Young people's experiences in accessing sexual and reproductive health services in sub-Saharan Africa: a content analysis

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ABSTRACT

Increasing resources have been targeted at addressing the sexual and reproductive health (SRH) needs of the young people since the International Conference on Population and Development (ICPD) in 1994. Yet after two decades, the adoption of SRH services by the young people, a critical segment of the population, is very low, particularly among those in sub-Saharan Africa. This review focuses on the needs and experiences of the young people around SRH services with an aim of finding out possible reasons for the low adoption. A content analysis was used for both quantitative and qualitative studies on barriers to SRH services access and utilization among the young people in sub-Saharan Africa. This analysis identified three major categories of service-accessibility, utilization and quality. Most of the barriers including worries over abusive and discouraging remarks by health service providers; feeling of embarrassment, shame and fear; inadequate or no information on SRH service as well as lack of confidentiality and privacy could all be linked to the negative attitude of health services providers. Nonetheless, misconceptions about SRH services most especially the notion of contraceptives causing infertility when young women eventually get married was also prominent. The review has shown that most of the barriers to SRH services by the young people could be linked to the negative attitude of health service providers as well as misconceptions on SRH services from the young people. There is therefore, the need to intensify training of providers on youth friendly SRH services as well as intensify education of the young people on misconceptions about SRH services to improve adoption.

KEYWORDS Young people; Sexual and reproductive health services; Barriers; sub-Saharan Africa

INTRODUCTION

In 2014, it was estimated that half of the world's population was under 25 years old and the young people under the age of 25 years constituted 1.8 billion.[1, 2, 3] Due to high fertility rates, the proportion of young people is far greater for the developing regions especially, sub-Saharan Africa (SSA).[1] Young people continue to suffer greater risks of sexually transmitted infections (STI), human immunodeficiency virus (HIV) and unintended pregnancies. For instance, one-half of all people currently infected with HIV are females less than 25 years.[2] Since the International Conference on Population and Development (ICPD) drew attention to the special needs of the young people regarding sexual and reproductive health in 1994, [4] many programmes, activities and research studies have been carried out to address their sexual and reproductive health needs. Yet after twenty years, the adoption of services by the young people is very low, particularly among those in SSA. This is because there are many challenges that prevent the young people

from wanting to use SRH services even when they are available. A common misconception that the young people should not be sexual beings and general stigma around their sexuality make it difficult for them to gain needed information and SRH services. Young people may be too embarrassed to talk about sexuality with parents and experience communication difficulties with their sexual partner, leaving them unable to articulate their reproductive desires.[5-8]This is particularly true for girls, who also are subject to norms governing gender-appropriate expression of sexual needs and desires. Young people especially girls report experiencing fear, shame and embarrassment because of the stigma they encounter in seeking family planning information and services and using contraceptives.[9]

Specifically, in many sub-Saharan countries, condoms are often associated with promiscuity, making girls reluctant to use them as male partners might view them as having "loose morals".[9&10] For young men, condom use may also be stigmatized, given its association with a lack of masculinity, distrust of partner, or carrying a disease, resulting in boys being reluctant to use them.[8, 10 & 11] Also, belief that condom will decrease sexual pleasure, lack of knowledge of how to use condoms, or fear of rejection by a partner discourage young men from using condoms.[9] However, the benefits of promoting the SRH of young people are far-reaching. For example, positive interventions can reduce the likelihood of teenage pregnancy and its social and economic costs. Delaying marriage and parenthood can allow for greater educational achievements and thus improve career and employment opportunities. The prevention and treatment of STI and HIV/AIDS also reduce social stigma and help young people remain healthy, enabling them to better care for and invest in their families, communities and countries.

Several studies have looked at SRH service utilization, youth service preferences, and important factors for young people when seeking SRH services.[12-14]Most of the studies have not defined the barriers to successfully obtaining services. Senderowitz described four categories of reasons why adolescents avoid using SRH services: (i) policy constraints, (ii) operational barriers (hours of operation, transportation, cost), (iii) lack of information, and (iv) feelings of discomfort (belief that services are not for them, concern over hostile staff, fear of medical procedures, etc).[15] This gives a comprehensive categorization but there is the need to develop one targeting specifically at SRH services since challenges relating to point of SRH service need to be addressed and treated with utmost priority to overcome the lack of SRH adoption by the young people particularly in sub-Saharan Africa over the past two decades. This would help realised the demographic dividend and allow the young people to be at the centre of the post-2015 agenda for sustainable development in the region. Hence, this review is both urgent and timely. From the search of the literature, there is no publication presenting a content analysis of studies of barriers affecting young people's access to and use of SRH services in the sub-Saharan African region. This review is examining empirical studies published between 1994 and 2015 identifying and classifying barriers young people experience in accessing SRH services in sub-Saharan Africa.

M E T H O D S

Data search

A search of the following electronic databases was conducted: PubMed, Google Scholar, CINAHL, PsychINFO, Popline, and JSTOR to identify studies in which the primary focus was on factors affecting young people's access to, use and perceptions of SRH services in sub-

Saharan Africa. Since issues relating to SRH became more prominent following the ICPD in 1994[4] and the MDG 5b aims to achieve by 2015, universal access to reproductive health, each database was searched for articles published in English between 1994 and 2015 using a combination of the following keywords: young people, young persons, young women, young men, youth, teen, adolescent, sexual health service, reproductive health service, contraceptive service, STI services, unsafe sex, and youth friendly services among others. The lists of references in the retrieved documents were also examined with a view to identifying additional publications of interest. Two hundred and fifty three articles and reports were obtained (Figure 1, Appendix). The literature review was guided by this question: What are the barriers young people experience when accessing SRH services?

Exclusion and inclusion criteria

The search was limited to studies from sub-Saharan Africa due to cultural variations with other regions of the world. This brought the number down from 253 to 83 articles and reports for further exploration. Subsequently, studies focusing primarily on SRH service type utilization or preferences, facilitators of SRH service utilization and intervention studies as well as reviews and reports were excluded. Apart from the reviews and reports, articles were excluded because they did not address the research question since they focused on the health providers' or parents' perspectives on SRH service. Intervention studies were excluded since they primarily focused on a different methodology to service provision (e.g., peer model, nurse-led services, HIV/AIDS service and so on). This brought the number of papers down to 17 articles which fulfilled the inclusion criteria of being: (i) based on empirical research; (ii) focused on10 to 24-year-olds; (iii) focused on at least one barrier category and (iv) having a minimum sample size of 200 survey for the quantitative studies, and qualitative studies also having young people's voices represented. The 17 studies that were finally selected presented findings from Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. Three studies were done in multiple countries (Table 1, Appendix).

Data analysis

This review included both qualitative and quantitative studies. There is a growing number of review articles combining qualitative and quantitative data to synthesise evidence.[17 & 18] Content analysis explores text.[16] The text used for this analysis was the written material from the results of the selected studies. The reason for selecting this method was to provide a structure by classifying the experiences, expectations, opinions or views and perceptions of barriers to SRH service presented in the selected studies. This is because content analysis creates new knowledge by drawing important information from the data and structuring it.[19]This review used the inductive approach. This approach was used since a conceptual framework or theory was not adopted or adapted to guide the data analysis process. This means that the categories were derived from the data.[19]

The first step of the inductive data analysis consisted in identifying the results from each study relating to experiences, expectations, opinions or views and perceptions of barriers to SRH services which eventually formed the sub-categories (Table 2, Appendix). This created various codes about the experiences, expectations, opinions or views and perceptions of barriers to SRH service, which were developed into a coding scheme, and involved reading and rereading the articles while coding the data.[20] The next step was to find the commonalities between these sub-

categories, which, after careful consideration, yielded three major categories: service-accessibility, service-utilization, and service-quality which formed a structure of barriers experienced by young people and were defined as follows:

1. Service-accessibility relates to barriers experienced by young people that stop or do not encourage them to access the SRH services they need. They included: distance to SRH service, feeling embarrassed, ashamed or fear, inconvenient location, difficulty locating SRH service, frequently closed SRH service facility, inconvenient hours of operation, age limitation, gender limitation, not aware of where to go for SRH service, high cost of SRH service, parental disapproval, young person's disapproval and young person partner's disapproval as well as misconceptions about contraceptives which also include the following: contraceptives cause infertility, condoms get stuck in vagina, condoms break, contraceptive cause missing menstrual periods, excessive bleeding during menstrual periods, and no or less pleasure from condom use,
2. Service-utilization also involves barriers young people encounter from the time they enter the SRH facility till they exit. They included: lack of confidentiality or privacy, fear of being seen by others, long waiting time, uncomfortable waiting room, and adult clients unwilling to talk to young people, and
3. Service-quality comprise perceptions of barriers from young people's perspective and included: abusive, discouraging remarks by health provider, discrimination against the unmarried, no attention from health provider, not allowed to express oneself enough, no direction to SRH service area, refused SRH service, not provided with enough SRH information, and service delivery by older or adult health provider.

RESULTS

Selected studies

From Table 1, six selected studies used quantitative[26, 27, 29-32] and another six used qualitative[23, 24, 28, 33, 34 & 36] methods. The remaining five combined both methods in each study[21, 22, 25, 35 & 37] Six studies had their participants from clinics, three used participants from households, [26, 29 & 30] another three recruited participants from both currently in school and out of school,[23, 24 & 35] and two used only participants in school.[27 & 31] One study recruited only participants from out of school[33] and the remaining two combined multiple settings.[21 & 22] One combined school and community and the other combined clinic and households. Two articles focused on only females[28 & 34] whilst one focused on only male[23] and the remaining fourteen considered both gender. Seven of the studies focused on barriers to SRH services,[22-24, 27, 28, 34 & 37] three on SRH education,[23, 30 & 31] another three on acceptance of SRH services,[25, 35 & 36] two on SRH services preferences,[26 & 29] and one each on satisfaction from SRH services[32] and SRH services utilization.[33]

Service accessibility

According to the studies by Nare et al., 1997; Koster et al., 2001; Erulkar et al., 2005; Berhane et al., 2005; Nobelius et al., 2011; Kinaro, 2013 and Godia et al., 2014, young people feeling embarrassed, ashamed or afraid was the most reported barrier that barred them from accessing SRH services (Table 2, Appendix).[22, 23, 26, 27, 33, 35 & 36] This emotion was usually as a result of the

attitude of some health service providers as reported under service quality. Nare et al. (1997) using mystery clients (trained people who visit programme facilities in the assumed role of clients) in Senegal reported that the mystery clients said their first contact with the clinics was negative. Some felt afraid, embarrassed, or disappointed as shown in the following illustration: *"I was afraid because they* [SRH service providers] *took me each time to a different person," and "I was very disappointed because I expected a much friendlier welcome."*[22] Furthermore, from some of the selected studies, the young people reported that they were not aware of where to go for SRH service.[23, 26, 29, 34 & 35]This was particularly true for studies from the rural setting. Again, some of the selected studies reported that the young people found the operation hours of SRH services inconvenient since they were usually in school.[29 & 32] Others found the location inconvenient because they might be seen by parents or guardians who disapprove of their use of SRH services or they might be seen by their peers who might mock at them.[22] In addition, some of the studies reported that cost was sometimes mentioned as an important barrier to obtaining SRH services.[26, 27, 29, 32 & 36]

Another barrier experienced by the young people was parental disapproval to SRH services especially, contraceptive use was reported by various studies.[23, 28, 31, 35 & 36]The quantitative studies[28 & 31] reported significant associations between parental approval and contraceptive use. Sometimes the selected studies reported that young people themselves disapproved of SRH services for personal or religious reasons[22, 31, 33 & 35] or their partner disapproved it for the same reasons. Several studies reported that young women fear that contraceptive use would make it difficult for them to conceive when they eventually get married.[24, 28, 30, 33 & 36] Other misconceptions about condoms that hinder young people's access to SRH services that were reported by the studies include the following: that condoms give less pleasure[21, 24 & 34] or frequently break[21, 23 & 24] or get stuck in vagina.[23] Other studies reported that missing menstrual periods[24 & 27] and excessive bleeding during menstrual periods were worrying and therefore, served as barriers to SRH services by young women. Some selected studies reported that other issues that were also worrying to young people were restrictions to SRH services such as limiting service to only married persons[22, 25, 35 & 36] and for persons older than 18 years.[25]This finding is illustrated by the study in Ghana (Koster et al., 2001) where one boy in FGD for out-of-school participants in urban Ghana said: *"Sometimes when you go, they look at your features and they feel that you are not of age. They ask a lot of questions, like; "Who sent you?" You are too small." This is what they say and they send you away."*[23] The reviewed studies reported that men complained a lot that the SRH services were oriented to women and only married couples.[22, 25, 34 & 35]

Service utilization

From the selected studies, young people viewed lack of confidentiality as the most important barrier that hinder their utilization of SRH services.[23, 25, 26, 29, 32, 35 & 37] (Table 2, Appendix). Young people who went to smaller health facilities experienced this more often. In one of the studies, [25] half of the young people who participated believed that the health facility staff (i.e., cashiers, receptionists, and medical clerks) could not be trusted to maintain their confidentiality. One boy summed up the common feeling in FGD among in-school participants in Ghana as follow: *Like me, if I go to the service and I am looking for a condom, they inform my mother [all participants agree with 'hmm']. But I came there for these reasons and then my mother will do something to me, so I feel shy, I am afraid to go, and rather contact my friends"*[23]. Another

barrier that was of great concern to young people reported by the studies was lack of privacy.[23, 25, 29, 32 & 37] Young people usually reported this barrier together with lack of confidentiality.

The reviewed studies reported that the fear of being seen by parents or other familiar young people is worrying to the young people[25, 27 & 36] and this served as a major barrier for SRH service utilization. Investigators in one of the study[27] reported that 72% of the young people reported that fear of being seen by parents or people whom they know hinder their utilization of SRH services. Also, studies reported that long waiting time affected SRH services utilization negatively.[26, 36 & 37]Long waiting time tend to exacerbate the feeling of embarrassment, shame and fear that deter young people from accessing SRH services. In addition, one selected study reported that young men stated that they did not feel comfortable sitting in the waiting area, *"between women"*[36]. Again, one study reported that young adults often felt that other adult clients in the clinics were biased against them as illustrated by the following quote: *"clients don't want to talk with us young people, since they think we are too young for that."* [22]

Service quality

From the reviewed studies (Table 2, Appendix), attitude of SRH service providers dominated all the barriers reported by young people.[22, 23, 25, 26, 28, 29, 32, 35 & 36] Young people reported several abusive and discouraging remarks from service providers. In one of the studies that the investigators used mystery clients, service providers sent young people away and told them*: "go to the pharmacy" or "you would do better to focus on your studies."*[22] The included studies reported that young people spoke of being scolded by nurses for many things, such as if they had got previous doses of contraception from a private health service provider, or had used a fixed clinic when their home was serviced by a mobile clinic, or for not arriving at the clinic early in the morning despite the fact that, for most, visiting the clinic was only feasible after school hours.[28]

Furthermore, the selected studies reported that the young people complained that the SRH information provided them was at best scanty.[22, 23, 28, 32, 36 & 37]Though, they reported that pharmacies and chemical shops provided much more compared to clinics or hospitals. Findings from one of the studies showed that the majority of boys (in and out-of-school) felt that both public and private health care staff do not provide sufficient information to the youth about contraceptive use and prevention of sexually transmitted infections. [23] Also, according to the studies included in this review, the young people did not use SRH services because they felt service providers discriminated against them since they were not married.[22, 25, 35 & 36]

In addition, the selected studies reported that the young people especially girls stressed the need to be allowed to express themselves enough.[22, 32, 36 & 37] Girls described how "simple" things really mattered to them such as: health service provider's reception and facial expressions, greetings and being given the chance to express themselves and explain their problems. Other barriers that did not enhance SRH services patronage by young people reported were: no clear direction to SRH service area,[22 & 37] young people being refused SRH services,[22 & 35] and health service providers being older or adult.[23 & 37]

DISCUSSION

The review brought out three major categories of barriers that deter the young people from SRH services patronage: barriers of service-accessibility that discourage or prevent them from

accessing SRH services; barriers of service-utilization that young people experience from the time they entered the SRH services facility till they exit and that of service-quality which are encountered at the time of receiving service.

Health service provider attitude stood out as the most important barrier to the young people. Health care providers' attitude can either facilitate the use of services or constitute a barrier to the young people seeking SRH services.[38, 39 & 40] Some SRH service providers were not sympathetic or were less sympathetic to the young people who presented SRH cases at their facilities. This included turning away young people who came to ask about services, especially those seeking abortion and STI services as well as dictating the type and nature of services young people should have. The young people complained that discouraging and sometimes abusive remarks were a great source of worry and a major barrier to them seeking SRH services. Similar observations were made in studies in sub-Saharan Africa and across the world.[41-46]

Negative attitude of health service providers mainly was responsible for the embarrassment, fear and shame that the young people experienced which made them find it difficult to seek SRH services. This was another prominent barrier that was very conspicuous in this review. Again, studies in sub-Saharan Africa and across the world had made similar findings.[42, 44, 46-48] Misconceptions about contraceptive methods especially, that the use of hormonal methods like the pill and injectable cause infertility were found in the various studies to be major deterrent to some young women from seeking SRH services. These findings imply that education regarding hormonal contraceptives and messaging or social marketing of these requires renewed attention. Other studies in sub-Saharan Africa and South America have reported similar findings where contraceptive use by young girls was not approved by young people, community members and health service providers because it was considered to affect fertility of young girls.[24, 49 & 50]

Confidentiality and privacy also came out strongly in this review as another worrying barrier issue to the young people. This again, could be linked to bad attitude of health service staff. Young people may be particularly reluctant to seek services where breach of confidentiality and privacy exist or are perceived to exist. A recent systematic review of contraceptive service delivery for young people in the UK showed that the most significant concerns for young people were anonymity and confidentiality.[51] In another recent study in UK, a young woman of 19 years had the experience of her GP sharing something she had told the GP during consultation with her aunt with whom the young woman was currently residing.[52] Yet another concern highlighted by this review that is traceable to the attitude of health service professionals is the provision of inadequate SRH services information or sometimes complete refusal. Kumi-Kyereme et al. (2014) made similar observations in in-depth interviews with young people where the attitudes of health providers in respecting young people as individuals, ensuring confidentiality and meeting their needs for information and services emerged as important considerations for young people who either sought or contemplated seeking health care.[39]

CONCLUSION

The review identified significant findings in relation to issues regarding the barriers to SRH services by young people. It has been shown that most of the challenges impeding SRH services' adoption could be connected to the negative attitude of health service providers as well as

misconceptions about SRH services on the part of the young people. There is therefore, the need to intensify training of providers on youth friendly SRH services as well as intensify education of the young people on SRH services to improve acceptance. Based on the findings, the following recommendations are made:

Implications for practice

- Training of providers in interpersonal communication, youth counselling skills, youth friendly services should be intensified. Training should also focus on making providers realize that young people may be sexually active or not, married or single and HIV positive or not.
- Training curriculum should focus more on making service providers to understand what makes young people seek services, but more importantly, what prevents them from coming and the need for SRH service providers to adapt to the needs of young people, particularly their preventive health needs.
- Providers need an understanding of the diversity of young people, their level of knowledge, and their perception of need to be able to serve them appropriately.
- In addition, health service providers should be mindful of the fact that not all young people accessing health services are literate, confident, know exactly what to expect, or are capable of explaining what they need or want.
- Managers of health services in the region should be proactive in advocating for changes in policies and laws that restrict access to SRH services for young people.
- SRH education for young people also ought to be pursued by governments and other stakeholders in SRH services to achieve the needed success as far as adoption of SRH services and post-2015 agenda of sustainable development in the region is concerned.

Implications for research

Future studies should aim to establish whether SRH service-accessibility better predict non-use of SRH services by the young people compared to service-utilization or service-quality. Such understanding is needed to know to what extent the identified barriers deter young people from seeking SRH services. Similar review could be done in the future to know how the identified barriers to SRH services compare with other developing regions of the world.

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Conflict of interest

The author declares no conflicts of interest in relation to this content analysis.

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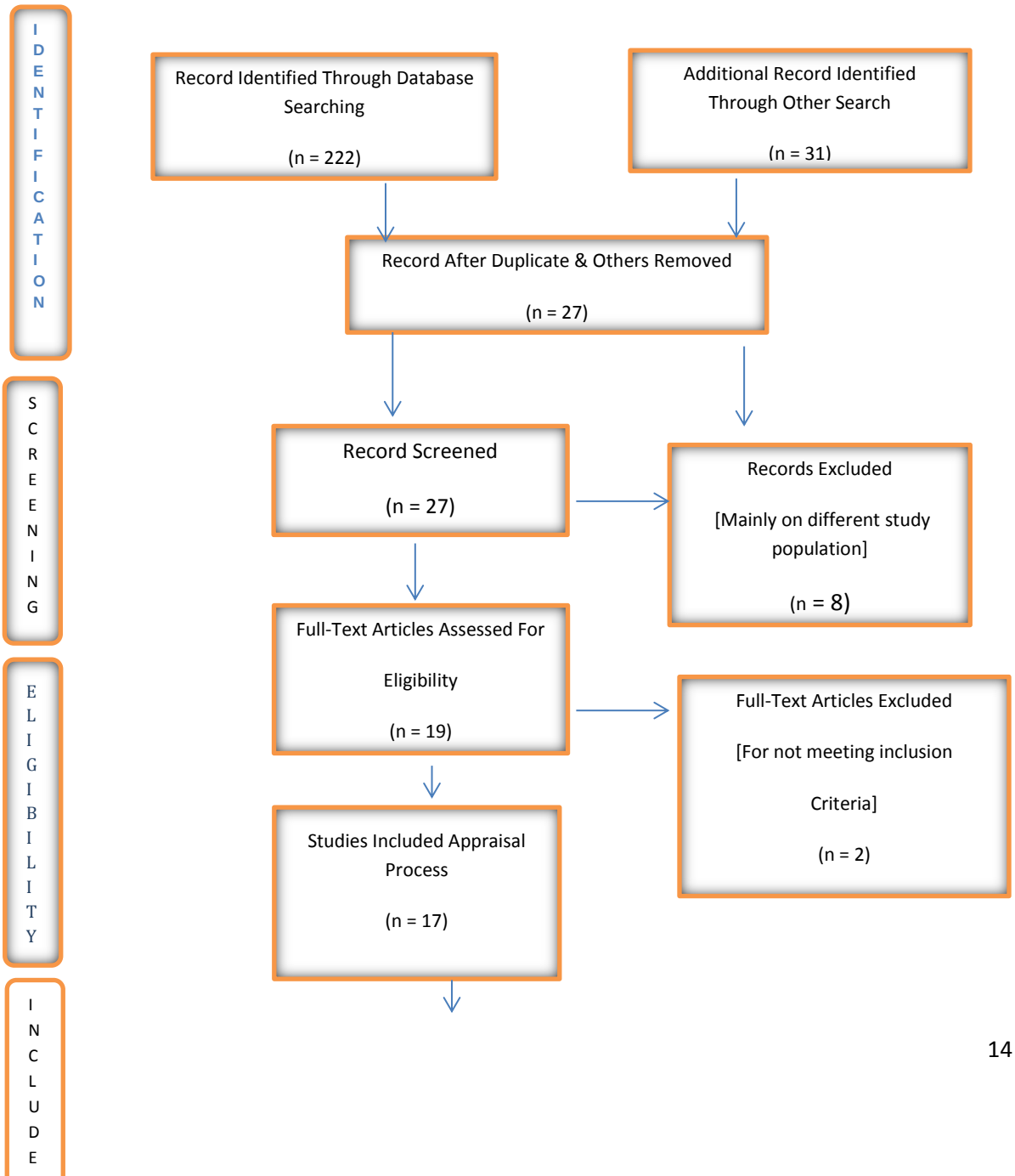
APPENDIX

Figure 1: Flowchart of included and excluded studies



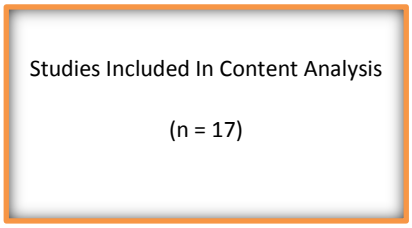

Studies Included In Content Analysis
(n = 17)

Table 1: Selected studies

No.	Authors	Year	Country	Approach	Method	Study setting	Number of participants	Sex	Age
1.	Amazigo et al.	1997	Nigeria	MM	Survey, IDI, FGD, Essays	Schools & Community members	> 2,460	Both	< 25
2.	Nare et al.	1997	Senegal	MM	Survey, FGD, MC	Households & Clinics	> 2,909	Both	15-20
3.	Koster et al.	2001	Ghana	QL	FGD, SSI, II, Obs, QA	Both in & out of school	86	Male	15-19
4.	Otoide et al.	2001	Nigeria	QL	FGD	Both in & out of school	149	Both	15-24
5.	Mmari et al.	2003	Zambia	MM	Survey, IDI, FGD	10 clinics – 8 YFS & 2 Non-YFS	ND	Both	10-24
6.	Erulkar et al.	2005	Kenya & Zimbabwe	QN	Survey	Households	1,883	Both	10-24
7.	Berhane et al.	2005	Ethiopia	QN	Survey	Schools	2,647	Both	10-24
8.	Biddlecom et al.	2005	Burkina Faso, Ghana, Mali & Uganda	QN	Survey	Households	19,528	Both	12-19
9.	Wood & Jewkes	2006	South Africa	QL	IDI, FGD	Clinics	-	Female	14-20
10.	Bankole et al.	2007	Burkina Faso, Ghana, Mali & Uganda	QN	Survey	Households	8,837	Both	12-14
11.	Adeokun et al.	2009	Nigeria	QN	Survey	Schools	989	Both	10-24
12.	Mayeye et al.	2010	South Africa	QN	Survey	Clinics	200	Both	16-19
13.	Nobelius et al.	2011	Uganda	QL	FGD, IDI	Out of school	> 31	Both	13-19
14.	Mbeba et al.	2012	Tanzania	QL	FGD, CS, QA	Clinics	> 72	Female	10-18
15.	Kinaro	2013	Kenya	MM	Survey, FGD, IDI	Both in & out of school	1,119	Both	15-19
16.	Godia et al.	2014	Kenya	QL	FGD, IDI	Clinics	> 180	Both	10-24
17.	Obong'o & Zani	2014	Kenya	MM	FGD, EI	Clinics	> 200	Both	15-19

QL, qualitative; QN, quantitative; MM, both qualitative and quantitative; IDI, in-depth interviews; MC, mystery client; FGD, focus group discussion; SS, semi-structured interviews; II, informal interviews; Obs, observations; QA, service quality audit; ND, not defined; F, female; M, male; CS, case study; EI, exit interview; and YFS, youth friendly services.

Table 2: Identified categories from selected studies

CATEGORY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	Total
Service accessibility																		
Distant SRH service						*			*									2
Embarrassment, fear		*	*			*	*						*		*	*		7
Inconvenient location		*																1
Difficulty locating SRH service [not aware?]		*										*						2
Frequently closed SRH service facility																		
Inconvenient hours of operation									*			*						2
Age limitation					*													1
Gender limitation					*											*		2
Not aware of where to go for SRH service			*			*			*					*	*			5
High cost of SRH service						*	*		*			*				*		5
Parental disapproval			*					*			*				*	*		5
Young person's disapproval		*									*		*		*			4
Young person partner's disapproval													*		*			2
Misconceptions about contraceptive																		
Missing menstrual periods				*			*											2
Excessive menstrual periods				*			*											2
Contraceptives cause infertility				*				*		*			*			*		5
No or less pleasure for condom use	*			*										*				3
Condoms get stuck in vagina													*					1
Condoms break	*		*	*														3
Service utilization																		
No confidentiality			*		*	*			*			*			*		*	7
No privacy			*		*				*			*					*	5
Fear of being seen by others					*		*									*		3
Long waiting time						*										*	*	3
Uncomfortable waiting room																*		1
Adult clients unwilling to talk to young people		*																1

Service quality																		
Abusive, discouraging remarks from HW		*	*		*	*		*	*			*			*	*		9
Discrimination against the unmarried		*			*										*	*		4
No attention from HW		*			*											*		3
Not allowed to express oneself enough		*										*				*	*	4
No direction to SRH service area		*															*	2
Refused SRH service		*													*			2
SRH information not enough		*	*	*				*				*				*	*	7
Adult health worker (HW)			*				*											2
Health worker is of opposite sex			*				*					*						3
Different HW each visit		*										*						2