

Accepted Manuscript

Title: NURSES' PERCEPTIONS OF ADOLESCENTS
ACCESSING AND UTILIZING SEXUAL AND
REPRODUCTIVE HEALTHCARE SERVICES IN CAPE
TOWN, SOUTH AFRICA: A QUALITATIVE STUDY

Authors: Kim Jonas, Nicolette Roman, Priscilla Reddy, Anja
Krumeich, Bart van den Borne, Rik Crutzen



PII: S0020-7489(19)30132-4
DOI: <https://doi.org/10.1016/j.ijnurstu.2019.05.008>
Reference: NS 3360

To appear in:

Received date: 30 September 2018
Revised date: 10 May 2019
Accepted date: 11 May 2019

Please cite this article as: Jonas K, Roman N, Reddy P, Krumeich A, den Borne Bv, Crutzen R, NURSES' PERCEPTIONS OF ADOLESCENTS ACCESSING AND UTILIZING SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES IN CAPE TOWN, SOUTH AFRICA: A QUALITATIVE STUDY, *International Journal of Nursing Studies* (2019), <https://doi.org/10.1016/j.ijnurstu.2019.05.008>

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

NURSES' PERCEPTIONS OF ADOLESCENTS ACCESSING AND UTILIZING SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES IN CAPE TOWN, SOUTH AFRICA: A QUALITATIVE STUDY

Kim Jonas^{a,b,c,*}, Nicolette Roman^d, Priscilla Reddy^{d,e}, Anja Krumeich^f, Bart van den Borne^a, and Rik Crutzen^a

^aSchool of Public Health and Primary Care (CAPHRI), Department of Health Promotion, Faculty of Health, Medicine and Life Sciences, Maastricht University, P.O. Box 616, 6200 MD, Maastricht, the Netherlands.

^bHealth Systems Research Unit (HSRU), South African Medical Research Council (SA-MRC), Cape Town, South Africa

^cDivision of Child and Adolescent Psychiatry, Adolescent Health Research Unit, University of Cape Town, Rondebosch, Cape Town, South Africa

^dFaculty of Community and Health Science, University of the Western Cape, South Africa.

^eHuman Sciences Research Council (HSRC), Population Health, Health Systems and Innovation Unit, Cape Town, South Africa

^fDepartment of Health, Ethics and Society/ Global Health, Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, the Netherlands.

Email addresses:

KJ: kim.jonas@mrc.ac.za NR: nroman@uwc.ac.za PR: preddy@hsrc.ac.za

AK: a.krumeich@maastrichtuniversity.nl BVDB: b.vdborne@maastrichtuniversity.nl and RC: rik.cruzen@maastrichtuniversity.nl

*Corresponding author details: South African Medical Research Council (SAMRC), Health Systems Research Unit, Francie van Zijl Drive, Parow Valley, Cape Town, 7501

Email: kim.jonas@mrc.ac.za

Telephone: +27 21 938 0344

ABSTRACT

Background: In Sub-Saharan Africa access to and utilization of sexual and reproductive healthcare is unsatisfactory. Consequently, rates of teenage pregnancy and unsafe abortions among adolescents in Sub-Saharan Africa, including in South Africa remain a public health challenge. The aim of this study was to explore nurses' views on and perceptions of adolescent girls' barriers and needs to accessing and utilizing sexual and reproductive healthcare services.

Methods: Twenty-four purposively selected healthcare workers from nine public healthcare facilities in Cape Town, South Africa participated in this qualitative descriptive study. Data were collected through nine group discussions, and audio-recorded with hand-written notes taken during the discussions. Data were analyzed using thematic analysis, following the Tesch's eight steps for coding and analysing qualitative data.

Results: Sexual and reproductive healthcare nurses are generally supportive of adolescents who ask for and use contraceptives. Non-compliance to family planning regimens and repeated requests for termination of pregnancies were perceived by nurses as irresponsible behaviours which are particularly frustrating to them and not in concordance with their personal values. The subsequent nurse-adolescent interactions sometimes appeared to hinder access to and utilization of sexual and reproductive healthcare services by adolescents.

Conclusions: Nurses perceive certain behaviours of adolescent girls as irresponsible and warrant their negative attitudes and reactions toward them. The negative attitudes and reactions of nurses potentially further compromises access to and utilization of sexual and reproductive healthcare services by adolescent girls in South Africa and requires urgent attention. Adolescent-friendly clinic hours together with youth-friendly nurses is likely to encourage adolescent girls to access sexual and reproductive healthcare services and improve the use thereof.

Keywords: Adolescents, Behaviours, Family Planning, Healthcare workers, Compliance, Provider perspectives, Sexual and Reproductive healthcare Termination of pregnancy

1. Introduction

Globally, about 16 million girls between the ages of 15 and 19 years give birth every year, translating to 11% of all births (WHO, 2015). Almost all these births (95%) occur in low- and middle- income countries (LMICs) with more than 50% attributed to Sub-Saharan Africa (WHO, 2014). Furthermore, Sub Saharan Africa had the highest prevalence of teenage pregnancy in the world in the year 2013 (UNFPA, 2015). More than 220 million women have an unmet need for family planning in LMICs, with the majority being adolescents in SSA (Singh and Darroch, 2012). Consequently, rates of teenage pregnancy, unsafe abortions and sexually transmitted infections (STIs), including HIV infection rates are highest among adolescents in Sub Saharan Africa, including in South Africa (Tilahun et al., 2012; Morris and Rushwan, 2015; Jonas et al., 2016; Lopez et al., 2012). According to the South African Demographic Health Survey of 2016 (SADHS 2016), of the 969 415 births registered in 2016, 136 996 (13,9%) were born to mothers aged between 10 and 19 years old. However, adolescent fertility rate in the country has declined from 76 in 1998 to 71 births per 1 000 girls aged 15 to 19 in the SADHS 2016 though it still remains high (Statistics SA, 2016).

Adolescent girls' access to and utilization of sexual and reproductive healthcare services, especially family planning services, is influenced by a number of factors. For example, community reactions as well as societal norms pertaining to contraceptive use stigma as an example, and health system related factors, such as clinic operating hours all affect their access and utilization. Influential people include schoolteachers, healthcare workers, parents, other family members, and their own peers (Morris and Rushwan, 2015; Wood and Jewkes, 2006). In South Africa, only a small proportion of adolescent girls who need sexual and reproductive healthcare services actually access the services, as many are discouraged by these structural and related factors described above (Müller, 2017). Moreover, adolescent girls perceive healthcare workers' negative attitude and behaviour as key barriers. Adolescent girls report that rude, judgmental, scolding, unfriendly treatment, and lack of respect from nurses hinder their access and utilization of sexual and reproductive healthcare services (Morris and Rushwan, 2015; Tsawe and Susuman, 2014; Macleod and Tracey, 2010; Alli et al., 2013; Biddlecom et al., 2007; Hokororo et al., 2015; Geary et al., 2015). However, there is limited research on how reproductive healthcare nurses perceive adolescent girls who access and utilize sexual and reproductive healthcare services. The few studies that examined nurses' perspectives found that nurses perceive young people as ignorant of the available sexual and reproductive healthcare information and services and believe that the

services are easily accessible to them (Holt et al., 2012). Additionally, nurses report that their limited knowledge and competency in providing sexual and reproductive healthcare services to young people may hinder access and utilization of services (Holt et al., 2012; Jonas et al., 2016). Nurses also perceived shortage of staff, age of the sexual and reproductive healthcare nurse, and transport costs as other barriers faced by adolescents (Holt et al., 2012; Jonas et al., 2016; Herrman, 2013; Müller et al., 2016).

An insight into the nurses' perspectives of adolescent girls who access and utilize sexual and reproductive healthcare services might offer an explanation to their reported negative attitudes and behaviours towards them. For example, nurses may behave unfriendly towards adolescent girls seeking sexual and reproductive healthcare services because of their perceptions of adolescent girls' sexual activity. For instance, some nurses think that providing adolescent girls with contraceptives would promote their sexual activity, which they use to legitimize their unfriendly treatment (Tilahun et al., 2012; Tsawe and Susuman, 2014; Ahanonu, 2014; Nalwadda et al., 2011). Additionally, the contradictory nature of the sexual and reproductive healthcare policies and the legal age for consensual sex in South Africa leave nurses in a predicament when it comes to providing the services to adolescent girls, and influences their behavior toward them (Müller et al., 2016). This study therefore explored nurses' views on and perceptions of adolescent girls accessing and utilizing sexual and reproductive healthcare services, notwithstanding the legal framework pertaining to sexual and reproductive healthcare services for adolescents in South Africa. Nurses' views can complement those of adolescent girls and help build a bridge between the provider and the user, alleviating challenges on both sides for better access and utilization of sexual and reproductive healthcare services by adolescent girls. Understanding the nurses' perceptions of their adolescent girls clients will help develop interventions that aim to enhance nurses' relationship with adolescent girls seeking sexual and reproductive healthcare services, while concurrently improving access and utilization of services. This study focused on the personal perspectives of healthcare providers providing sexual and reproductive healthcare services, in order to strengthen and increase efforts to improve adolescent girls' access to and utilization of the services in South Africa. It builds on Muller et al., (2016) who focused on the legal frameworks around providing sexual and reproductive healthcare services to adolescents in South Africa. Moreover, this study specifically focused on sexual and reproductive healthcare services for adolescent girls as the vulnerable and fragile population affected by unwanted and unintended pregnancies, and sexually transmitted infections (STIs) including HIV.

2. Methods

2.1. Design and setting

This qualitative study was conducted among healthcare workers at public health clinics situated in the urban centres of Cape Town. The facilities included the primary health clinics and community health centers. Primary health clinics are defined as facilities that provide a range of primary health care services. Community health centers are defined as facilities that usually provide more extensive services than provided by the primary health clinics, with 24-hour maternity, accident and emergency services and beds where health care users can be observed for a maximum of 48 hours and which normally have a procedure room but not an operating theatre (Cullinan, 2006). Both primary health clinics and community health centers typically provide similar services to adolescent girls, except in the case where the services are not being provided in primary health clinics. For example, termination of pregnancy services are not offered in some primary health clinics, so these primary health clinics refer to community health centers and other secondary levels of care for such services. However, not all community health centers operates on a 24-hour bases, some community health centers were previously primary health clinics but due to improvements in the clinics they were renamed to community health centers but not necessarily

function as the second level of care.

A qualitative descriptive study design was employed in this study. This design is applied when a research study seeks to discover and describe a phenomenon, a process, or perspectives and views of the people involved (Neergaard et al., 2009; Caelli, Ray & Mill, 2003). Qualitative descriptive study designs offer comprehensive information of an event (Sandelowski, 2000). The design also provide means to voice the views and opinions of the nurses and is useful in research that aims to transform nursing and midwifery practice, including health care services in general and can influence health care provision through recommendations and policy changes (Bradshaw, Atkinson & Doody, 2017; Sullivan-Bolyai et al., 2005). Therefore, based on the nature of this study which aimed to uncover the perspectives and views of nurses in the sexual and reproductive healthcare services, this design was considered appropriate and fitting to better describe the nurses' views and perceptions of adolescent girls seeking sexual and reproductive healthcare services.

2.2. Sampling

The sampling framework for healthcare facilities consisted of public healthcare facilities that provided sexual and reproductive healthcare services in the district. There were 46 clinics in Cape Town, of which 13 were the community health centers and 33 were primary health clinics. Not all these facilities provided sexual and reproductive healthcare services, but all community health centers did. The selection of clinics was therefore based on the clinic having to provide sexual and reproductive healthcare services, the community profile that the clinic was serving in order to have views from the different socio-economic status of the Cape Town communities, and, lastly, the feasibility to conduct the study (e.g., in terms of logistics).

Public healthcare facilities that provide sexual and reproductive healthcare services were therefore selected purposively. The clinics had to provide sexual and reproductive healthcare services to adolescent girls or have a youth clinic program within the facility where they offer a variety of services to the youth, including family planning services to adolescent girls. However, the most important purposive criterion for this study was the presence of at least four or more healthcare providers in the facility, of which two had to be providing sexual and reproductive healthcare services to adolescent girls on a regular basis. This criterion was also necessary in order to obtain permission from the City of Cape Town municipality, as that would ensure that the study would not disrupt clinic procedures and compromise patient care. Therefore, the City of Cape Town municipality approved the conduct of this study on condition that the clinic operations would not be disturbed. Furthermore, the researchers had to ensure that patient care would not be disrupted in any way by the study's activities. Thus, to ensure that the clinic operations were not disrupted, it was agreed that only a portion of the healthcare workers in a specific clinic could participate in the study, based on the participants' purposive sampling criteria described below. Furthermore, safety and distance to the clinic were also considered in selecting the clinics due to the high rate of crime, gang violence, and violent protesting in some areas; and therefore, clinics in such areas were not selected. And thus, twelve clinics were selected for this study. However, two clinics were excluded as they were deemed unsafe for visits due to protests in the vicinity unrelated to the focus of this study, and one was used for the pilot. Hence, the sample consisted of nine clinics, of which seven were primary health clinics and two were community health centers. All clinics were based in urban settings and spread across the different socio-economic status settings of Cape Town, with three clinics located in the higher socio-economic status neighbourhoods and six in the lower socio-economic status neighbourhoods.

2.3. Participants

Nurses who were trained in family planning services and were providing the services, nurses who were designated family planning sisters or youth clinic sisters, and nurses who regularly provided sexual and reproductive healthcare services to adolescent girls were targeted from the selected

clinics. Family planning and youth clinic sisters are nurses assigned to provide family planning and other sexual and reproductive healthcare services only to adolescent girls and young people at a specific clinic. One to eight (1-8) family planning nurses are employed in the primary health facilities, depending on the total number of all nurses employed in a particular clinic. In the sampled clinics, three clinics had four family planning nurses, the next three clinics also had three family planning nurses, and the last three clinics had two family planning nurses employed at the time of data collection.

Because some clinics had the minimum number of four healthcare providers in their facility, only two nurses could be approached and invited to the study as per the City of Cape Town municipality approval conditions in those facilities. Thus, a total of 28 professional healthcare workers who worked in sexual and reproductive healthcare services were purposively approached face-to-face and recruited from the clinics visited (with help from the facility managers). They were then invited to participate in the group discussions that were conducted within the facility that they worked at. Of these, 24 of them agreed and participated in the study, including male nurses who provided sexual and reproductive healthcare services. Four nurses refused to participate because of limited time and patient overload in their facilities. Because of the shortage of professional healthcare workers in public healthcare facilities in South Africa generally, and especially sexual and reproductive healthcare designated nurses, two to four nurses were included in the group discussions. The possibility of conducting the group discussions after hours was explored but this was not an option for the healthcare workers as they had family responsibilities to fulfill.

Although the original intention of this study was to conduct focus group discussions with four or more participants, we found it was not always possible to do so. We therefore conducted a mix of focus group discussions (when four or more participants were available) and otherwise interviewed two to three participants in a group as in-depth discussions albeit not focus group discussions. In total, nine group discussions, (5 in-depth discussions and 4 focus group discussions) were conducted. The in-depth discussions provided time for a deep exploration into the topic of concern for this study.

Participants' education consisted of the usual general nursing curriculum with no speciality courses in adolescent health and behaviour. Although training and refresher courses on sexual and reproductive healthcare services including family planning are offered throughout the year, none of these are specific to adolescent health. The participants were diverse in terms of demographic characteristics (see Table 1). Each participant received an incentive of approximately €10 (i.e., R200) in a form of a grocery voucher to compensate for his or her time spent participating in this research.

2.4. Data collection tools

An open-ended semi-structured guide with probes was used to explore nurses' views on and perceptions of adolescent girls' barriers and needs to accessing and utilizing sexual and reproductive healthcare services in SA. Examples of the probing statements and questions included the following: 1) Can you tell me more about your own personal opinions about adolescent girls' sexual activity; 2) Do you think your personal opinions about adolescent girls' sexual activity affects the way you deal with those seeking sexual and reproductive healthcare services like family planning? Please elaborate; and 3) Are there certain situations or circumstances in the facility that prevents you from providing adequate sexual and reproductive healthcare services to adolescent girls? Please explain. To ensure that the probing questions and statements were applicable and understandable to participants, two pilot interviews were conducted with healthcare professionals in sexual and reproductive healthcare services, and modifications and adaptations were implemented as necessary (e.g., the next statement was modified after the pilot as the previous

statement was not easily understandable by the nurses: Healthcare workers approve of adolescents using contraceptives if they are sexually active. Probe for further details).

All group discussions were conducted between June and August 2016, in English, audio-recorded and hand-written notes were taken during the discussions, which lasted about 30 minutes to an hour. There was no translation required of the transcripts. A brief questionnaire to document nurses' socio-demographic characteristics was also used.

2.5. Procedure

Two researchers (KJ and RC) co-facilitated the group discussions. Both researchers, male and female are experienced researchers with one having obtained a PhD (RC) and the other one a Masters degree (KJ) at the time of data collection. One researcher (KJ), is a Black African female, born in South Africa, has studied and worked in the country for a minimum of six years at the time of data collection. The other researcher (RC), is a White non-South African. A research assistant who is a Black African woman, born in South Africa, was trained for this specific study and was always present during the group discussions and took notes. There was no existing relationship with participants prior to data collection for this study and therefore no conflict of interest between the participants and the researchers. All group discussions were conducted at the clinics. Data saturation was discussed after the sixth group discussion and it became clear that there were no new views transpiring from the discussions by the ninth group discussion and data was deemed saturated at this point. Data triangulation was also conducted utilizing written notes and observations during data collection.

2.6. Data analysis

Data were analysed using thematic analysis. The data analysis followed the Tesch's eight steps for coding and analysing qualitative data (Tesch, 1990). Data were transcribed verbatim from the audiotape recordings, and analysed.

Typed transcripts were read and codes were developed and defined based on the objectives of the study, thus themes were derived from the data. Two independent researchers developed and checked the coding until they reached consensus. Then, codes were grouped into sub-themes and then into themes. Data were coded and analyzed using *Nvivo* qualitative data analysis software. The coded transcripts were analyzed by running query reports and primary document tables of codes by theme, to explore the issues from the various group discussions. To strengthen the trustworthiness of the data, data triangulation was conducted. Written notes and observations during data collection were compared with the data from group discussions and corroborated the findings of this study. Furthermore, more than one person performed data analysis independently and analyses were compared. The two researchers met regularly to compare and discuss their findings until consensus was reached.

3. Results

3.1 Participants

Table 1 shows the demographic characteristics of the nurses who participated in the group discussions. The majority of nurses were aged between 25 to 56 years old and were either married or living together with their partner. Male nurses also participated in the study, although only few, and all of them were married.

The results of the group discussions are presented below according to the following themes derived during data analysis: adolescents' lack of knowledge about sexual and reproductive healthcare risks and services available, adolescents are fragile and scared to access sexual and reproductive

healthcare services, and finally, adolescent' behaviours potentially influencing access to and utilization of sexual and reproductive healthcare services.

3.2 Themes

3.2.1. Adolescent girls' lack of knowledge about sexual and reproductive healthcare risks and services available

During the group discussions, nurses were asked what they thought are the challenges experienced by adolescent girls in accessing sexual and reproductive healthcare services. All nurses reported that adolescent girls need more information and education regarding family planning services, including the different types of contraceptive methods available. Nurses perceive adolescent girls' limited knowledge of sexual and reproductive healthcare services as a barrier and attribute it to their poor access to and under-utilization of sexual and reproductive healthcare services. Nurses also believe that adolescent girls' knowledge is clouded with the myths around contraceptive use, which discourages them from using contraceptives.

"Like most of them [adolescent girls] I find that they don't have a lot of knowledge of what's happening, what sexual and reproductive healthcare services are available for them, and what are the methods that we do have to offer to them." **Diploma qualified nurse, aged between 32-37 years old**

"...because of the stigma, if they coming to the clinic it means they have boyfriends or something like that." **Diploma qualified nurse, 38-43 years**

It also appears that social norms regarding the use of contraceptives exist such as the need to prove fertility, which prevents adolescent girls from accessing and utilizing the sexual and reproductive healthcare services. Adolescent girls' sexual activity is also viewed as a taboo by some nurses based on their religious and cultural beliefs which oppose sex before marriage.

"...they see this in their communities, other pregnant women and they think its cool...so they also do it and their peers do it...like they are trying to prove a prove a point [that they can also bare children] ..." **Degree qualified nurse, aged 32-37 years**

"Let me tell you... some of the nurses here in this clinic still get angry when they see these girls in school uniform coming for family planning and they talk...saying these kids should not be having sex, they are too young to be having sex... but we have to be realistic..." **Diploma qualified nurse, aged 32-37 years**

"...But we also have to be realistic, these kids are having sex and they are going to continue having sex, we cant change that, no matter what we tell them or what are beliefs says... you see, me I'm a born again Christian and I don't believe in sex before marriage but I cant trust that if I tell this child not to have sex she will listen to me so I just have to educate and make sure she's protected...of course I get tempted when it's a 12-14 years old girl, she is still a child..." **Diploma qualified nurse, aged 32-37 years**

3.2.2. Adolescent girls are fragile and scared to access sexual and reproductive healthcare services

Nurses acknowledged that adolescent girls are emotionally fragile and are often scared to seek sexual and reproductive healthcare services, especially contraceptives. According to the nurses, they feel that adolescent girls are scared of what the nurses would say and how they would react to them when they come for contraceptives, or what they would find out when they reach the clinic,

such as discovering that they are already pregnant or worse, infected with HIV. Thus, nurses feel that it is important for them to be friendly and sensitive when they attend to adolescent girls requiring contraceptives.

“They are still scared, fragile and emotional...So you need to be more sensitive to them and speak their language so that they can easily reach you.” **Male nurse, degree qualified, aged between 32-37 years old**

“You need to be sensitive and open or warm to them when they come for family planning, because they are already scared and worried what we [the nurses] going to say to them, whether they will get the service they need...” **Degree qualified nurse, aged between 32-37 years old**

In almost all group discussions nurses commonly reported fear of being seen in the clinic for contraceptives as a barrier for adolescent girls' contraceptives use. Nurses also felt that using their previous personal experiences to better relate to and communicate with adolescents is important to enable adolescent girls to easily reach and trust them. According to the nurses, they find that putting themselves in the adolescent girl's shoes and recalling their own experiences as teenagers is important when providing sexual and reproductive healthcare services to adolescent girls, as that reminds them of how to better treat adolescents. The nurses believe that this makes it easier for adolescent girls to reach them and be able to ask them questions about whatever sexual and reproductive healthcare issue they might have, and thus encourage them to continue to access the services for their sexual and reproductive healthcare needs.

“As a teenager yourself, you can remember how difficult and stressful it was to go to the clinic for these things [contraceptives] ... so you try and make it easy for these adolescents because you don't want them to go through what you went through, or end up being pregnant because they are afraid of you. That is how we, as sexual and reproductive healthcare Sisters can help our communities reduce teenage pregnancy...” **Diploma qualified nurse, aged 38-43 years old**

Nurses also recognize that their attitude is not always accommodating adolescent girls who are seeking sexual and reproductive healthcare services. Nurses feel that their attitude, as well as the atmosphere at the clinic is an important factor affecting adolescent girls' access to and utilization of sexual and reproductive healthcare services. With regards to the atmosphere at the clinic, nurses reported that the manner in which the reception desk is set up might actually be driving adolescent girls away as it has no privacy.

“I think we are not really accommodating, because they [adolescent girls] gave feedback on our outreach program saying that the staff attitude is a problem for them, so maybe that is why they don't come to this specific clinic because of the staff attitude.” **Diploma qualified nurse, aged between 25-31 years old**

“And the fact that our reception is very open and then you have to speak loud if you come for something, so if you are young and you already scared, and then you have to say loudly that “I'm coming for family planning” then they rather end up not coming or just leave the clinic.” **Diploma qualified nurse, aged 38-43 years old**

In addition to the atmosphere at the clinic, nurses strongly feel that adolescent girls need their own physical space. They should be able to visit sexual and reproductive healthcare services without being seen by family relatives or other adults or by neighbours who would most likely tell their

parents. Nurses do not only find this as a potentially serious barrier to accessing sexual and reproductive healthcare services and the use thereof, but also a contributing factor to family planning non-compliance.

“Just like the other one, she came in for family planning and the mother also came in for family planning but she didn’t know that the daughter is using family planning, and they were sitting on the same line, and she said “I saw my daughter here” so now she [the daughter] will not feel comfortable to come back the next time because she knows her mother is also having the same return date.” **Diploma qualified nurse, aged 32-37 years old**

3.2.3. Adolescent girls’ behaviours potentially influencing access to and utilization of sexual and reproductive healthcare services

When the nurses were asked about their perceptions of adolescent girls using sexual and reproductive healthcare services such as contraceptives, most of them were rather ambiguous. The nurses have categorized the behaviours of their adolescent sexual and reproductive healthcare patients as either responsible or irresponsible, and this categorization comes with different treatment and attitudes from the nurses. On the one hand, nurses feel that adolescent girls who are using contraceptives are responsible girls and they praise them for taking that decision for their sexual and reproductive healthcare needs. Nurses reported that they particularly praise an adolescent girl who returns on time for their follow-up appointments as that emphasizes the responsible behaviour of the girl, especially, as pointed out by some nurses, because that way unwanted pregnancies can be avoided. The nurses reported that they also encourage responsible behaviour and continue to motivate adolescent girls who uphold it. Encouraging and motivating responsible adolescent girls enhances continuous use of contraceptives by adolescent girls. Nurses also reported that the responsible behaviour also helps them to be more understanding and lenient when the adolescent girl is a couple of days late for her follow-up appointment due to some unforeseen circumstances, as the records would show that the adolescent girl’s typical behaviour has always been responsible. Consequently, these responsible adolescent girls receive better treatment and care, and positive attitudes from the nurses.

“... when they come first time to the clinic, for me personally, I really praise them, because they have taken a good decision for themselves.” **Degree qualified nurse, aged 32-37 years old**

“...but some do stick to their follow up appointments and you kind of know them and that tells you that this one is responsible, because you can see on their appointment cards. So when they are late by a day or 2 you understand, even when they are late by a week you don’t yell at them, you just re-emphasize and educate because you know she’s responsible....” **Male nurse, degree qualified nurse, 32-37 years**

On the other hand, nurses described adolescent girls’ irresponsible behaviours such as non-compliance with their contraceptive regimen, unsafe sex practices, “know it all” attitude, or generally not taking things and life seriously. These irresponsible behaviours particularly frustrated the nurses. Not only because it hindered them to provide adequate sexual and reproductive healthcare services to adolescent girls, but also because this would lead to repeated requests of termination of unwanted pregnancy. Some nurses feel that some adolescent girls are just not grasping the seriousness and importance of using contraception to prevent unwanted

pregnancy. The “know it all” attitude of some adolescent girls hinders provision of adequate sexual and reproductive healthcare information by nurses, as this attitude prevents the nurses from elaborating on some sexual and reproductive healthcare information. This appears to disturb the nurses.

“They think they know but they don’t know. They don’t think about their future, they think in front of their feet, they think about their happiness, they don’t think this is a delay somehow to their life, it’s a fashion to them in a way [to have boyfriends]” Diploma qualified nurse, aged more than 50 years

With regards to unsafe sex practises, nurses reported that many adolescent girls do not want to use condoms and as a result they repeatedly come for STI management or are found positive for HIV. This unsafe and risky sex practices did not only frustrate the nurses, but also affected them emotionally.

“When you give them the injection and then you give them condoms, they say “and then, what’s this for now, isn’t this [the contraceptive injection] for that purpose? Why must I eat a sweet in a paper?” you see they have those kind of things, at their age, it’s not right. Their attitude, I so wish I can just take it out from them because the way they think it’s not right for them...” Male nurse, degree qualified, aged 32-37 years old

“Because, I don’t want to lie to you, it actually disturbs you when you get a 12 year old and you test that child positive for HIV...” Degree qualified nurse, aged 25-31 years old

All nurses reported that adolescent girls’ non-compliance with a proposed family planning regimen is one of the most frustrating irresponsible behaviours in sexual and reproductive healthcare services. They explained how much they dwell on this compliance issue when adolescent girls come to initiate family planning use. However, nurses explained that the health systems’ challenges and non-prioritization of sexual and reproductive healthcare services also contribute to the non-compliance though they do not see it as a major contributing factor. This non-compliance behaviour also has an influence on how the nurses treat adolescent girls who continue to miss their follow up appointments, as they reported to use the harsh and unfriendly attitude towards the adolescent girl who continues to miss their follow up appointment.

“...because they don’t always keep their date, they come 2 weeks later, a month later saying Sister I was in Eastern Cape, or Sister this and Sister that. So usually I get mad with them, because I told them the very first time they come, you must be adherent to your contraceptive, should you miss them, then you are going to get pregnant and you don’t need pregnancy at this time.” Degree qualified nurse, aged 32-37 years old

“Of course, I’m going to be like angry at you and my style will be different, but I will give you the service and afterwards I will realise that I was blowing off steam, I need to calm down. And I will just explain this time nicely like okay this and that, please follow up on your appointments, because I’m tired now I have been telling you the same thing over and over again.” Diploma qualified nurse, aged 38-43 years old

“...when there’s a shortage of staff, we close the family planning side then we come to the sick side where there’s an emergency so the family planning clients are always not priority...” Degree qualified nurse, 32-37 years

*“but if anything happens in the sense that there’s no staff or something happens, they will need me or her to help the other patients in other sections then my patients will be sent home or my patients will be cancelled for the day because that is not a priority.” **Diploma qualified nurse, 44-49 years***

Nurses also reported to be frustrated by the “repeated” requests of termination of pregnancy from adolescent girls. Nurses perceive this behaviour as unacceptable and disturbing. They reported to have some empathy the first time the girl requests termination of pregnancy, and use the worst-case scenarios as explanation warranting her to seek termination of pregnancy, such as maybe she was raped or fears to dropout of school or university as a consequence of the pregnancy. However, when the girl returns the second time for termination of pregnancy or the third time, the nurses reported that they actually do not feel sorry or empathise with her anymore as it shows that she is not responsible and that she is using abortion as a contraceptive method.

*“For the first time you think this child is young, maybe your counseling was not enough, but for the second time, you just know that they are not taking responsibility for their actions.” **Degree qualified nurse, aged 38-43 years old***

*“...for me, I think about this girl’s future and think about her family situation...if she keeps the baby she might not be able to go back to school and finish... so I might not agree with termination of pregnancy but if a girl comes asking for it, I provide the services” **Diploma qualified nurse, aged more than 50 years***

*“if she’s coming for the first time to do termination of pregnancy, I empathize, I consider she may have been raped, she made a mistake or something...because with termination of pregnancy comes emotions and all other stuff...but also they are babies dumped in the streets because the mothers cannot afford them or they don’t want the baby, there are many reasons. But for a teenager these days, bad things happen to them, so you have to provide termination of pregnancy, but I make sure I educate her and make her understand that this is not good for her she must use family planning.” **Degree qualified nurse, aged 32-37 years***

Thus, it appears that nurses create categories and come up with explanations that enable them to deem the way they provide certain services or treat some adolescent girls in certain ways warranted, such as the “worst-case” scenarios to provide termination of pregnancy services to adolescent girls. This potentially threatens and sometimes violates the rights of adolescent girls to fully access and utilize sexual and reproductive healthcare services for their needs and is a cause for concern. Furthermore, this undermines the mandates set out by the international treaties for improving access to and utilization of sexual and reproductive healthcare services by adolescent girls.

It is worth noting that perspectives of nurses on adolescent girls’ use of sexual and reproductive healthcare services in this study did not vary by education or age differences. Only one nurse of the age group more than 50 years had strong and opposing views against termination of pregnancy, as she stated that it is the only thing in her profession she will never perform, the rest of the views were similar. Additionally, the 24-37 age group of nurses seemed to be bothered too much about the quality of services they provide to adolescent girls while the 38 year old and above nurses were more concerned about preventing termination of pregnancy and that somehow set the basis of their motivations to provide family planning services to adolescent girls. With regards to the educational qualifications, similarly only two diploma-qualified nurses had differing opinions about family planning use by adolescent girls due to their religious beliefs which don’t condone sex before marriage.

4. Discussion

The findings of this study show that nurses are generally supportive of adolescent girls using sexual and reproductive healthcare services such as contraceptives and continue to encourage them to use the services. However, nurses acknowledged the challenges faced by adolescent girls, which prevent them from optimally accessing and utilizing sexual and reproductive healthcare services. Amongst other factors, misconceptions of and myths around contraceptive use are the main challenges hindering adolescent girls to fully access and utilize sexual and reproductive healthcare services, according to the nurses. This finding echoes previous research where contraceptive education for adolescent girls, as well as the need to address societal misconceptions and contraceptive myths have been identified as areas needing attention in order to improve access to and utilization of sexual and reproductive healthcare services (Morris and Rushwan, 2015; Lopez et al., 2012; Tsawe and Susuman, 2014). The findings of this study are not unique to adolescent girls only, but also relevant to adolescent boys and those identifying themselves as homosexuals, as Muller et al., (2018) report significant challenges in accessing sexual and reproductive healthcare services for the minority groups of adolescents, including homosexual adolescents.

Nurses particularly find non-compliance to family planning regimen by adolescent girls as the main irresponsible behaviour that makes them unfriendly towards the adolescent girls perceived to be non-compliant. Subsequently, the adolescent-nurse relationship is negatively affected as the nurses use a harsh tone and unfriendly treatment towards that particular non-compliant adolescent girl. Consequently, the negative adolescent-nurse relationship is likely to discourage the adolescent girl to come for her family planning follow-up appointment and exacerbate the non-compliance behaviour, as they are afraid of further scolding. Indeed, it has been reported that the unfriendly treatment from nurses discourages youth to attend clinics for their family planning follow-up appointments (Tsawe and Susuman, 2014; Smith and Harrison, 2013; Jewkes et al., 2009). However, the nurses in this study do not seem to acknowledge that the scolding and “blowing off steam” caused by the late follow-up visit of some adolescent girls is perpetuating the non-compliance. Some of the nurses believed that the scolding is necessary to show that coming late for a follow-up appointment is wrong and the scolding is meant to reiterate to the girl that she should not repeat such. The nurses may have good intentions emphasizing the importance of family planning compliance to their adolescent girls; but how they do it might actually be perpetuating the poor access to and utilization of sexual and reproductive healthcare services by adolescent girls. However, it should be highlighted that the adolescent girls’ behaviours reported by the nurses in this study are typical teenage behaviours intertwined with environmental and socio-economic dynamics within which the girls live in. Thus, it is important for nurses to understand and treat adolescent girls with cognizant of their development phase, as well as considering these environmental and socio-economics factors in order to influence change in their lives and promote healthy behaviours. An intervention to educate and remind nurses about the complexity of human development in adolescence, and how the environmental and socio-economic challenges affect behaviour may be beneficial to the nurses and help improve the adolescent-nurse relationship.

Furthermore, nurses acknowledged the health systems’ challenges such as the clinic reception set-up, the lack of staff and subsequent non-prioritization of sexual and reproductive healthcare services as contributing factors to adolescent girls’ non-compliance with family planning. The nurses believe that the reception is not private enough for adolescent girls who are already shy in accessing contraceptive services and the fact that in some clinics there is no adolescent (youth) clinic times. The adolescent girls come to clinics the same time as adults, and as elaborated above, is associated with the non-compliance, as adolescent girls will go away if they see someone they know in the clinic. Nurses in this study appeared to be particularly frustrated by the health systems’ challenges they face every day but cannot do anything about it as they stated that there’s nothing they can do, especially with the non-prioritization of their family planning clients. Nurses feel that

the health system can be unfair sometimes as it does not consider the consequences brought by neglecting some services. This finding echoes findings from Muller et al., (2016) where nurses also reported the infrastructural, health systems-related factors, including staff shortages as contributing factors to poor access and use of sexual and reproductive healthcare services, and to the quality of services rendered to those adolescent girls who come seeking the services. Nonetheless, nurses in this study still get frustrated by adolescent girls who come late for their appointments, despite the possibility of reasons behind the defaulting could be healthcare systems challenges. Moreover, the reactions of nurses to adolescent girls' family planning non-compliance might also act as a barrier to them in accessing and utilizing sexual and reproductive healthcare services. This may further increase adolescent girls' vulnerability to even more serious consequences such as contracting HIV infection or carry out unsafe and illegal termination of pregnancy, as they may not access healthcare for their sexual and reproductive healthcare needs because they fear the nurses' reactions (Tsawe and Susuman, 2014; Svanemyr et al., 2015; Rehnström Loi et al., 2015; Mannava et al., 2015). Thus, a multitude of factors need to be addressed in order improve family planning compliance by adolescent girls in South Africa. Such factors include first and foremost, the healthcare systems' challenges such as adequate staffing and youth-friendly clinic operating hours.

Repeated requests of termination of pregnancies from adolescent girls also bothered the nurses. It appears that some girls might be using abortion as a method of contraception, according to the nurses' perspectives. This is a challenge needing to be addressed. Previous studies reported nurses' strong feelings against termination of pregnancy in general, and that might drive away adolescent girls after seeking termination of pregnancy services, from further accessing and using contraceptives services thereafter (Tilahun et al., 2012; Ahanonu et al., 2014; Rehnström Loi et al., 2015; Mannava et al., 2015; Harries et al., 2009; Mngadi et al., 2008; Godia et al., 2013). This finding is not unique and supports previous research on healthcare providers views on termination of pregnancy services. It has been reported that nurses sometimes undermine access to termination of pregnancy services by not sharing necessary information regarding termination of pregnancy facilities or by actively discouraging clients from doing a termination of pregnancy (Harries et al., 2009; Jewkes et al., 2005). Moreover, nurses appear under certain conditions, to support termination of pregnancy services, such as when a girl has been raped, or when schooling and the girl's future would be at jeopardy. Rohrs et al., (2017) also identified that nurses make moral judgments and create categories or groups to justify for the types of services they provide to the different groups as they see fit, morally (Rohrs et al., 2017). Additionally, in the previous study that we conducted, we also found the same strong feelings against termination of pregnancy from some nurses (Jonas et al., 2018).

Nurses reported that adolescent girls are often scared to seek sexual and reproductive healthcare services, but when they do come for the services, some nurses are not that positive and happy to provide them with the sexual and reproductive healthcare services they require, particularly termination of pregnancy (Jonas et al., 2018). Similar to previous research, some nurses consider the foetus as a living human being and according to their belief, providing termination of pregnancy is killing a human being and therefore complicit (Rehnstrom Loi et al., 2015; Harrison et al., 2000). Furthermore, nurses feel that health facilities are a place to save lives not destroy them, and that "the foetus should also have rights" (Rehnstrom Loi et al., 2015). It is highly likely that the nurses' reactions towards adolescent girls seeking termination of pregnancy do not encourage them to continue seeking sexual and reproductive healthcare services, such as contraceptives, or it perpetuates the non-compliance with contraceptive use, as the adolescent girl might be even more terrified to return to the clinic for her follow-up appointment post termination of pregnancy services. Consequently, this may further lead to repeated requests for termination of pregnancy by adolescent girls, as they would not come to seek contraceptives, or as a result of family planning non-compliance.

Nurses in this study seem to perceive their adolescent girls as fragile and needing more information regarding their sexual and reproductive healthcare services that are available to them. Nurses also acknowledged the limited knowledge of their adolescent clients regarding sexual and reproductive healthcare services, as well as the need for more counseling with regards to condom use. Previous research in Sub Saharan Africa at large, including South Africa, has also identified the need for more sexual and reproductive healthcare information and contraceptive knowledge improvement as necessary information adolescents need to be provided with in order for them to make informed decisions regarding their sexual and reproductive healthcare needs (Tsawe and Susuman, 2014; Holt et al., 2014; Atuyambe et al., 2015; Ochako et al., 2015; Chandra-Mouli et al., 2014, 2013). Furthermore, nurses emphasized the importance of being sensitive when dealing with the adolescent girls.

It is important to understand how nurses perceive adolescent girls' needs and challenges in order to develop specific interventions that can help improve the adolescent-nurse relationship and ultimately, access to and utilization of sexual and reproductive healthcare services. Nurses reaction to adolescent girls' non-compliance as pointed out above by using harsh language, needs to be improved in order not to scare away them from accessing sexual and reproductive healthcare services they need. However, other healthcare systems' challenges also need to be addressed, such as the staffing, adolescent or youth space at the clinics, and the re-enforcement of respecting the rights of adolescent girls to access the sexual and reproductive healthcare services they need. Furthermore, efforts to develop interventions to help nurses manage their personal feelings and values' clarification regarding termination of pregnancy should be escalated if access to and adequate provision of sexual and reproductive healthcare services is to be achieved.

Generally, nurses appear to be supportive and encouraging adolescent girls to use contraceptives and tend to treat those who are compliant with their family planning with warmth and positive attitudes. However, the same cannot be said about adolescent girls who come for STI treatment and termination of pregnancy services. Nurses seem to particularly dislike dealing with adolescent girls coming for termination of pregnancy services, although they provide the services because of their professional obligation. Some, despite the professional obligation to provide the services, still refuse to provide termination of pregnancy services to adolescent girls regardless of its legalization in the country.

In addition to the sexual and reproductive healthcare nurses who are the key persons providing contraceptive education, perhaps parents and schoolteachers such as the Life Orientation teachers should also provide contraceptive education to adolescent girls. Although it has recently been acknowledged that the Life Orientation and life skills program teachers are not necessarily following the curriculum as it is stipulated and therefore compromise the quality of this sexual and reproductive healthcare education intervention (Smith et al., 2013). More efforts to enable both teachers and parents to communicate sexual and reproductive healthcare information to young people are needed to help eliminate the contraceptive misconceptions among them.

4.1. Limitations

There are a few limitations to this study which should be considered when interpreting the results. Firstly, this study only studied nurses providing sexual and reproductive healthcare services in a big urban city and not in rural areas. Therefore, caution is to be exercised when interpreting the findings of this study as they pertain to the conditions in urban settings where culture and other traditional norms and practices may be different compared to rural settings. In rural areas, culture, religion and traditional practices are important elements shaping the community norms and values, especially with regards to adolescent girls' sexual activities. Therefore, the results of this study are limited to the urban settings. A similar study would need to be undertaken in rural settings to

compare our findings. Secondly, this study focused on adolescent girls only instead of including adolescent boys as well, as adolescent boys also need to be taken into account when developing and rolling out programmes to enhance access to and utilization of sexual and reproductive healthcare services by young people. Thirdly, this study intended to conduct mainly focus group discussions but that proved challenging and the study had to adapt and conducted in-depth discussions where two to three participants were available. The in-depth discussions provided fewer issues than in the group discussions with four or more participants. Finally, only a small number of male nurses were included in this study due to limited number of males in general in the nursing profession. However, the few issues were discussed thoroughly as the in-depth discussions allowed time for deep exploration of the issues brought up. Despite these limitations, the findings of this study provide relevant information regarding the nurses' perceptions of adolescent girls' needs and barriers to accessing and utilizing sexual and reproductive healthcare in Cape Town, as well as areas for improvement.

5. Conclusion

Professional healthcare workers in sexual and reproductive healthcare services are enthusiastic and willing to provide sexual and reproductive healthcare services to adolescent girls. However, the nurses in this study perceive certain behaviours of adolescent girls as irresponsible and warrant their negative attitudes and reactions toward them. The negative attitudes and reactions of nurses potentially further compromises access to and utilization of sexual and reproductive healthcare services by adolescent girls in South Africa and requires urgent attention. Healthcare systems factors, such as operating clinic hours, the youth-friendly space and youth clinic program play a role in the perceived adolescent girls' irresponsible behaviours and need to be addressed. Adolescent-friendly clinic hours together with youth-friendly nurses is likely to encourage adolescent girls to access sexual and reproductive healthcare services and improve the use thereof. Furthermore, this can also help improve the adherence to family planning regimen by adolescent girls and thereby reduce the irresponsible behaviour of non-compliance and subsequently improve nurses' attitudes toward adolescent girls seeking family planning services. As with any kind of work or profession, better working conditions, in this case, improved health systems structures for nurses in family planning services including prioritization of family planning clients will likely improve the attitudes of nurses and alleviate the stresses they experience in their work place.

TRIBUTION OF THIS PAPER

What is already known about the topic?

- Adolescent girls' access to and utilization of sexual and reproductive healthcare services is poor.
- Nurses can be rude, judgmental, and unfriendly towards adolescent girls seeking sexual and reproductive healthcare services.

What this paper adds to the existing knowledge?

- Nurses in South Africa can be very supportive of and encourage contraceptive use by adolescent girls.
- Nurses in South Africa create categories with explanations that enable them to justify how and when they provide certain services or treat some adolescent girls in certain ways.
- Healthcare systems' factors in some South African public health clinics contribute to the

perceived irresponsible behaviours of adolescent girls.

Ethical approval

Permission to conduct the study was obtained from the University of the Western Cape Research and Ethics Committee (Ethics Reference Number: HS/16/3/49). Informed consent was explained in English to the participants, and a signed informed consent was obtained from each participant before they participated in the group discussions. Permission to access the health facilities was applied for via the City of Cape Town municipality website and approval was received from the research manager. All the clinics included in this study were listed and covered by the approval letter, and permission from the Western Cape Department of Health was not needed as the approval letter from the City of Cape Town covered all the clinics including the community health centers. The Department of Health's approval would have been needed if the study was conducted on the 24hrs types of community health centers, which are the secondary level of healthcare. This study was only conducted on the primary healthcare levels, including some community health centers which are not operating 24hrs and therefore remain under the primary level of healthcare covered by the City of Cape Town municipality approval.

Acknowledgements

This study was funded by the Netherlands Fellowship Program (NFP) / Nuffic. The financial support of the National Research Foundation (NRF) towards this research is also hereby acknowledged. Opinion expressed and conclusions arrived at, are those of the authors and are not necessarily to be attributed to the NRF.

References

1. World Health Organization (WHO). Maternal, newborn, child and adolescent health. 2015. http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/. Accessed 14 April 2016.
2. World Health Organization. Adolescent pregnancy. Fact sheet No. 364. September 2014. <http://www.who.int/mediacentre/factsheets/fs364/en/>. Accessed May 19th, 2016.
3. UNFPA. Girlhood, not motherhood: Preventing adolescent pregnancy. New York: UNFPA; 2015.
4. Singh S, Darroch JE. Adding it up: costs and benefits of contraceptive service. Estimates for 2012. New York: Guttmacher Institute and UNFPA; 2012 <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>.
5. Tilahun M, Mengistie B, Egata G, & Reda AA. Health workers' attitudes toward sexual and reproductive health services for unmarried adolescents in Ethiopia. *Reprod Health*. 2012. 9(1): 19. DOI: 10.1186/1742-4755-9-19
6. Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology & Obstetrics*. 2015. 131: S40-2.
7. Jonas K, Crutzen R, van den Borne B, Sewpaul R, Reddy P. Teenage pregnancy rates and associations with other health risk behaviours: a three-wave cross-sectional study among South African school-going adolescents. *BMC Reproductive Health*. 2016. 13(1): 50. DOI: 10.1186/s12978-016-0170-8
8. Lopez LM, Hiller JE, Grimes DA. Education for contraceptive use by women after childbirth. *Cochrane Database Syst Rev* 2012;8: CD001863.
9. Statistics South Africa. South African Demographic and Health Survey (SADHS): Key Indicator Report. 2016. Pretoria. <https://dhsprogram.com/pubs/pdf/PR84/PR84.pdf> Accessed 10th April 2018.
10. Preventing early pregnancy: What the evidence says. Geneva: WHO; 2011.
11. Wood K, Jewkes R. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reprod Health Matters*. 2006. 14(27): 109–18.
12. Müller A. Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. *BMC international health and human rights*. 2017 Dec;17(1):16.
13. Tsawe M, Susuman AS. Determinants of access to and use of maternal health care services in the Eastern Cape, South Africa: a quantitative and qualitative investigation. *BMC research notes*. 2014. 7(1): 723. DOI: 10.1186/1756-0500-7-723
14. Macleod CI, Tracey T. A decade later: follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. *South African Journal of Psychology*. 2010. 40(1): 18-31.
15. Alli F, Maharaj P, Vawda MY. Interpersonal relations between health care workers and young clients: barriers to accessing sexual and reproductive health care. *Journal of community health*. 2013 Feb 1;38(1):150-5.
16. Biddlecom AE, Munthali A, Singh S, Woog V. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African journal of reproductive health*. 2007;11(3):99.
17. Hokororo A, Kihunrwa AF, Kalluvya S, Changalucha J, Fitzgerald DW, Downs JA. Barriers to access reproductive health care for pregnant adolescent girls: a qualitative study in Tanzania. *Acta Paediatrica*. 2015 Dec 1;104(12):1291-7.
18. Geary RS, Gómez-Olivé FX, Kahn K, Tollman S, Norris SA. Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa. *BMC health services research*. 2014 Jun 16;14(1):1.
19. Holt K, Lince N, Hargey A, Struthers H, Nkala B, McIntyre J, Gray G, Mnyani C, Blanchard K. Assessment of service availability and health care workers' opinions about young women's sexual and reproductive health in Soweto, South Africa. *African journal of reproductive health*.

2012. 16(2): 283-94.
20. Jonas K, Reddy P, van den Borne B, Sewpaul R, Nyembezi A, Naidoo P, Crutzen R. Predictors of nurses' and midwives' intentions to provide maternal and child and healthcare services to adolescents in South Africa. *BMC Health Services Research*. 2016. 16:658. DOI: 10.1186/s12913-016-1901-9
 21. Herrman J. The provision of reproductive health services by school-based health centers: Policy Implications. In 42nd Biennial Convention (16 November-20 November 2013) 2013 Nov 18. STTI.
 22. Müller A, Röhrs S, Hoffman-Wanderer Y, Moulton K. "You have to make a judgment call". – Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa. *Social Science & Medicine*. 2016 Jan 1;148:71-8.
 23. Ahanonu EL. Attitudes of healthcare providers towards providing contraceptives for unmarried adolescents in Ibadan, Nigeria. *Journal of family & reproductive health*. 2014 Mar;8(1):33.
 24. Nalwadda G, Mirembe F, Tumwesigye NM, Byamugisha J, Fanelid E. Constraints and prospects for contraceptive service provision to young people in Uganda: providers' perspectives. *BMC health services research*. 2011 Sep 17;11(1):1.
 25. Cullinan K. *Health Services in South Africa*. 2006.
https://www.health-e.org.za/wp-content/uploads/2013/04/Health_services_briefing_doc.pdf.
Accessed November 16, 2016.
 26. Caelli K, Ray L, Mill J. 'Clear as mud': toward greater clarity in generic qualitative research. *International journal of qualitative methods*. 2003 Jun;2(2):1-3.
 27. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description—the poor cousin of health research?. *BMC medical research methodology*. 2009 Dec;9(1):52.
 28. Sandelowski M. What's in a name? Qualitative description revisited. *Research in nursing & health*. 2010 Feb;33(1):77-84.
 29. Bradshaw C, Atkinson S, Doody O. Employing a qualitative description approach in health care research. *Global qualitative nursing research*. 2017 Nov 21;4:2333393617742282.
 30. Sullivan-Bolyai S, Bova C, Harper D. Developing and refining interventions in persons with health disparities: The use of qualitative description. *Nursing outlook*. 2005 May 1;53(3):127-33.
 31. Tesch R. (1990). *Qualitative research: Analysis types and software tools*. Bristol, PA: Falmer.
 32. Müller A. Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. *BMC international health and human rights*. 2017 Dec;17(1):16.
 33. Smith KA, Harrison A. Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa. *Sex education*. 2013 Jan 1;13(1):68-81.
 34. Jewkes R, Morrell R, Christofides N. Empowering teenagers to prevent pregnancy: lessons from South Africa. *Cult Health Sex*. 2009; 11 (7):675–88.
 35. Svanemyr J, Amin A, Robles OJ, Greene ME. Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches. *Journal of Adolescent Health*. 2015 Jan 31;56(1):S7-14.
 36. Rehnström Loi U, Gemzell-Danielsson K, Fanelid E, Klingberg-Allvin M. Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data. *BMC public health*. 2015;15(1):139.
 37. Mannava P, Durrant K, Fisher J, Chersich M, Luchters S. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalization and health*. 2015 Aug 15;11(1):1.
 38. Harries J, Stinson K, Orner P. Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health*. 2009 Aug 18;9(1):1.
 39. Mngadi, P. T., Fanelid, E., Zwane, I. T., Höjer, B., & Ransjo-Arvidson, A. B. Health providers' perceptions of adolescent sexual and reproductive health care in Swaziland. *International*

- nursing review. 2008. 55(2): 148-155.
40. Godia PM, Olenja JM, Lavussa JA, Quinney D, Hofman JJ, Van Den Broek N. Sexual reproductive health service provision to young people in Kenya; health service providers' experiences. *BMC health services research*. 2013 Nov 14;13(1):1.
 41. Röhrs S. The influence of norms and values on the provision of termination of pregnancy services in South Africa. *International journal of Africa nursing sciences*. 2017 Jan 1;6:39-44.
 42. Jonas K, Crutzen R, Krumeich A, Roman N, van den Borne B, Reddy P. Healthcare workers' beliefs, motivations and behaviours affecting adequate provision of sexual and reproductive healthcare services to adolescents in Cape Town, South Africa: a qualitative study. *BMC health services research*. 2018 Dec;18(1):109.
 38. Atuyambe LM, Kibira SP, Bukonya J, Muhumuza C, Apolot RR, Mulogo E. Understanding sexual and reproductive health needs of adolescents: evidence from a formative evaluation in Wakiso district, Uganda. *Reproductive health*. 2015. 12(1): 1. DOI: 10.1186/s12978-015-0026-7
 39. Ochako R, Mbondo M, Aloo S, Kaimenyi S, Thompson R, Temmerman M, Kays M. Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. *BMC public health*. 2015 Feb 10;15(1):1.
 40. Harrie J, Stinson K, Orner P. Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *Bio Med Central Public Health*. 2009, 9(296-306).
 41. Harrison A, Montgomery E, Lurie M, Wilkinson D. Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu-Natal. *Health Policy & Planning*. 2000, 15 (424-431). Jewkes R, Gumedde T, Westaway MS, Dickson K, Brown H, Rees H. Why are women still aborting outside designated facilities in metropolitan South Africa? *BJOG: An International Journal of Obstetrics and Gynaecology*. 2005, 112 (1236-1242).

Table 1. Demographic characteristics of the nurses

Demographics Characteristics		
	N	Percentage (%)
Gender		
Male	3	12
Female	21	88
Age group		
1 (25-30)	4	17
2 (31-36)	5	21
3 (37-42)	4	17
4 (43-48)	3	12
5 (49+)	8	33
Education		
Certificate in nursing*	2	8
Diploma in nursing [§]	13	54
Degree in nursing [†]	9	38
Total	24	100

* A certificate in nursing is lower than the diploma, with little practical experience and skills of nursing care

[§] A diploma qualification is obtained through colleges and often takes up to three years

[†] A university degree takes four years and includes training in extensive clinical skills