

## ORIGINAL RESEARCH ARTICLE

# Assessment of Service Availability and Health Care Workers' Opinions about Young Women's Sexual and Reproductive Health in Soweto, South Africa

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## Abstract

Young women in South Africa experience high HIV and unintended pregnancy rates. Health care workers' (HCWs') opinions about sexual and reproductive health (SRH) issues impact young women's ability to access SRH services. We explored HCW opinions through interviews with a purposive sample of 29 HCWs in three primary health clinics in Soweto, South Africa and examined service availability through facility assessments. Most HCWs believed young women should not have sex before marriage and thought that young women ignore information they receive about HIV and pregnancy prevention. HCWs acknowledged outside factors influencing young women's ability to protect themselves. Most thought injectables were the most appropriate contraception for young women; all recognized the importance of condoms for dual protection. Some services were only reported to be provided to those over 18 years. HCWs may benefit from workshops providing technical and policy information and values clarification exercises highlighting the impact of opinions on service provision (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 283-293*).

## Résumé

Les jeunes femmes en Afrique du Sud connaissent de taux élevés du VIH et de grossesse non voulues. Les opinions des membres du personnel soignant (MPS) sur les problèmes de la santé sexuelle et de reproduction (SSR) influencent la capacité des jeunes femmes d'avoir accès aux services de la SSR. Nous avons exploré les opinions des MPS à travers les interviews en profondeur avec un échantillon calculé de 29 MPS dans trois cliniques de santé primaire à Soweto, Afrique du Sud et nous avons examiné la disponibilité des services à travers les évaluations des établissements. La plupart des MPS ont cru que les jeunes ne devraient pas avoir des rapports sexuels avant le mariage et ont cru que les jeunes femmes ignorent les informations concernant le VIH et la prévention de la grossesse. Les MPS ont reconnu les facteurs extérieurs qui influent sur la capacité des jeunes femmes de se protéger. La plupart croyaient que les injectables constituaient la contraception la plus appropriée pour les jeunes femmes ; toutes les femmes reconnaissaient l'importance des préservatifs pour une double protection. Certains services ont été rendus aux femmes qui avaient plus de 18 ans. Les MPS peuvent profiter des ateliers qui donnent des informations sur les techniques et la politique ainsi que les exercices sur la clarification de valeurs qui ne mettent pas en lumière les influences des opinions sur l'assurance des services (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 283-293*).

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## Introduction

According to a 2008 nationally representative survey of high school students in South Africa, 30% of females had ever had sex and 24% of those had been pregnant. Fifteen percent of sexually active female students reported not usually using contraception when they have sex and 67% reported not always using condoms (compared to 71% percent of sexually active male students who reported not always using condoms). The most commonly used contraceptive methods reported by sexually active young women were condoms (42%); 12% reported injectables and less than 5% reported use of the pill or other modern methods. In a previous national household survey conducted in 2003, two-thirds of the pregnancies reported by sexually active 15-24 year olds were reported to be unwanted.<sup>2</sup> In that same survey, 15% of young women ages 15-24 were HIV positive, compared to 5% of young men,<sup>2</sup> and 10% of females reported ever having been physically forced to have sex.<sup>3</sup>

The availability, accessibility, and acceptability of health care services for young women significantly impact their use of prevention methods, which in turn influences their risk for pregnancy and HIV infection. The 2005 South African Children's Act lowered the age of majority to 18 years and allows those above 12 years of age to access health care services, including HIV testing, contraceptives, and termination of pregnancy (TOP) services (which are available in South Africa up to 12 weeks without restriction as to reason), without parental consent<sup>4</sup>. Current contraception policy guidelines from the Department of Health describe the method mix at different levels of the health care system and indicate that pills, male condoms, and injectable contraceptives are commonly available at public-sector clinics, intra uterine devices (IUDs) are offered generally only in urban areas and referral facilities, and female condoms are only available in limited facilities<sup>5</sup>. The guidelines also state that female sterilization services are generally not accessible for logistical reasons and that male sterilization and implants are not currently offered as part of the contraceptive method mix.

It is important to investigate whether these sexual and reproductive health (SRH) services are indeed accessible to young women. Previous research has documented the role of health care workers (HCWs) as gatekeepers to young women's SRH services and the importance of confidential and private services<sup>6</sup>. One recent study conducted in a semi-rural area of South Africa examined young women's experiences with nurses and found that nurses stigmatized adolescent sexuality and harshly treated adolescent girls seeking contraceptive services<sup>7</sup>.

We present here the results of a study on the availability of and access to SRH services for young women in Soweto, South Africa, from the perspectives of HCWs. Our aims were to explore the availability of SRH services for young women, HCWs' opinions about adolescents' sexual behavior and utilization of SRH services, and the potential impact of HCW's opinions on service provision. We also elicited input from HCWs about ways to improve services and address young women's SRH needs.

## Methods

We conducted a cross sectional study with HCWs, including nurses, counselors, operations managers, midwives, and social workers, in three of the 27 (11%) (personal communication with the Information Management Directorate of the Department of Health and Social Development, Gauteng Provincial Government, September 2010) public primary health care clinics in Soweto, South Africa. The three clinics were selected purposively based on geographic location (Soweto), existing relationships with management at the clinics, patient volume, and service offerings. All of these high volume clinics offered family planning (FP), antenatal care (ANC), and HIV services, and one offered TOP services.

During March and April 2009 we conducted semi-structured qualitative interviews with HCWs in FP, ANC, HIV, and TOP service departments. HCWs working in these departments who had seen adolescent patients in the last year were eligible to participate. We obtained a list of all 45 eligible staff and purposively selected a sample of 30 HCWs ensuring representation from all three clinics, all four departments, and different job

functions. Each selected HCW was contacted telephonically and asked to participate. Thirteen HCWs declined participation or were not able to participate due to having left the clinic or being on vacation during the interview period. These individuals were replaced using the same purposive criteria. Key issues explored in the interviews included: opinions about SRH issues that young women face (probing specifically about unprotected sex, unintended pregnancy, HIV, and gender-based violence (GBV)) and how to address these issues; opinions about services and information available to young women, including the best FP methods for young women and whether or not young women should have access to TOP and HIV prevention and testing services; and opinions about young women's sexual behavior. Participants were asked about "young women" generally and we did not collect information on how participants interpreted "young women." All participants provided written informed consent prior to the interview that lasted on average 32 minutes (range= 20-54 minutes) and was conducted in a private setting.

During November and December 2009 we conducted facility assessments where we collected information on service availability, number and types of staff, training received by staff, referral structure and other clinic policies, including policies for adolescent friendly services. Assessments were conducted via in-person interviews with facility managers (or, in one case, the chief professional nurse) and a self-administered form completed by the facility managers or chief professional nurse or their designees. The facility assessments and semi-structured interviews were conducted in English as this is the common language for meetings and trainings in health care facilities in South Africa.

Results from the facility assessment were entered into SPSS statistical software (SPSS 14.0, Chicago, IL); open-ended questions were coded into categorical variables and descriptive frequencies for all variables were generated.

Semi-structured interviews were digitally recorded and transcribed verbatim. Qualitative data were analyzed inductively using a modified grounded theory approach, which emphasizes the emergence of themes from the data<sup>8</sup>. *An a priori*

list of preliminary codes was created using the interview guide and other themes and patterns emerged during review of the data; new codes were created and agreed upon by members of the study team. The computer software package ATLAS-ti (version 5.2 Scientific Software Development, Berlin, Germany) was used to facilitate data management and coding. Allendale Investigational Review Board and the Human Research Ethics Committee at the University of the Witwatersrand reviewed and approved the study protocol; the Provincial Department of Health, Gauteng, and the City of Johannesburg also gave permission to conduct the research.

## Results

### Participants

We interviewed almost all of the HCWs in the FP and ANC departments; a smaller proportion of staff in the TOP and HIV departments participated, likely due to high demand for services and a shortage of HCWs in these two departments. We interviewed 30 staff in total but the recording for one interview was inaudible and therefore we did not include it in the analysis. Our analysis is based on interviews with 29 (64%) of the 45 staff. The majority were nurses; we also interviewed six counselors, an operations manager, a midwife, and a social worker. This reflects the staff complement in the departments, where services are mainly provided by nurses. Table 1 summarizes the total number of staff in each department and clinic at the time of interview recruitment and the proportion interviewed for this study. The HCWs had provided reproductive health services at their respective clinics for an average of 7 years [range=0-26 years] (data missing for three participants, average and range calculated from 26 participants; data not shown).

### Description of services from facility assessments

The facility assessments revealed many similarities between the study clinics. They all offer a range of services for men and women, and these are generally available six days a week. SRH services are offered both as part of general primary health care services (e.g. Pap smears, STI

**Table 1:** Proportion of staff interviewed in each department, by clinic

Clinic department	Clinics and number of staff per department (Interviewed/Total)			
	Clinic 1	Clinic 2	Clinic 3	Total
Ante Natal (ANC)	3/3	3/6	9/9	15/18
Family Planning (FP)	4/5	2/2	1/1	7/8
HIV	3/6	2/4	1/5	6/15
Termination of Pregnancy (TOP)	N/A	1/4	N/A	1/4
		8/16	11/15	
<b>Total</b>	10/14 (71%)	(50%)	(73%)	29/45 (64%)

testing/treatment) or within dedicated departments (HIV testing/treatment/counseling, antenatal and post natal care, FP, TOP). Each clinic has two social workers and two or three health promoters who provide information to people in the clinics and in community settings via door-to-door campaigns and visits to schools or other venues.

As noted above, only one of the clinics offered TOP services. This is likely due to requirements for designation as a TOP facility and shortages of providers in South Africa. Although TOP is available to all girls over 12, this one clinic reported offering the service only to young women over the age of 18. Two of the three clinics reported offering sexual health counseling and one reported offering GBV counseling. As per Department of Health contraception policy described above, injectable contraceptives, male condoms, and female contraceptive pills were available at all three sites; whereas female condoms, IUDs, and tubal ligation were only available at one or two sites, and implants and vasectomies were not available anywhere. One clinic reported offering HIV counseling to those over 18 only, and one reported offering FP counseling and provision to those over 16 only, even though officially all girls over the age of 12 are eligible for all services. Finally, the clinics were offering services free of charge with the exception of one clinic that reported charging for initiation of HIV treatment and two clinics charging for the female condom.

During the facility assessment, we also asked how staff obtains information on Department of Health and/or clinic policies; all responded that this information is conveyed at meetings and assemblies and that referral lists and service specific information are distributed during in-

service training. None of the clinics reported having current adolescent friendly clinic policies or that any of their staff had received adolescent friendly services training in the past six months.

### Opinions about young women's sexual behavior

HCWs' feelings about young women's sexual behavior provide context for their opinions about the SRH challenges young women face and their thoughts on how to address them. When asked how they felt about young women having sex, most answered that they should not be having sex before marriage, either for religious reasons, because of concerns for young women's futures, or due to a belief that young women are not capable of making decisions regarding sex. Many HCWs used the phrase "indulging in sex" to describe young women's behavior; for example a nurse in a TOP department said: "I would say 80-85% of them indulge in unprotected sex...some of them they tell you of burst condom, but majority they don't use condoms." (nurse, TOP department) We interpret the word "indulge" to be a value judgment; the idea being that young women are excessively or irresponsibly engaging in sex.

HCWs' responses revealed a range of different feelings regarding sex before marriage. Some stated that they didn't believe it was right and then described how important it was to use condoms if young women did decide to have sex, suggesting that they might be able to put aside their personal beliefs when counseling young women about prevention. Others were firm in their belief against pre-marital sex; one HIV counselor, when asked whether condoms were appropriate for young women, said, "If all went according to me... if you are not married why [is there any need to] use a condom?" (counselor, HIV

department). A few made comments about sex being something natural for young women to experience during adolescence regardless of whether they are married or not.

Several HCWs expressed that it was a young woman's "right" to have sex, though this was mostly stated in a disparaging way, implying that they did not agree with young women having these rights afforded them by the government because they did not believe in adolescents' decision-making abilities. Some HCWs pointed out that young women still need information to be able to make their own decisions, or emphasized that they should not be having sex, even if it is their right. Several said things like, "they think they know and yet they don't," or called young women naïve or not mature enough to have sex. A few HCWs described that they take it personally when young women have unprotected sex. Many said "I feel bad" when asked how they felt about young women having sex because they see the consequences when young women come into clinics. A sense of frustration or exasperation came across in several interviews where HCWs described not understanding why young women continue to have unprotected sex before marriage and end up with HIV or pregnant. For example, an HIV counselor said:

*"I feel bad, honestly, I feel bad and that thing sometimes it gives me a problem....it's a personal issue for me, 'coz I keep on ask myself 'why, why these young women are doing this thing of sex and yet there are people that go to schools that give them information about abstinence and be faithful...or else use 'condom', but they don't do that..."*  
(counselor, HIV department)

A few of the HCWs described feeling like the young women's mothers; for example, one ANC nurse said:

*"With the young ones you need to go deep and advise them because they are still young and naïve, so you are to be the mother, a social worker and a nurse."* (nurse, ANC department)

### **Opinions about adolescent pregnancy, HIV infection, and other SRH issues**

When asked what they thought were the most common SRH challenges that young women in their community face, HCWs most commonly

mentioned HIV. Many also mentioned pregnancy and STIs, and one HCW mentioned TOP. This was a reflection of both HCWs' experiences seeing young women at the clinic and their knowledge of local and/or national statistics.

HCWs expressed different views regarding the causes of young women's high HIV and pregnancy rates. Many HCWs did not view young women's pregnancies as "unintended" and instead felt that young women were not taking advantage of the information they receive (both about abstinence and FP services). Reasons for this included that young women are "ignorant" (in the sense that they ignore information they receive or are heedless) or that young women actually want to get pregnant, because they see their peers doing it, because their family wants them to get pregnant, or because they want to get a child support grant (money provided by the South African government for primary caregivers making less than a certain amount of money per month). Some mentioned that young women don't like FP because of side effects and because they don't like to miss their periods. Several HCWs also talked about young women's denial that they will get infected with HIV and expressed a view that young women "don't care to condomize." A nurse in an ANC department said:

*"They just don't care, they leave the condoms, being there, but information they know...when you ask them 'now why don't you condomize,' they will just smile because they've got no good reason for not condomizing,"* (nurse, ANC department).

Some HCWs implied that young women do not tell them the truth about whether they are using condoms, saying that many young women blame non-use or problems with use on their partners' aversion to using them or blame pregnancy or an STI on a burst condom. A nurse in an ANC department said, "I don't know, are these condoms strong enough, or are they lying" (nurse, ANC department).

HCWs also recognized the outside factors that influence young women's ability to prevent pregnancy and HIV infection. Many HCWs pointed out that because of unemployment and poverty, young women cannot demand condom use because of their reliance on men for money,

food, and shelter, or that they become pregnant to keep a man who will then support them. Two HCWs mentioned that “broken families” and the community moving away from its culture and morals impact negatively on young women’s SRH. Some HCWs also pointed out that alcohol and drug use, as well as unemployment and a lack of activities to keep young people entertained or busy, lead to young people having unprotected sex.

According to the HCWs, gender dynamics in relationships also play a role in determining young women’s risk. Peer pressure to have sex was seen as a contributing factor to unprotected sex in communities. HCWs also mentioned the “culture” of submission to male partners who do not wish to use condoms. Two HCWs added that some young women like “sugar daddies” who can drive them around and buy them fancy things. Finally, two HCWs pointed out that young women don’t use condoms because they trust their partners.

Many HCWs also believed that young women don’t have sufficient information about consequences of sex and the importance of prevention. HCWs often talked about poor communication between young women and parents, for example when mothers take their daughters for FP but do not discuss sex or why the daughter might need FP. One person pointed out that because parents don’t talk to their children about sex, young people end up getting incorrect information from other sources.

Only two HCWs mentioned GBV in the context of discussions about adolescent pregnancy and HIV rates. However, when asked if GBV was a problem in their community, many agreed that it was. Several said that they were unsure, and some pointed out that they don’t see it a lot because young women don’t report it (both because they are scared of their partners and also because, in some cases, the young women don’t see it as abuse but rather as a normal consequence of depending on a man for things). One respondent pointed out that she was not clear whether some situations where young teenagers are living with their older partners are truly “violence” or if the woman is consenting to being in that relationship:

*“I’m not quite sure if in this community you would call that, like, like ‘violence’...You’ll find that maybe a 16 year-old is staying with a man, so like you don’t know whether it’s true they’re consent[ing], or maybe it’s by force, and sometimes you find a very young girl being pregnant. But when you ask her exactly like, ‘are you pregnant, is it a boyfriend,’ and she will tell you, ‘it’s a husband,’ so I’m not sure whether the male is it a boyfriend or a man...but cases of reported violence, like no, they are rare.” (nurse, FP department)*

Two HCWs mentioned young women being scared to disclose HIV status to partners/husbands for fear of abuse (because they would assume she was unfaithful). Another mentioned the link with unemployment: too much idle time together in the house leads to violence.

### **Knowledge and opinions about FP and HIV prevention services for young women**

HCWs largely believed FP information to be easily accessible to young women, though, as mentioned above, they saw a need for more education about the importance of protecting oneself as many young women “ignore” the information they receive from clinics, schools, or the media. Several HCWs described their strategies for getting this information across to young women. An ANC nurse pointed out that young women must be treated differently than older women because they feel that they know everything:

*“... when you’re giving [information], let’s say maybe, a young person, let’s say maybe from the ages of 18 to 26, you base it mostly on HIV and AIDS and lifestyle modification... but once they are, let’s say maybe from 35, they’re now stable and you find that it differs in that way, even though you still teach about HIV and AIDS, but it’s not the same when you’re teaching a young one, a young parent, because they still feel like they know everything.” (nurse, ANC department)*

Another ANC nurse described striving to be approachable and to provide information about sexuality:

*"It is the same service, but though with, with young women, you know, they have issues, you have to be, you know, very - make sure you are approachable, especially when you're dealing with the young, young women, so it's like you'll have to establish how much she knows as far as sexuality is concerned ... with teenagers, honestly you cannot be giving it the same as you would give to somebody who is a grown up, you see, because there's a lot that they don't know of."* (nurse, ANC department)

A counselor in an ANC department described the importance of persistence in providing information to young women:

*"They have information, it's just that some of them, they will say, 'ag man, there's nothing like that, these people just like talking, talking,' you know, sometimes they get bored about HIV. You'll find then that they are talking secretly but unfortunately you overhear them saying, 'ag man they are bothering us because they always talking HIV, HIV to us.'...but we continue doing it because we see that we have to talk about it, you can't leave it and it's very important that, even if they, they have negative attitudes, we've got to try to talk to them until one sees that, 'hmm, these people here, what they are telling me, it's genuine.'"* (counselor, ANC department)

All HCWs interviewed were asked what they thought was the best FP method for young women. The most common response, given by almost half, was that injectables were the ideal method because they allow young women to not worry about their contraceptive method for a period of two or three months. Abstinence was the second most common response, given by six HCWs who, when probed, said that condoms were best if young women were going to have sex. Three HCWs mentioned the IUD (or "loop" as it is sometimes referred to in South Africa) as ideal due to it being a long term method; though several HCWs in ANC or HIV departments indicated not knowing what IUDs/loops were and one nurse in a FP department said she was not trained in IUD insertion, despite working in clinics where they were reportedly

available. Many also were unfamiliar with implants, though that method was not being provided at any of the three clinics. The pill was not mentioned by anyone as an ideal method, even though it was available at all of the study clinics. Opinions about this method reflected HCWs' concerns that young women would forget to take it every day. One respondent felt that she couldn't comment on what the best method was because each woman needed to decide for herself.

Two HCWs spontaneously mentioned condoms as the best contraceptive method for young women. However, once probed about appropriate contraceptive methods for HIV positive women, the majority talked about the importance of condoms as a method of dual protection not only for HIV positive women but for women generally. Some HCWs felt that condoms should only be provided to those who are HIV positive, while others felt that if young people wanted to start having sex they should be provided with condoms in addition to being educated that it is important for one to know one's status as well as the status of one's partner. A nurse in the FP department said: "...I normally encourage, you know, all the girls that come for FP, 'do you know your status, no, test to know your status'." (nurse, FP department)

### Opinions about TOP services for young women

When asked whether young women should have access to TOP services, a few HCWs said that they shouldn't because TOP was a "sin." More commonly, HCWs said that young women should have access to TOP services. However, some HCWs felt that, though they could understand that other people may have different beliefs or circumstances, they personally didn't believe that TOP was a good option. In some cases, HCWs expressed a positive belief about young women's ability to make choices for themselves, while others saw young women's legal right to choose as a barrier to providing young women advice about what is best for them. As mentioned above, several HCWs expressed their frustrations with young women's right to access SRH services, when they believed that women should be abstaining from sex or that young women didn't have the proper

decision making skills. For example, one nurse in an HIV department said,

*"Since the government provided these rules [regarding TOP] that you can do whatever you want, you can't even advise them, to tell them 'oh people, but you're killing yourselves'." (nurse, HIV department)*

### **Ideas for improvement of services**

When asked for ideas about how SRH services for young women could be improved, HCWs commonly stated that staff shortages and lack of equipment and supplies need to be addressed if clinics are to provide a quality service to clients. Two HCWs also mentioned the importance of integration of ANC and FP services. Conversely, one HCW advocated for separate HIV and SRH clinics so that the staff in each one could be highly specialized in their area to address specific needs of their patients.

Two HCWs also acknowledged that their bias or opinions should not come to the fore as services need to be provided without judgment and that the attitudes of HCWs generally need to change if they are to provide a quality FP service to young women. The social worker from an HIV department said:

*"I understand we are all human beings, sometimes we tend to use our own judgment and it affects other people... we are from different backgrounds, different religions, different cultures... sometimes they [HCWs] will use that 'why, why are you here for a TOP, don't you know that it's a sin?' ... So it discourages some people and [they] end up doing, not coming for the service and [doing] something else, dangerous to them. So some of us, as service providers, sometimes we do contribute to, to the disadvantage of women." (social worker, HIV department)*

Other suggestions for improving SRH services included offering youth friendly services provided by staff who are dedicated to youth only and have a clear understanding of the issues young women face, extended clinic hours for youth who end their school/working day after the clinics close, and continuous outreach programs with youth, parents,

and communities to educate regarding issues such as HIV, FP, and unprotected sex. Throughout the interviews, HCWs commonly referred to the importance of educating parents to ensure that they are prepared to teach their children about preventive services, the consequences are of unprotected sex, or why their children should remain abstinent until married. They placed great importance on the role of the parent in teaching children so that they can make informed, healthy decisions as they reach adolescence. HCWs added that schools are another place where young people should be educated on these issues and that HCWs should do the educating there. They felt that if young women are empowered with knowledge and skills, they can break the cultural barriers that put them at risk of HIV and unintended pregnancy.

### **Discussion and Recommendations**

One aim of this study was to explore the availability of SRH services for young women in Soweto. In the facility assessments, the reported contraceptive method mix was consistent with current Department of Health policy. However, several findings from the interviews with HCWs suggested potential HCW contraception training needs. The finding that several HCWs in ANC and HIV departments in clinics where IUDs were reportedly available were not familiar with IUDs suggests the need for refresher courses on contraceptive methods for staff in those departments as they may be in a position to counsel positive women, women testing for HIV, or pregnant women coming for ANC services about contraception. Many HCWs were also unfamiliar with implants as they are not currently offered in the public sector; refresher courses on contraceptive methods should ideally cover the full range of methods so that HCWs are prepared to answer questions young women may have about methods such as the implant or vasectomies that are available only in the private sector. Additionally, the fact that a nurse in a FP department where the IUD was reportedly available was not trained in IUD insertion points to the need for training in IUD provision.

In the self-administered portion of facility assessments, study clinics reported limiting certain

services to women 18 years old and over, suggesting limited access for young women under 18 years old. One clinic reported charging for HIV treatment initiation and two reported charging for female condoms (even though HIV and contraceptive services should be offered free of charge in public clinics in South Africa). Additionally, none of the clinics reported having current adolescent friendly clinic policies or that any of their staff had received adolescent friendly services training in the past six months. When interpreting these findings regarding service availability it is important to remember that these data represent perceptions of the staff members asked to fill out self-administered questionnaires and may reflect misunderstandings of clinic policies and not real service availability. These findings should be further explored in order to ensure accessibility of services to all young women and consistency between public-sector clinics in Soweto, and efforts should be made to ensure clinic staff are aware of national policy regarding the rights of children over age 12 to access services without parental consent and the no-cost provision of various SRH services in the public sector.

A second aim of this study was to explore HCWs' opinions about adolescents' sexual behavior and utilization of SRH services and the potential impact of HCWs' opinions on service provision. Interviews with HCWs revealed a common belief that young women should not have sex before they are married and approximately one-fifth of HCWs described abstinence as their preferred method of FP for young women. Additionally, many HCWs revealed a sense of exasperation with young women for not protecting themselves more or not being abstinent before marriage, and many believed TOP was a "sin." We cannot be sure how these opinions affect service provision given that we did not explore HCWs' interactions with young women in this study, but these findings point to an underlying source of HCWs' harsh treatment and negative attitudes in South Africa, as identified by Wood and Jewkes.<sup>7</sup> Encouragingly, some HCWs in our study recognized the need to provide comprehensive FP and HIV prevention counseling to young women regardless of their own beliefs, due the reality that

many young women are sexually active before marriage.

Many HCWs acknowledged the outside social and economic factors that place young women at risk of pregnancy and infection, and, though many felt young women already had access to a lot of SRH-related information, some saw a need for better education of young women about the consequences of sex and the importance of protection. This recognition that it is more than just young women's individual choices that put them at risk for pregnancy and HIV infection suggests that many HCWs are willing to have a dialogue about the need for non-judgmental services to young women seeking prevention methods and other SRH services such as TOP and GBV counseling. The frequent comments about the need for better communication between parents and adolescents suggest that HCWs see it as parents' responsibility to teach their children about the importance of protecting oneself from pregnancy and STIs. A recent ethnographic study explored the South African cultural norms that dictate that parents do not talk with their children about sex,<sup>9</sup> and it would be interesting to conduct similar follow-up research with HCWs to further explore their willingness (or unwillingness) to talk about sex with young women. Research on interventions to help HCWs understand how culture puts young women at risk of unprotected sex would also be useful.

People working on initiatives to promote adolescent friendly SRH services may consider including workshops or trainings for HCWs regarding the importance of putting aside personal beliefs when providing services to young women. Addressing HCWs' personal beliefs and their impact on service provision can be very challenging, though interventions including values clarification exercises have had positive results in South Africa.<sup>10,11,12</sup> Body language and communication style are also critical to provision of quality services to young women, and initiatives to promote adolescent friendly SRH services could also focus on methods for communicating with young people. Prior efforts such as the National Adolescent Friendly Clinic Initiative have attempted to address acceptability of SRH services for young women,<sup>13,14</sup> although our results suggest

more work can be done to ensure such programs reach all HCWs and effectively impact service provision by preparing HCWs to provide non-judgmental services. The National Department of Health in South Africa is currently working with Love Life on the “Youth Friendly Services” Quality Assurance Program;<sup>15</sup> this and other efforts must continue to strive to ensure that policies ensuring young people’s SRH rights are implemented on the ground.

Availability of services and HCWs’ ability to provide quality services are of course also impacted by resource constraints – especially human resource constraints, which are crucial to consider for efforts to improve SRH services for young women. This could possibly be addressed through integration of services, as pointed out by HCWs from ANC departments in this study.

This study has limitations. First, the extent to which our findings are reflective of experiences in other areas of South Africa (particularly more rural areas) is uncertain given our focus on Soweto. However, our sampling strategy that ensured representation from different departments and job functions, and the resulting large proportion (64%) of HCWs interviewed in ANC, FP, HIV, and TOP departments in study clinics allows us a depth of knowledge about three of the 27 (11%) public primary health care clinics in Soweto. We did not define for participants what we meant by “young” when asking for their opinions of young women’s sexual behavior and SRH services; therefore, our findings do not apply to a specific age group and respondents may have understood the questions about “young women” differently.

In conclusion, our study highlights possible areas for expanding service availability—including providing refresher courses for HCWs on the full range of contraceptive methods and ensuring that SRH services are provided to all young women over the age of 12 for free in the public sector—and also suggests values clarification exercises and workshops on methods for communicating with young people to support HCWs in providing quality SRH services to young women. Efforts to improve accessibility and acceptability of healthcare services for young people must include a focus on ensuring first that HCWs are aware of country policies already in

place that pertain to adolescent SRH, second that they understand the policies and their implications, and lastly that the implementation of the policies is monitored. We also recommend additional research with young women about their experiences with HCWs, and to test interventions aimed at supporting HCWs in providing acceptable and accessible adolescent-friendly services. HCWs are a vital component of the public sector health system and must be included in efforts to address rates of unintended pregnancy and HIV in South Africa.

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## References

1. Reddy SP, James S, Sewpaul R, Koopman F, Funani NI, Sifunda S, Josie J, Masuka P, Kambaran NS and Omardien RG. UmthenteUhlabaUsamila – The South African Youth Risk Behaviour Survey 2008. Cape Town: South African Medical Research Council, 2010.
2. Pettifor AE, Rees HV, Kleinschmidt I, Steffenson AE, MacPhail C, Hlongwa-Madikizela L, Vermaake K and Padian NS. Young people’s sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. *AIDS* 2005;19:1525-1534.
3. Pettifor AE, Measham DM, Rees HV and Padian NS. Sexual Power and HIV Risk, South Africa. *Emerg Infect Dis* 2004; 10(11): 1996-2004.
4. Republic of South Africa. Government Gazette. Cape Town: 2006. Accessed May 31, 2011, <<http://www.education.gov.za/LinkClick.aspx?fileticket=XMF%2FuqNr52U%3D&tabid=271&mid=1140>>.
5. Department of Health. National Contraception Policy Guidelines [no date provided]. Accessed June 1, 2011, <<http://www.doh.gov.za/docs/facts-f.html>>.
6. Ringheim K. Ethical and human rights perspectives on providers' obligation to ensure adolescents' rights to privacy. *Stud Family Plann* 2007; 38(4): 245-252.
7. Wood K and Jewkes R. Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa. *Reprod Health Matter* 2006;14(27): 109-118.

8. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. Thousand Oaks, California: Sage, 2006.
9. Mkhwanazi N. Understanding teenage pregnancy in a post-apartheid South African Township. *Cult Health Sex* 2010; 12( 4): 347-358.
10. Turner KL, Hyman AG and Gabriel MC. Clarifying values and transforming attitudes to improve access to second trimester abortion. *Reprod Health Matter* 2008;16(31 Supplement):108-116.
11. Mitchell EMH, Trueman K, Gabriel M and Bock LBB. Building alliances from ambivalence: Evaluation of abortion values clarification workshops with stakeholders in South Africa *Afr J Reprod Health* 2005;9(3):89-99.
12. Varkey SJ, Fonn S and Kethlapile M. Health workers for choice. Johannesburg, South Africa: Women's Health Project, 2001.
13. Dickson KE, Ashton J, Smith JM. Does setting adolescent-friendly standards improve the quality of care in clinics? Evidence from South Africa. *International Journal for Quality in Health Care* 2007; 19(2):80-89.
14. Mathews C, Guttmacher SJ, Mtshizana YY, Nelson T, McCarthy J, Daries V. the quality of HIV testing services for adolescents in Cape Town, South Africa: Do adolescent-friendly services make a difference? *Journal of Adolescent Health* 2009;44:188-190.
15. LoveLife. Youth Friendly Services [no date provided]. Accessed March 15, 2012, [http://www.lovelife.org.za/what/youth\\_services.php](http://www.lovelife.org.za/what/youth_services.php).

