescents stated that they underwent full medical checks before clinic staff provided them with contraceptives.

4.3.2.2. Sub-theme 2.2: Some female adolescents received health education regarding contraceptive usage from nurses and life orientation teachers.

Some participants stated that they received health education from the school nurses as well as life orientation teachers. Topics presented by the school nurses were on the different family planning methods, the importance of condom usage to prevent HIV and STIs and to prevent pregnancy. Participants indicated that school nurses’ visits were not on a regular basis but admitted to being given information on sex education by teachers and nurses. The life orientation teachers presented talks on sex education to adolescents. Responses from the participants were as follows:

“When I was in grade 11, our teacher explained everything to us about life... and the nurses also came to the school to explain about family planning”. (Participant 5, page 14, line 416)

"The school nurses also come to school and teach us about family planning". (Participant 8, page 22, line 666)

"They teach about life especially sleeping around with boys and how to look after ourselves". (Participant 8, page 22, line 661)

According to a study done by Savage-Oyekunle and Nienaber (2015:545), the Integrated School Health Policy 2012 supports collaboration between the DoH and the Department of Basic Education (DBE) and allows for the provision of sexual and reproductive services at schools. In a study done by Mturi (2016:10), there is no proof of behavioural change among the youth over the years; the DBE has highlighted the accomplishments of the programme and recognised challenges in the content of the sex education programme. For sex education programme to be effective, strategies should be put in place to enhance its improvement. In this study, adolescents emphasised the critical role the teachers and the school nurse perform in providing them with all the relevant information on sex education and family planning; therefore, parents are encouraged to be involved in their adolescent's development (Mturi, 2016:10). Loaiza and Liang (2013:11) also emphasised that it is the right of every adolescent to receive customer-focussed health information and education, especially regarding sexual and reproductive health, and access to good effective reproductive health care services.

Participants expressed concern about the number of adolescents who were pregnant at schools, and they also indicated that school nurses visited the school every six (6) months and shared relevant information but not in detail with them regarding contraceptive usage. The responses from participants were as follows:

"At that time there was a lot of young students pregnant at our school. So, the nurses came to us and told us that there are three (3) methods we could use, there is a three (3) and a two (2)-month injection…" (Participant 4, page 12, line 339)

"Sometimes the school nurses do come to the school but once in six (6) months. The nurses also talk about family planning, not in detail; they always say we must come to the clinic for more information." (Participant 9, page 26, line 760)

The participants indicated that school nurses only visited the school occasionally and emphasised that the focus of their visits to the schools was mainly on family planning and health education. In one case, the participant expressed that the nurses came to her school because several learners were pregnant. A study conducted by Dibakwane and Peu (2018:6), in South Africa, presented results indicating that schools experienced a shortage of nurses. The findings of this study confirm that a small nursing staff component threatens the quality of care to female adolescents.

4.3.2.3 Sub-theme 2.3: Some female adolescents experienced a degree of family support regarding contraceptive usage.

Despite many of the participants stating that they did not receive support from their families, there were some who acknowledged being supported by parents regarding contraceptive usage, especially their mothers. For instance, some participants were encouraged by their mothers to go for family planning to prevent pregnancy. Extended family members also encouraged participants to use contraceptives. The responses from participants regarding parental support were as follows:

"The first time my mother went with me to the clinic to have my first ever family planning done that was two (2) years ago." (Participant 4, page 12, line 347)

"My mother advised me to use contraceptives especially if I am going to have a boyfriend…" (Participant 8, page 22, line 647)

"My parents said next time I go to the clinic, I must ask for family planning because I have a boyfriend and they are worried that I might fall pregnant." (Participant 9, page 24, line 719)

A study by Savage-Oyekunle and Nienaber (2015:550) identified socio-cultural factors as a barrier to contraceptive use for adolescents as adolescents often finding it difficult to communicate with their parents regarding contraceptives. Hence, adolescents prefer to communicate with their peers due to the communication breakdown with their parents. When parents neglect to talk to their adolescents about sex, they often end up obtaining incorrect information from their peers (Holt *et al*., 2012: 288). Evidence suggests that emotional support from their mothers promotes adolescent compliance with contraceptive usage (Quinn, Mitchell, and Lewin, 2017:36). In this study, adolescents appreciated the support they received from their parents, although some adolescents found it difficult to communicate with their parents.

Certain participants indicated that their extended family supported them regarding contraceptive usage. The following quotes demonstrate the involvement of extended family members in the lives of the participants and how they were sources of knowledge regarding contraceptive usage.

"I had to find out at home from my mother and grandmother, my cousin as well, they explained to me about contraceptives." (Participant 1, page 2, Line 73)

"Sometimes, I am sorry I did not listen to my aunt and my sister because they said I must use contraceptives to prevent, uhm, unwanted pregnancy." (Participant 10, page 27, line 787)

"My sister and my granny said that contraceptives are important to use, but we don't need to they won't force us to use it if we not comfortable. But prefer it if we want to be safe at the end of the day." (Participant 11, page 31, line 895)

Some of the participants received good support from their extended families, such as aunts and grandmothers regarding contraceptive usage. The extended family of adolescents played a particularly important role in their lives by informing them about contraceptives and encouraging them to stay safe. A study by Motsomi, Makanjee, Basera and Nyasulu (2016:4), highlighted that adolescents appeared more comfortable discussing sexual and reproductive health issues with senior members of the family like their grandparents, as they tend to take a less strict role enabling their grandchildren to be more at ease when discussing sensitive issues. In a South African study on learners, most of the participants were in the care of their grandparents or other family members (Mokone, 2006:187).

4.3.3 THEME 3: FEMALE ADOLESCENTS PROVIDED SUGGESTIONS REGARDING THE OPTIMISATION OF CONTRACEPTIVE USAGE

During the interviews, the participants provided suggestions that could assist with optimising the use of contraceptives among adolescents. Participants proposed an increase in sexual and reproductive health education at the clinics. Furthermore, they mentioned the need for consistent school nurse involvement regarding contraceptive usage. The sub-themes that underpin Theme 3 are presented below:

4.3.3.1 Sub-theme 3.1: Female adolescents called for an increase in reproductive health education at the community health centres

Most of the participants acknowledged receiving information on reproductive health education but expressed the need for community health centres to be more involved in creating platforms to educate young people, such as healthcare educational roadshows. Participants articulated the fact that some of the youth attend clinics because they are sick. However, no one would talk to them regarding contraceptives, and that is the opportunity that the nurses should take to educate adolescents about family planning. Here are the views presented by the participants.

"I would suggest that hospitals and clinics have roadshows inviting teenagers over to have fun and good talks …for teenagers to start asking questions and not to be shy about the sex topic." (Participant 6, page 17, 528)

"I think they must focus on telling us how the family planning things work because children fall pregnant because they don't understand, some of the young people go the clinic because they are sick and must be asked about family planning…..like if they are safe." (Participant 5, page 15, line 444)

"Giving out condoms, outreach programmes, even booklets or pamphlets, the more people read about it, the more they would understand, and they would take these talks more seriously." (Participant 2, page 7, line 242)

Education is key to providing adolescents with the most basic skills to function and contributes to society (Loaiza and Liang, 2013:11). According to Childs, Knight and White (2015:315) adolescents require comprehensive sexual education to be able to know options and negotiate reproductive desires. They state that nurses, in general, have the responsibility to deliver nursing care services to adolescents, whether it is at the community healthcare location or in the clinics. They should be able to determine whether adolescents have a clear understanding of sex and should provide adolescents with all relevant and correct information about safe sex practices, contraceptive use as well as the consequences of unprotected sex (Childs *et al*., 2015:315). Clinics and health centres can be an excellent source of sexual health information for adolescents as stated by Mturi (2016:9) because health practitioners are trained to provide such services, such as providing contraceptive methods and counselling.

In this study, adolescents requested an increase in reproductive health education at the community health centres, where nurses are obliged to provide adolescents with all relevant information about safe sex practices and the consequences of unprotected sex.

4.3.3.2 Sub-theme 3.2: Female adolescents expressed the need for regular school visits by school nurses.

Participants identified the importance of regular school visits by nurses. Participants stated that school nurses should be allowed to give talks during school assembly periods in order to expose more learners to information regarding contraceptive usage. The participants argued that learners are keen to learn more about contraceptive usage. Participants requested that school nurses should arrange awareness campaigns and outreach programmes, especially and distribute condoms and pamphlets during sports days. Some adolescents even stated that adolescents should be encouraged to abstain. Here are some of the responses from the participants.

"[The nurses] should come to the school regularly so that we are taught on sex education and HIV at school so that we can have all the details so that we can know these things". (Participant 9, page 26, line 764)

"Sometimes the school nurses do come to the school, but once in six (6) months". (Participant 9, page 26, line 758)

Sex education empowers adolescents by providing them with scientific facts and valid knowledge on human sexuality considering aspects such as biological, cognitive, mental, emotional, and social in order to contribute to the psychosexual development of the adolescent. Sexual education aims to enhance healthy and normal psychosexual development and to provide all the necessary skills and information (Vassilikou, and Ioannidi-Kapolou, 2014:147). Therefore, learning about adolescent reproductive health should form part of all training programmes for school health nurses (Mushwana *et al.*, 2015:17).

In a South African study by Ramathuba *et al.* (2012:2), it was stated that community healthcare services should foster collaboration with schools to address matters such

as sexuality, contraception, and contraceptive education to strengthen life skills. Introducing peer educational programmes will encourage adolescents and will promote norms, attitudes, and conduct positively. Adolescents will be able to have relevant information to make decisions about safe sex and to negotiate safe sex (Ramathuba *et al.*, 2012:6).

According to Ramathuba (2016:313), very few adolescents were using contraceptives. Further discovery revealed that they had no clear understanding of contraception methods. It is unacceptable that many adolescents leave school not having enough information on contraception. Therefore, the provision of knowledge and the availability of contraception for adolescents is one of the fundamental intervention strategies to improve women's health. In this study, adolescents expressed the need for school nurses to visit schools on a regular basis. Participants stressed that sex education, including awareness campaigns, would empower adolescents with more information so that they can take responsibility for making healthier choices. The participants' responses and suggestions highlight the fact that sexual and reproductive health behaviours among adolescents should remain a public health concern (Jonas, Crutzen, van den Borne, Sewpaul, Reddy: 2016:12).

4.4 CHAPTER SUMMARY

This chapter sought to explore and describe the experiences of female adolescents regarding issues relating to the use of contraceptives. The findings highlighted that the availability of contraception for adolescents is one of the fundamental intervention strategies to improve women's health. In the following chapter, the researcher will present recommendations that will assist in improved structures for female adolescents receiving contraceptives. Chapter Five will discuss the limitations of the study and will provide recommendations for future nursing practice and nursing education.

CHAPTER FIVE

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the preceding chapter, the researcher discussed the data that were analysed and verified using a literature control. This chapter will discuss the conclusions based on the data findings drawn from the previous chapter. The researcher will present recommendations with regard to encountering barriers to access contraceptive services, the support female adolescents received from clinics and community concerning the use of contraceptives, and on the subject of optimisation of contraceptive usage. The researcher will conclude with recommendations aimed at nursing practice, nursing research and nursing education. This section will also discuss the limitations of the research study.

5.2 THE AIM AND OBJECTIVES OF THE STUDY

The study aimed to explore and describe the experiences of adolescents attending community health centres in Buffalo City Health District regarding their use of contraceptives.

5.3 RESEARCH FINDINGS

The analysed data indicated that adolescents faced various obstacles in accessing contraceptive services. Some participants revealed that they had to wait for extended periods to be assisted when all they required were contraceptives. They complained that they had to stand in long queues to wait to receive their contraceptives and stated that the only time that was convenient for them to go to the clinic was in the afternoon; keeping in mind that clinics close at 16:30. In addition, they noted that there was often only one (1) nurse on duty who had to attend to all of them due to a shortage of staff. As a result, some participants indicated that they became impatient and frustrated, and often left the clinic without seeing the nurses.

Some of the participants indicated that the contraceptives that they used caused side effects such as dizziness, weakness, spotting and continuous bleeding. This finding corresponds with findings of the DoH, indicating that side effects are one of the reasons why female adolescence refrain or sway from using contraceptives (Department of Health, 2012:15).

Some of the participants expressed that although they found it difficult to discuss sexual matters with their families, the potential lack of support of families will make the management of the daily lives difficult. The analysed data suggest that the lack of communication of sexual matters and fear of parents seem to have contributed to the failure of contraceptive usage. Furthermore, the adolescents stressed that peer groups were their primary information source regarding sexual matters.

In the research study, adolescents voiced negative emotions towards the consequences of not using contraceptives. Unwanted pregnancy was the main consequence of not using contraceptives and participants revealed that it interfered with their educational aspirations. Others admitted that caring for their babies placed a burden on their academic activities. Adolescents expressed concerns regarding their future and the potential risk of not being able to support their families. Most of the study participants stressed that the education of the adolescent mother remains on hold during pregnancy, and some adolescents decided to drop out of high school and find a job to support themselves. Participants expressed feelings of sadness and remorse and even a sense of loneliness and rejection.

Some of the adolescents also expressed that the care received from the clinic staff was not always adequate as some clinic staff treated them with disrespect. Participants articulated frequent violations of their right to privacy as they had to share consulting rooms.

However, on the other hand, some participants indicated that they received high quality clinical and community support, by receiving good support from the nurses

and teachers and sound healthcare education regarding contraceptive usage; while some received various forms of family support regarding contraceptive usage.

Participants also provided recommendations on how contraceptive usage education can be improved. In this study, adolescents expressed the need for school nurses to visit schools regularly. Most of the participants expressed the need for community health centres to be more involved in creating platforms to educate young people, such as healthcare educational roadshows. Participants stressed that sex education, including awareness campaigns, would empower adolescents with more information so that they can take responsibility for making healthier choices. The participants' responses and suggestions highlight the fact that sexual and reproductive health behaviours among adolescents should remain a public health concern.

5.4 RECOMMENDATIONS BASED ON THE FINDINGS

Based on the data findings presented in Chapter Four, the researcher identified the following recommendations.

5.4.1 Barriers encountered by female adolescents accessing contraceptive services

The barriers female adolescents encountered in accessing contraceptives services included challenges related to access of contraceptives; adverse effects of contraceptive use; lack of family support regarding contraceptive usage and negative emotions regarding the consequences of not using contraceptives. The following recommendations can be made based on these findings.

5.4.1.1 Female adolescents highlighted challenges related to accessing contraceptives at clinics

The study found that female adolescents experienced many challenges related to accessing contraceptives services. Several participants revealed that they had to

wait for lengthy periods before being attended too. Participants expressed frustration with the extended time spent clinics, as they only needed contraceptives. They expressed disapproval to be in queues inclusive of sick patients. Furthermore, the participants felt the clinic times were inconvenient. Participants expressed frustration by having to wait for one (1) nurse attending to all patients.

Ideally, staff shortages should be addressed to avoid long waiting times at clinics. However, this is a challenge that can only be addressed at the district or provincial level, and it is a major concern. Furthermore, perhaps the community health centres could extend the clinic consulting times beyond 16:30 on certain days to allow adolescents to attend. However, this may not be realistic as adolescents have more free time than patients who are working. It is probably better for adolescents to be educated on taking responsibility and managing their time effectively so that they ensure that they attend the clinic once every three months.

Participants recommended that nursing staff consult with adolescents in a private consulting room. Nursing staff should strive within reason to preserve the privacy, anonymity as well as the confidentiality of patients. Parallel to this, the DOH should ensure that clinics have sufficient consulting rooms so that nurses can treat individuals in private.

5.4.1.2 Some female adolescents described lack of family support regarding contraceptive usage

Some participants revealed that they required more information about family planning. The participants found it difficult to communicate about sexual matters with their families, with some saying communication on sexual matters is minimal. Fear of parents also may have contributed to some adolescents failing to use contraceptive methods. Participants with children had to take responsibility for raising their babies and did not receive any assistance from the family. Participants were reluctant to visit clinics regularly. If they visited the clinics more frequently, it might have helped prevent them from falling pregnant.

5.4.1.3 Female adolescents expressed a range of negative emotions regarding the consequences of not using contraceptives

Participants articulated that their pregnancies interfered with their academic aspirations. Most participants were from disadvantaged socio-economic backgrounds expressing greater financial hardships by having to take care of their children.

Adolescent mothers need parental support and advice, especially if they are uninformed and battling to parent, and are likely to battle with the school. The participants highlighted their need to obtain support and advice from their families and suggested training programmes for parents. It is recommended that parents of adolescents receive training on the need for focusing on longer years of education for adolescents and the need to improve communication between themselves and adolescents. The study has highlighted the need for a parenting education programme into the preventive care service package. Participants highlighted the need for teachers to continue to provide academic support to the learners. Therefore, the study proposes that a counselling programme be available at the schools.

5.4.1.4 Some female adolescents experience side effects using contraception

Participants complained that they encountered various unwanted side effects while using contraceptives. In some instances, participants stopped using contraception because of the side effects.

It is recommended that professional nurses provide adolescents with vital information about the possible side effects that may occur from the use of various contraceptive methods. The research findings suggest that once adolescents are well informed, they will not discontinue their contraceptive method. Nurses at the clinics should encourage the adolescents to persevere with the contraceptives and that they should only stop them on the advice of the professional nurse.

5.4.1.5 Female adolescents felt that nurses do not always provide quality care

Some of the adolescents complained about the treatment they received from clinic nurses. It was challenging for adolescents to discuss their problems with the nurses because of the judgemental attitudes of healthcare workers. Shared consultation rooms are another concern voiced by participants; where nurses consult with more than one (1) patient at a time.

Healthcare workers should always strive to treat adolescents with respect and courtesy. The nursing staff should be friendly towards adolescents so that they will always be able to counsel them, and they should also be sensitive toward the adolescents' needs. The DOH should ensure that clinics have sufficient consulting rooms so that nurses can treat individuals in private.

5.4.2 Female adolescents experienced clinical and community support regarding contraceptive usage

The research findings indicated that the participants experienced clinical and community support regarding contraceptive usage. They stated that they received health education regarding contraceptive usage from nurses and teachers, and a number of participants received various forms of family support regarding contraceptive usage.

5.4.3 Female adolescents were attended to by nurses providing patient-centred, holistic care

From the data analysed, participants expressed views about youth-friendly services highlighting the positive support from nursing staff. They perceived the environment as being conducive to the needs of young people due to a service which catered exclusively for the youth. Most of the youth-friendly services had more than one (1) professional nurse responsible for the healthcare of youth. Participants alluded that the staff were friendly, which enabled them to be relaxed, comfortable, and they were able to express themselves regarding contraceptive usage.

It is recommended that awareness is increased regarding youth-friendly services and that clinics make available suggestion boxes so that adolescents can be involved in their care. The adolescents requested privacy in a separate consulting area during consultations. Furthermore, participants requested that more clinics should offer youth-friendly programmes. There is a large youth population so the DOH would need to consider these requests, but of course, there are financial implications, and it is unlikely that such a request would be considered.

5.4.3.1 Female adolescents received health education regarding contraceptive usage from nurses and life orientation teachers

The research findings indicated that participants attained a certain level of health education from school nurses as well as from the life-orientation teachers. Topics presented by the school nurses were on the different family planning methods, the importance of condom use to prevent HIV and STIs and to prevent pregnancy. Participants also expressed concern regarding the infrequency of school nurse visits.

The adolescents indicated that their Life Orientation teachers presented talks on sex education to adolescents. The teachers also stressed the importance of the participants not to have sex and fall pregnant at such a young age, which will affect their school career. However, it was not clear that they gave specific advice regarding the use of contraceptives.

It is recommended that school nurses should visit schools on a regular basis. Participants requested healthcare services to arrange awareness campaigns and to distribute condoms and pamphlets at schools. The findings of this study confirm that a small nursing staff component threatens the quality of care to female adolescents. The DoH is requested to channel resources to employ more nurses to ensure sustainable and frequent nursing visits at schools.

5.4.3.2 Most female adolescents experienced various forms of family support regarding contraceptive usage

Some of the participants acknowledged being supported by family members regarding contraceptive usage. They indicated that different family members encouraged them to use contraceptives but regretted not taking the advice.

5.4.4 Recommendations provided by adolescents regarding the promotion of the usage of contraceptives

The participants provided suggestions on the promotion of contraceptive usage. This included an increase in reproductive education at clinics and regular school involvement regarding contraceptive usage.

5.4.4.1 Female adolescents called for an increase in sexual and reproductive health education at clinics.

Most of the participants acknowledged being given information on reproductive education; participants requested that life-orientation teachers, as well as the school nurses, offer more sex education. Teenagers felt more comfortable when young professional nurses spoke to them than the older sister. Participants expressed the need for their parents to be educated about sex education so that they could have the knowledge and skills to enable them to approach teenagers more sympathetically. It was recommended that contraceptives should be readily available at clinics and pamphlets and booklets should always be accessible. Participants recommended that nursing should be made more attractive to young people through better salaries and working conditions.

5.4.4.2 Female adolescents expressed the need for regular school involvement regarding contraceptive usage

Adolescents stressed the importance of regular nurse visits to schools as vital. Although the shortage of nurses has always been a challenge, it is essential that the DOH should employ more nurses.

Adolescents also emphasised that school nurses should be allowed to give talks during the school assembly period to expose more students to the information. Participants believe that this will drop the pregnancy significantly. The study results emphasised the need for teachers who should give talks to learners in the class as learners are hungry for information. Participants requested that school nurses should arrange awareness campaigns and outreach programmes especially during sports days.

It was recommended that health education should be increased at schools focusing on various contraceptive methods. Participants recommended that mobile trucks visit schools to increase the accessibility of contraceptives to all youth who are sexually active.

5.5 RECOMMENDATIONS FOR NURSING EDUCATION, PRACTICE AND RESEARCH

Research recommendations from the study can be applied in nursing education, nursing practice and nursing research.

5.5.1 Recommendations for nursing education

The findings of the study highlighted the hesitation of adolescents to visit healthcare facilities and attributed poor patient-nurse dynamics as their primary concern. Furthermore, adolescents listed that poor communication, the negative attitudes of nurses and the incomplete knowledge of contraceptive methods as barriers in optimally accessing contraceptives. Considering the findings, the researcher suggests continuous in-service training of healthcare workers, especially nurses, to be better prepared to provide sexual and reproductive care to adolescents. Firstly, training should focus on counselling techniques. Nursing education institutions should redesign health counselling and prevention to better suit adolescents. Secondly, training should focus on effective communication techniques with adolescents and parents, devoid of judgement. Lastly, nurses should receive

continuous training on new and improved contraceptive methods as some study participants expressed concern about the knowledge deficits of healthcare workers about contraceptive methods and treatment guidelines.

5.5.2 Recommendations for nursing practice

- Allocation of young professional nurses to work with the youth
- Extending clinic hours to increase the accessibility of contraceptives
- Intervention programmes should be put in place to help minimise the psychological and social problems experienced by adolescents especially in cases of unplanned pregnancies
- Healthcare services could offer crisis management skills to help deal with the trauma, and social support structures should be made available for adolescents.

5.5.3 Recommendations for nursing research

The finding of this research study can be used as the basis for further research concerning the phenomena of experiences of female adolescents regarding contraceptive usage. It is suggested that a quantitative approach be incorporated to answer the same study questions in order to reach a larger geographical area.

5.6 LIMITATIONS TO THE STUDY

As this is a qualitative study, the findings cannot be generalised to all female adolescents because it focused on female adolescents in three community health centres in Buffalo City Health District, Eastern Cape. Hence, the sample was not as diverse as it would have been preferred, as not all population and cultural groups were represented in the sample. However, the population groups do represent the majority of patients who visit the community health centres in question. The study also did not include the experiences of adolescents in other clinics, or hospitals. Although, it was not the intention of the study to do so. Confidentiality and privacy were ensured, the interviews were conducted individually and in quiet private

settings. The researcher encountered difficulties in adhering to a fixed interview schedule due to the academic schedules and parental obligations of the participants. As a result, some interviews had to be followed up at the residential homes of participants which also undermined the privacy of the interview process.

5.7 CONCLUSION

In conclusion, this qualitative study aimed to describe the experiences of female adolescents attending the community health centres regarding the use of contraceptives. The issue of access to contraceptives and their usage is a challenge to many female adolescents attending the community health centres in Buffalo City Municipality. Many adolescents described a lack of family support regarding contraceptive usage, while others experienced a degree of family support. Adolescents expressed a range of negative emotions regarding the consequences of not using contraceptives and some also complained about the side effects of using contraception. Some adolescents felt that nurses did not always provide them with quality care, while others experienced receiving patient-centred, holistic care from clinic nurses, as well as health education regarding contraceptive usage from nurses and life orientation teachers. However, female adolescents called for an increase in reproductive health education at clinics and hospitals. They also expressed the need for regular school involvement regarding the education of adolescents on the various aspects of contraceptive usage. Hence, it is hoped that the recommendations from this study will assist the DoH to assist adolescent females with contraceptive usage better.

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Annexure 1: *Data collection instrument and participant questions*

Interview guide

Section A

DEMOGRAPHIC DATA

1. **Age**
2. **Name of institution**
3. **Age at which contraceptives was first used**

Section B

INTERVIEW QUESTIONS

a. How do you experience the contraceptive services?
b. How have you experienced using contraceptive services at this community health centre?

FOLLOW-UP QUESTIONS AND PROBING QUESTIONS WILL BE GUIDED BY THE PARTICIPANTS RESPONSES

Annexure 2: ***Participant consent/ assent form***

Experiences of female adolescents attending community health centres regarding the use of contraceptives in Buffalo City Health District

I give consent for you to conduct an interview with me. I understand the purpose of the study and understand that:

- I may decide to withdraw at any time without penalty
- All information obtained will be treated in the strictest confidence
- The participants' name will not be identifiable and used in any written reports
- A report of the findings will be made available to me.
- I may seek further information on the project from Glenda Summerton on:

Cell: 0726303944 **Tel.:** 043 7332774

Fax: 043-7339211 **Email:** glendasummerton@gmail.com

______________________________ ______________________________

Participant **Signature**

____

Date

Annexure 3: ***Letter to Department of Health***

G. Summerton
4 Venn Place
Buffalo Flats
East London
0726303944/
043 7332774
s212449524@live.nmmu.ac.za

18 April 2016

Mr Z. Merile
Deputy Director: Epidemiological Research & Surveillance Management
Department of Health
BISHO
Tel.: 040 608 0830

Dear Mr Merile,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Glenda Summerton, and I am a master's student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my master's degree in Primary Health Care is entitled: *Experiences of Female Adolescents Attending Community Health Centres Regarding the use of Contraceptives in Buffalo City Health District*. The project is being conducted under the supervision of Dr M. Williams and Dr D. Morton at the Department of Nursing Science at the NMMU.

The goal of the study is to explore the perceptions of adolescents regarding contraceptive use in order to improve contraceptive usage among adolescents with the aim to prevent adolescent pregnancy in the East London area.

The data will be collected by interviews to be conducted with adolescents attending a community health centre. The questions will be based on reasons for low contraceptive usage among adolescents. I will ask the adolescents the following questions:

- Tell me how it has been for you to use contraceptives?

- Tell me how you have experienced the services from the community health centre regarding contraceptive advice and support?

The information gathered will be managed confidentially. I will be the only person to interview the adolescents. The identity of the clients will be protected. The study will be of the benefit of all adolescents, midwives and the community at large.

I am hereby seeking your consent to conduct research at East London community health centres. I have attached a copy of my proposal which includes copies of the approval letters which I received from the NMMU's Faculty Postgraduate Studies Committee (FPGSC) (Health Sciences) and the NMMU's Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health with a copy of the summary report. If you require any further information, please do not hesitate to contact me:

Cell: 0726303944 **Tel.: 043-7332774**

Fax: 043-7339211 **Email:** s212449524@live.nmmu.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

G. Summerton

Annexure 4: ***Letter to the Community Health Centre Manager***

G. Summerton
4 Venn Place
Buffalo Flats
East London
0726303944/043 73377
s212449524@live.nmmu.ac.za

18 April 2016

The Nursing Service Manager
Community Health Centre
Duncan Village CHC/ Empilweni Gompo CHC
East London

Dear Ms Nelani/ Ms Mali,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Glenda Summerton, and I am a master's student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my master's dissertation is entitled: Perceptions of adolescents in Buffalo City regarding the use of contraceptives. The project is being conducted under the supervision of Dr M. Williams and Dr D. Morton at the Department of Nursing Science at the NMMU. The goal of the study is to explore the perceptions of adolescents regarding contraceptive use in order to improve contraceptive usage among adolescents with the aim to prevent adolescent pregnancy in the East London area.

The data will be collected by interviews conducted with adolescents attending community health centres. The questions will be based on reasons for low contraceptive usage among adolescents. I will ask the adolescents the following questions:

- Tell me how it has been for you to use contraceptives?

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The information gathered will be managed confidentially. I will be the only person to interview the adolescents. The identity of the clients will be protected. The study will be of the benefit of all adolescents, midwives, and the community at large.

I am hereby seeking your consent to conduct research at East London community health centres. I have attached a copy of my proposal which includes copies of the approval letters which I received from the NMMU Faculty Postgraduate Studies Committee (FPGSC) (Health Sciences) and the NMMU's Research Ethics Committee (Human).

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Cell: 0726303944 **Tel.: 043-7332774**

Fax: 043-7339211 **Email:** s212449524@live.nmmu.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

G. Summerton

Annexure 5: *Community Health Centre Manager consent form*

Experiences of female adolescents attending community health centres regarding the use of contraceptives in Buffalo City Health District

I give consent for you to conduct an interview with me. I understand the purpose of the study and understand that:

- I may decide to withdraw the patient from the study at any time without penalty
- All information obtained regarding the patient will be treated in the strictest confidence
- The patients' names will not be identifiable and used in any written reports
- A report of the findings will be made available to the patients and me.
- I may seek further information on the project from Glenda Summerton on:

Cell: 0726303944 **Tel.: 043- 7332774**

Fax: 043-7339211 **Email:** s212449524@live.nmmu.ac.za

____________________________ ____________________________

Participant **Signature**

____

Date

Annexure 6: ***Letter to the participant***

G. Summerton
4 Venn Place
Buffalo Flats
East London
0726303944/043 73377
s212449524@live.nmmu.ac.za

18 April 2016

Dear Participant,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Glenda Summerton, and I am a master's student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. My study is called: *Experiences of female adolescents attending Community Health Centres in Buffalo City regarding the use of contraceptives in Buffalo City Health District.* My supervisors are Professor M. Williams and Dr D. Morton at the Department of Nursing Science at the NMMU. I want to find out how female adolescents feel about contraceptives in the East London area.

I will ask you the following questions:

- Tell me how it has been for you to use contraceptives?
- Tell me how you have experienced the services from the community health centre regarding contraceptive advice and support?

I will be the only person to interview you. You may decide to withdraw at any time from the interview or after the interview. All information obtained will be treated in strictest confidence. Your name will not be connected to any of the written reports. A report of the study will be made available to you.

Upon completion of the study, I undertake to provide the Department of Health with a copy of the summary report. If you require any further information, please do not hesitate to contact me:

Cell: 0726303944 **Tel.: 043-7332774**

Fax: 043-7339211 **Email:** s212449524@live.nmmu.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

G. Summerton

Annexure 7: *Witness of Gatekeeper/ Professional Nurse*

Witness of Gatekeeper/Professional Nurse

As the gatekeeper and professional nurse in charge of contraceptive services, I can categorically state that the researcher provided all the necessary information to the participant to ensure she could make an informed decision whether or not to participate in the study.

______________________________	______________________________
Gatekeeper	**Signature**

____

Date

Annexure 8: *Written information to participant prior participation and oral information given*

RESEARCHER'S DETAILS	
Title of the research project	**Experiences of female adolescents attending community health centres regarding the use of contraceptives in Buffalo City Health District.**
Reference number	**212449524**
Principal investigator	**Glenda Summerton**
Address	**4 Venn Place Buffalo Flats East London**
Postal Code	**5209**
Contact telephone number (private numbers not advisable)	**043 7332774**

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT		**Initial**
I, the participant and the undersigned		
ID number		
OR		
I, in my capacity as	(parent or guardian)	
of the participant	(full names)	

ID number		
Address (of participant)		

A.1 HEREBY CONFIRM AS FOLLOWS:		**Initial**
I, the participant, was invited to participate in the above-mentioned research project		
that is being undertaken by	Glenda Summerton	
from	Department of Health Science (Nursing)	
of the Nelson Mandela Metropolitan University.		

THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:			**Initial**
2.1	**Aim:**	The researcher is studying the views of teenagers regarding contraceptive use in the Buffalo City Metropolitan Health District with the aim to improve contraceptive use in order to reduce teenage pregnancies in the district	
2.2	**Procedures:**	I understand that	
2.3	**Risks:**	There are no risks related to participation in the study	

2. 4	**Possible benefits:**	As a result of my participation in this study, strategies will be put in place to improve contraceptive use.			
2. 5	**Confidentiality:**	My identity will not be revealed in any discussion, description, or scientific publications by the investigators.			
2. 6	**Access to findings:**	Any new information or benefit that develops during the course of the study will be shared as follows:			
2. 6	**Voluntary participation / refusal / discontinuation:**	My participation is voluntary	**YES**	**NO**	
		My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	**TRUE**	**FA LS E**	

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:									**Initial**
in	**Afrikaans**		**English**		**Xhosa**		**Other**		
and I am in command of this language, **or** it was satisfactorily translated to me by									
(name of translator)									

4.	No pressure was exerted on me to consent to participation, and I understand that I may withdraw at any stage without penalisation.	

5.	Participation in this study will not result in any additional cost to myself.	

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)									
I,					declare that:				
1.	I have explained the information given in this document to				(name of patient/participant)				
	and / or his / her representative				(name of representative)				
2.	He / she was encouraged and given ample time to ask me any questions;								
3.	This conversation was conducted in	**Afrikaans**		**English**		**Xhosa**		**Other**	
	And no translator was used, OR this conversation was translated into								
	(language)		by		(name of translator)				
4.	I had detached Section C and handed it to the participant				**YES**		**NO**		
Signed/confirmed at			on				20		
Signature of interviewer					Signature of witness:				
					Full name of witness:				

C. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant's participation in this study. Should, at any time during the study:

- an emergency arises as a result of the research, or
- you require any further information with regard to the study, or
- the following occurs

- You participate in the study against your will
- Your identity or any other confidential information was given by you being revealed

Kindly contact	Glenda Summerton
at telephone number	043 7332774

Annexure 9: ***Semi-structured interview***

140 **Participant Two- 18-year-old female residing in Buffalo Flats**

141 **IV-Could you tell me about all your experiences regarding the usage of**
142 **contraceptives?**

143 IE- Okay firstly I wasn't on any contraceptives in the beginning, once I was pregnant
144 with my daughter then I only started using the 2-month injection which I was advised
145 at the hospital after giving birth. My reasons for not using the contraceptives in the
146 beginning was because I didn't know about these things and I felt ashamed for the
147 fact that I was sexually active and my parents not knowing, and I was ashamed to
148 go to the clinic because people will look at you and judge you for what you are doing
149 at such a young age. My experience was tough with the 2-month injection it was
150 something different, something new to get used to because of your body changes.
151 I was pregnant at the age of 16 years old; my child is 2 years old and I am pregnant
152 again. Feeling ashamed of myself.

153 **IV-You say it's a tough experience?**

154 IE-With the tough experience it goes two ways. When I say tough experience, I
155 mean having to go and get every 2-month injection and the phases one goes
156 through. You get a juggle up in your hormones. And basically, when I refer to tough
157 times as a scholar its quite difficult to get a time to go to the clinic, nurses look at
158 you funny cause you in your school uniform they judge you for the fact that wearing
159 school uniform coming there to come and get injection. Even at school when you
160 ask to go to the clinic you get that judgemental look cause they wondering why are
161 you sexually active even though you have a childlike in my case they wondered why
162 I didn't go to the clinic earlier, why you only going now.

163 **Probe: You say you get judgemental looks can you tell me what do you**
164 **actually mean?**

165 IE-Well they say your parents should be the ones that should be teaching you about
166 sex and contraceptives and all of those stuff. And I was like they say child of the
167 wind in the beginning, I never took those things seriously we did a few things back

168 in my lower grade like assignments and those kind of stuff based on sex, and it was
169 still something shy to talk about in class well now it is different. Well back in grade
170 9 that was the time you got to learn about sex and condoms, contraceptives, and
171 periods and all that stuff. My reason is it never bothered me I never thought that I
172 would be in that kind of situation I never thought I would be so negligent and for me
173 to having to make a decision at such a young age to go and have contraceptives, it
174 wasn't something that I would be thinking about back then. But it is different now
175 that I have a child and I am at school. But my reasons for not using contraceptives
176 is not paying attentions I was negligent, and I felt ashamed for the fact that I was
177 already sexually active and learning about these things and not doing anything
178 about it.

179 **IV-What information did the nurse at the clinic or hospital give you regarding**
180 **contraceptives?**

181 It depends which clinic you are attending, no information, because the clinic was
182 always full. You just give your card then you get the injection, then you go. The
183 queues are always long. You can't talk privately even if you have a problem.

184 **IV-How does it feel to be pregnant at such a young age?**

185 Feeling bad and disappointed with myself, this thing that we as young people don't
186 want to listen to our parents is really a problem, because my education is in a mass.
187 My future is in a bad space. Feelings sadness and ashamed of what people are
188 going to think about me. People called me names. My parents said I was a disgrace
189 to the family. I will not advice my friends to go through what I went through.

190 **IV-How did you go through the stages of being a mother?**

191 Difficult because I had nobody to help me. My mother was hush with me, when the
192 baby was crying at night, she use to wake me up to see to my own baby. My friends
193 were far away from me. I couldn't go out at night with my friends. My boyfriend was
194 also a scholar so there was no income. My parents struggled with me and I promised
195 them that this will not happen again. To my surprise the child is 2 years old, I went
196 back to school, but I am pregnant again. I am so scared of my parents.

197 **IV-How do you feel about the services you got at the clinic or hospital**
198 **regarding contraceptives?**

199 IE-The only advantage is that when you come in your school uniform the fact that
200 you have to go back to school that's when they practically attend to you. But now
201 and again from time to time with my experience have been going right now at the
202 clinics there is pros and cons. Sometimes there is delays, sometimes they just rush
203 through things. And then you get those days where they actually sit you down, they
204 actually elaborate and give you more information about what you doing at the clinic.
205 They tell you in detail that this contraceptive that you using is only to prevent
206 pregnancies and that is where they give you pre-counselling on HIV/AIDS, they
207 issue you condoms also. I feel more relaxed and happy going to the clinic now.

208 **Probe-You say you feel more happier what has changed now?**

209 IE-There is a new section available for us teenagers and scholar it's a youth friendly
210 section with in the area of the clinic. Reason why I refer to it as more relaxed and
211 comfortable is because you receive individual undivided attention basically. There
212 is this one or two nurses that practically give you their undivided attention when you
213 go for your contraceptives, not only for contraceptives. It's the fact they can basically
214 introduce you to many other options and talk to you about many other things. We
215 even have conversations about relationship from time to time, so they help us with
216 those kind of things. How to deal with it in particular. What I like about the YOUTH
217 FRIENDLY section is the fact that when I go there it feels like I am going to talk to
218 someone, and you know that person is there to listen it is like a one on one. You
219 might get sessions when they speak to all teens to educate them about sex
220 sometimes drugs also, I mean there are times where teens have unprotected sex
221 under the influence of drugs and that's how babies are born because they do not
222 know about certain methods. They educate you on different things there, and now
223 and again the queues might be long you know because there is a lot of young people
224 going there because they feel comfortable going there then another section with in
225 the clinic. We choose to sit there because we know we will get attended to, that
226 person is not lazy, tired, or frustrated or giving us bad words because the queues
227 are so long and there is so many people that needs to be attended too. I like the fact

228 that the youth friendly section is within the clinic for teenagers or young parents like
229 myself to actually go there.

230 **IV-When you go for contraceptives do you feel comfortable with the support**
231 **you receive from the nurses?**

232 IE-I said earlier on with the new youth friendly clinic the fact that you get more
233 lessons there, it is support in the clinic is a nice thing to have there. Just for
234 everything they are doing there also it is nice to be treated privately.

235 Probing-you spoke about accidental pregnancies actually very nice regarding the
236 support and advice. They would always advise you to continue using condoms to
237 prevent not only HIV/AIDS but STIs to prevent accidental pregnancy at times
238 (especially for the girls that are on the pill) they also encourage you to get your
239 blood checked like your blood pressure your weight they even sometimes do check
240 your breast as a girl for lumps. They also talk to you to talk to others to come to the
241 clinic and to tell them what is happening at the clinic. So the

242 **What do they actually tell you about accidental pregnancy?**

243 IE-Sometimes girls make mistakes they take advantage of the fact that there is an
244 emergency pill available. When I say that the nurses encourage us to use condoms
245 it is because they would like teenagers to come and get this emergency pill and
246 that's when they would also advise you to continuously use condoms during sex.
247 When I say that they try to prevent accidental pregnancies you get some teenagers
248 that forget to take their pills for some sort of reason that they might not have taken
249 their contraceptives (pill). And they end up having sexual intercourse without using
250 a condom that's also how a girl can fall pregnant not on purpose but by mistake.
251 That's is what I mean by accidental pregnancy.

252 **Probing-So were you told where you can get the emergency pill?**

253 IE-Like we were told we can get it at the clinic but if it is late, they can receive it at
254 the family planning section with in the hospital. However, when it is late at night,
255 they can receive it at casualty. And from what I have learnt they don't actually want
256 to deal with these kinds of things at night, that is why they tell us to use
257 contraceptives and to continue using condoms as an alternative contraceptives.

258 **IV-Can you tell me in your own opinion what can be done to improve the**
259 **services for the teenagers?**

260 IE-Firstly I would like to say especially in the afternoon you see the youth friendly
261 section, doesn't only focus on contraceptive it is there for each and every young
262 person with their own problems. There is different reasons why they go there that is
263 the reason why it is always full especially in the afternoon because one doesn't get
264 a chance to go during the day to the clinic as a young students. And you sometimes
265 don't get a chance to go there after school like myself because I am a mother, I have
266 duties to attend to, so they could improve the working structure that they have
267 maybe divided every individual case into different sections of the clinic. You get that
268 one nurse that basically deal with everybody and I am sure that it is also a lot for
269 that nurse. They can even have more talks within our schools like when we have
270 sports days, they can bring out mobile trucks to teach the kids, or even telling them
271 more about the youth friendly department in the clinic you know inviting them over
272 to come and see what it is all about. More school visits by nurses, talks during
273 assembly, road shows and even doing lessons in class teachers could have open
274 talks with learners. Especially more over these topics that are so difficult for some
275 parents to have with their children. Giving out of condoms, outreach programs even
276 booklets or pamphlets, the more young people read about it the more they would
277 understand and they would take these talks more seriously. I would also like to point
278 out the MAIN issue the queues are very long at times and makes us feel
279 disappointed some of us end up leaving without getting seen so I hope that can also
280 be improved in future.

281 IV- thank you very much for your input I actually love your recommendations you
282 gave its very valuable.