CHALLENGES FACED BY FEMALE TEENAGERS IN ACCESSING CONTRACEPTIVES AT BYLDRIFT CLINIC, MALATANE VILLAGE, CAPRICORN DISTRICT OF LIMPOPO PROVINCE

BY

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DECLARATION

I hereby declare that this dissertation **Challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic, Malatane Village, Capricorn District of Limpopo Province;** is a presentation of my own original work and that all sources that I have used and quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any degree at other institution.

Ms K.A Mothogoane

Signature

____

DEDICATION

This study is dedicated to my beloved parents: Alpheus Patiki and Madimo Maggie Mothogoane. The love, care, guidance, good morals and values that you inculcated in me kept me focused and enabled me to always maintain a positive attitude in spite of difficulties. To my children Thato and Nkateko from whom I spent a lot of time away due to my commitment to completing this study.

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ACRONYMS

AIDS- Acquired Immune Deficiency Syndrome

HIV- Human Deficiency Immune Syndrome

IPPF- International Planned Parenthood

LARC- Long Acting Revisable Contraceptive

WHO- World Health Organisation

ABSTRACT

The study sought to provide deeper understanding on access to contraceptives by female teenagers. The aim of this study was to explore the challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic, Malatane Village, Capricorn District of Limpopo Province. Qualitative research method was applied in the study. The study utilised case study research design. Purposive sampling was used to select participants. Face to face interviews were conducted with ten (10) female teenagers. The age of participants ranges from 15 years to 19 years. Thematic Analysis was used to analyse data. The negative attitude of healthcare providers was cited as a challenge for teenagers accessing contraceptives, however other participants cited positive attitude of healthcare providers. The experience of side effects, parents and partners were cited as major challenges experienced while using contraceptives. The problem of inaccessibility remains a challenge in public health facilities; participants reported long waiting times, long distance to get to the clinic, shortage of staff, lack of confidentiality and lack of proper infrastructure. Most participants indicated that they discuss contraception with their peers, therefore peer influence remains an influential factor in accessing contraceptives. The study recommended that healthcare providers should give the effectiveness rate of the contraceptive method and ways to manage side effects, health facilities need to be more user friendly and that operating hours should be convenient to teenagers who are still schooling. This is evident that young women face challenges in accessing contraceptives.

Keywords: Access, challenge, contraceptives, teenagers

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CHAPTER ONE: GENERAL ORIENTATION OF THE STUDY

1.1. Introduction and Background

Section 27 of The Constitution of the Republic of South Africa, Act No. 108 of 1996 promotes reproductive rights and the right of access to reproductive health care. Therefore, it means that contraception in South Africa is a human right. The South African legislation intends to empower teenagers to choose the state of their own reproductive health from as early as 12 years of age. Through the Children's Act No. 38 of 2005, 12-year-old children are given the rights to access reproductive health without the consent of their parents (Hassim, Heywood and Berger, 2007). Hoffman-Wanderrer (2013) explains that The Constitution of the Republic of South Africa, Act No. 108 of 1996 defends the rights of all citizens in the country including children to make decisions concerning their reproduction and their rights to access services including reproductive health care. Law protects the Sexual and Reproductive Health of teenagers in South Africa; however, teenagers still face various challenges gaining access to Sexual and Reproductive Health including contraceptives (Hoopes, Chandra-Mouli, Steyn, Shilubane and Pleaner, 2015).

According to Save the Children (2007), teenage people face challenges during their teenage periods and need information, skills, opportunities and services to make healthy choices. There is evidence that better education and public health measures can be hugely beneficial to the health and development of teenagers (Lancet, 2012). The evidence of Kamau (2006) shows that girls are concerned about unintended pregnancies and menstrual cycle related problems. In order to meet these challenges, it is vital to investigate information on factors that facilitate or prevent access to contraceptives. There are no documented studies that have been conducted in Malatane village on access to contraceptives. This study therefore provides deeper understanding of access to contraceptives by female teenagers and informs interventions to improve the services to the female teenagers.

1.2. Research Problem

As a researcher and a resident of Malatane Village, I have singled out female teenagers of Malatane Village to be in need of contraceptives. The high number of teenagers falling pregnant at an early age is also a concern to the researcher. This led the researcher to investigate the challenges that female teenagers face while accessing contraceptives. Unplanned pregnancy creates a health concern. Teenagers engage in sexual activities at an early age with lack of knowledge on contraceptives. Taylor, Tinabhai, Dlamini, Sathiparsad, Eggers and De Vries (2014) report that South Africa has a high number of teenage pregnancy problem. Panday, Makiwane, Ranchod, and Letsoalo (2009) support this by stating that the Department of Health in South Africa discovered that teenage women had been pregnant by the age of nineteen (19) years. The figures released by Morake (2011) for the South African Provincial Education indicate that school girls' pregnancies have doubled in the past years even with a decade of children spending time on sex education, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Karra and Lee (2012) postulate that the prevalence of teenage pregnancy in South Africa has reached the alarming proportions (Morake, 2011). The survey conducted by the South African Demographic and Health Survey found that teenage fertility rate in South Africa has declined from 76% in 1998 to 71% birth per 1000 girls aged 15 to 19 years (SADHS 2016). Over 20 000 school children fell pregnant in the year 2016.

The United Nations Fund for Population Activities (UNFPA) (2013) states that in Sub-Saharan Africa, South Central and Southeast Asia, more than 60% of teenagers who wish to avoid pregnancy do not have access to contraception. The Guttmacher Institute and International Planned Parenthood Federation (IPPF) (2010) report that an estimated 7.4 million adolescent girls across Sub- Saharan Africa, South Central and South east Asia, Latin America and the Caribbean experience unintended pregnancies per year. In the system of patriarchy men are dominated and women are subordinated (Bhasim, 2006).

Patriarchy legitimise men's control over women's sexuality and reproduction. This make women to be reluctant to access contraceptives because of the fear of abuse from their sexual partners. Culturally, male partners have a privilege of dominance over female partners. In other words, male partners make decisions over their female partners regarding sexual matters and contraceptives. In the case of condom use, women are often unable to negotiate condom use due to their subordinate status within their sexual relations with their male partners (Jewkes, Morrel and Christofides, 2009; Macleod and Tracey, 2010). Communication on condom among partners is limited due to male dominance in most relationships.

Flanagan, Lince, Durao de Menezes and Mdlopane (2013) view the unmet need for contraceptives and note that teenagers in rural areas are not satisfied about contraception access. Rogan and Maharaj (2009) argue that there is evidence in South Africa that health care providers are reluctant to give emergency contraception to teenagers, because they think that it will lower girls' use of condoms, while among the Latinos, health care providers and health systems contribute to the low access of contraceptives (Rocca and Harper, 2012). Therefore, Holt, Lince, Hargey, Struthers, Nkala, McIntyre, Gray, Mnyani and Blanchard (2012) indicate that it is important to investigate whether sexual reproductive services are accessible to teenagers.

1.3. Theoretical Framework

The study used The Social Ecological Model to investigate the challenges faced by female teenagers in accessing contraceptives. The rationale for choosing the Social Ecological Model is that it is mostly used in health behaviour research and is applicable in investigating health challenges, as it is applicable for the present study. The framework conceptualises health broadly and focuses on multiple factors that might affect health. Binder, Stokols and Catalano (1972) founded the Social Ecological Model.

The Social Ecology Model also called Social Ecological Perspective enabled the study to examine the various effects and interrelatedness of social elements (Binder *et al.,* 1972); teenagers' perceptions on the use of contraceptives, the accessibility of the clinic that provides contraceptives, the health care providers' attitude towards the provision of contraceptives to teenagers and the role of peer pressure. The Social Ecological Model recognizes that whereas individuals are responsible for instituting and maintaining life style changes necessary to reduce risk and improve health, individual behaviour is influenced by factors at different levels (Elder, Lyttle and Sallis 2007). There are five levels within the framework: the individual, interpersonal, community, institutional, and societal. In order to effectively change a person's or a community's behaviour, it is important to be aware of the influences from each level.

The Social Ecological Model operates at five levels. These are:

1.3.1. Individual level

This level is at the centre of the Social Ecological Model. It includes personal factors that increase or decrease the likelihood of an individual's characteristics that influence behaviour. Individual factors which influence physical activity participation include; knowledge about different types of contraceptives; attitudes; behaviours; beliefs; perceived barriers; motivation, and enjoyment. The fear of experiencing severe side effects of some method may also deter teenagers to use

contraceptive. In this, case the risk of becoming pregnant in high. Teenagers may also fear getting in trouble if they ask an adult about contraception. Interventions for individual-level influences are often designed to affect an individual's social and cognitive skills and behaviour, and include approaches such as counselling, therapy, and educational training sessions (Powell, Mercy, Crosby, Dahlberg and Simon, 1999). Health education programmes such as peer based programmes and contraceptives access at school based health centres can enable teenagers to have accurate knowledge on how contraceptives works.

1.3.2. Interpersonal or relationship level

This level involves factors that increase risk because of relations with peers, intimate partners, and family members. It also involves processes, which provide social identity and role definition or social networks and social support systems that can influence individual behaviours. A person's closest social circle – peers, partners, school and family members – have the potential to shape an individual's behaviour and range of experience (Dahlberg and Krug, 2002).

The relationship of partners, parents or guardians also affect contraceptive access and use. Researchers have found that women who discuss the use of contraceptive methods with their partners are more likely to use contraceptive method (Paek, Lee, Salmon and Witte, 2008; Stephenson, Baschieri, Clements, Hennik and Madise, 2007). Partner involvement is a vital factor in the use of contraceptives, for example, a male partner may refuse to be in a relationship with someone who uses contraceptives or to get involved in sexual activity using a condom as a contraceptive method. Education and family support is essential in the promotion of contraceptive access and use. On the other hand, if parents have open communication with their teenagers regarding contraception increases the ability to access and use contraceptive.

1.3.3. Community level

The community level factors are factors that increase risk based on community and social environments in which an individual has experiences and relationships such as schools, workplaces, and neighbourhoods (McLeroy, Steckler and Bibeau, 1988). They also involve community with established norms and values, standards and social networks. The social norms that exist in society disapprove teenagers to use contraceptive is an influential factor that prohibit access to contraceptives. In this way, teenagers may be reluctant to seek contraceptives in order to avoid stigma attached by the community. They can be in a way of the relationships among organisations, institutions, and informational networks within defined boundaries. A school working with the clinic in ensuring easy access to contraceptives by teenagers is an important intervention in the community.

1.3.4. Institutional level

The institutional level involves rules, policies, formal and informal structures (McLeroy *et al.,* 1988). For an example, the rules that are designed by the clinic. The operating hours of the clinic also impede access to contraceptives as some clinics close early while some teenagers are still attending classes. The institutional therefore explores the role that the institution plays in intervention for example, the school condom availability programs. Evidence suggest that the presence on National Contraceptive policies together with strong governmental commitment may increase access to and use of contraceptive and decrease the level of unmet need for family planning (Bongaarts, 2014; Tsui, 20010.

1.3.5. Societal level

The societal level includes macro-level factors that influence access to contraceptives such as societal norms (Stokols, 1996). The beliefs that some societies have on contraceptives determine the likelihood of teenagers to use contraceptives. Societal norms hold the values that women must prove their fertility to their partners.

The beliefs that some societies have on contraceptives determine the likelihood of teenagers to use contraceptives. Societal norms hold the values that women must prove their fertility to their partners. This may also involve the attitude of health care providers who deny teenagers contraceptive, believing that it would encourage early sexual activity (Tavrow, 2010).

According to the Social Ecological Model, each level influences an individual and community's behaviour. In terms of contraceptive use, the Model emphasises that individual factors contribute to the use of contraceptives through knowledge, attitudes and perceptions. From the reviewed literature, it has shown that perception influences the use of contraceptives as teenagers have their own views about contraceptives especially on the side effects (Waddington, 2007). The interpersonal level highlights that teenagers turn to their peers to look for information and they share information about contraceptives. Sometimes the information they share with their peers might be incorrect, have an influence on whether to access, and use contraceptives. The institutional perspective is applied when the working hours of the clinic are not convenient to teenagers as most of them are still at school and the clinic requires parental consent for teenagers to receive methods to prevent pregnancy, teenagers may not seek contraceptives (Elder *et al.,* 2007). The community level may be useful to the accessibility of the clinic that provides contraceptives. A long distance requires someone to have money to get to the clinic. Lastly, the societal level may encompass the attitude of health care providers who deny contraceptives to teenagers and recommend that they abstain or not to engage in sexual activity as they are regarded as young people (McLeroy *et al.,* 1988).

1.4. Operational Definitions

1.4.1. Access

Access refers to the ability to use services when they are needed (Gulliford, Figuera-Munoz, Morgan, Hughes, Gibson and Beech, 2002). For purposes of this study, access is defined as the extent to which services are freely available or at cost and effort that is acceptable for those who need them.

1.4.2. Challenge

Macmillan Dictionary (2015:http://macmillandictionary.com) defines a challenge as something that needs a lot of skill, energy, and determination to deal with or achieve something. For purpose of this study, a challenge is defined as a difficult task or situation.

1.4.3. Contraceptives

Cronje and Grobler (2003) define contraceptives as agents that are used to temporarily prevent the occurrence of pregnancy such as pills, condoms, intra-uterine devices, diaphragms and injections. In this study, contraceptives are defined as modern contraceptive methods used to prevent pregnancy.

1.4.4 Perception

Perception refers to the conscious recognition and interpretation of sensory stimuli through unconscious associations, especially memory, that serves as a basis for understanding, learning and motivation of a particular action or reaction (Mosby, 2013). For the purposes of this study, perception refers to the beliefs and views that female teenagers have on the use of contraceptives.

1.4.5 Teenager

A teenager is defined as an individual between the ages of 10 and 19 years of age (Nodin, 2001). For the purpose of this study, a teenager refers only to girls between 13 to 19 years of age.

1.5. PURPOSE OF THE STUDY

1.5.1 Aim

The aim of this study was to explore the challenges faced by female teenagers in accessing contraceptives at Byldrift clinic, Malatane village, Capricorn District of Limpopo Province.

15.2. Objectives of the study

The study aimed to pursue the following objectives:

- to ascertain the health care providers' attitudes towards the provision of contraceptives to teenagers;
- to determine the teenagers' challenges on the use contraceptives;
- to examine the accessibility of the clinic that provides contraceptives;
- to examine the role of peer influence in accessing contraceptives.

CHAPTER TWO: LITERATURE REVIEW ON CHALLENGES FACED BY FEMALE TEENAGERS IN ACCESSING CONTRACEPTIVES

2.1. Introduction

The health of teenagers depends on their access to health care services. Teenagers face specific vulnerabilities that are unique to their age group: physiological vulnerability; high susceptibility to peer pressure; tendency to engage in risk-taking behaviour; less ability to discuss safer sex practices; and difficulty in accessing reproductive health information and services (Baloyi, 2006). With regard to access to health care, teenage girls are more likely to experience challenges than male teenagers due to their vulnerability to early pregnancy. Globally it is estimated that more than 220 million women have unmet need for family planning (Singh and Darroch, 2012). The unmet need for family planning is extremely high for both married and unmarried teenagers (Chandra-Mouli, McCarraher, Phillips, Williamson and Hainsworth, 2012). Apart from that, factors such as lack of freedom, male dominance in relationships, and gender-based violence also affect access to health care (Ridgeway and Correl, 2004; World Health Organization, 2009). As for Hamilton and Armstrong (2009), the beliefs of gender inequality often causes sexual problems for women. Lack of control in the decision-making about teenager's sexual health needs and bodies are due to male dominance in sexual relationships. Poor partner communication may result in male partner taking decision over the female partner regarding sexual matters.

However, Riyani, Afifi and Marby (2004) reported that education gives young women autonomy to make informed choices about their bodies. Early pregnancy and Sexual Transmission Infections (STI) including Human Immunodeficiency Virus (HIV) threaten the health of teenagers more than any other age group (Bearinger, Sieving, Ferguson and Sharma, 2007). According to Stover and Ross (2010), over 1.4 million teenagers give birth each year with 12, 8 births occurring in developing countries.

Population Reference Bureau (2017) reported that the fertility rate of teenagers is 17% in South Africa among teenagers aged 15-19 years. Therefore, this chapter reports on extensive literature study that was conducted on the topic. A number of social factors influences access to contraceptives. Williamson, Parkes, Wright and Petticrew (2009) state that young people experience the prejudice of health care providers, peer pressure and clinic environment that are not favourable for teenagers in accessing sexual reproductive health services including contraceptives. The literature identified the following aspects as influential amongst teenager's access to contraceptives; the health care providers' attitude towards the provision of contraceptives, teenagers' challenges on the use of contraceptives, the accessibility of the clinic that provides contraceptives and the role of peer influence in accessing contraceptives.

2.2. The health care providers' attitude towards the provision of Contraceptives to teenagers

Patient satisfaction with the health care provider and continuity of care has a significant impact on compliance behaviour (Goodman and Gilman, 2006). When teenagers are satisfied about the attitude of healthcare providers, they will use contraceptives consistently. Corroborated further, Peterson, Payne, Albright, Holland, Cabral and Curtis (2004) are of the view that counselling with motivational discussions may be a possible means of improving contraceptive compliance. According to Yee and Simon (2010), providers have the potential to positively influence women's access to and usage of contraception. Talking to teenagers in a friendly manner makes them to feel free for discussions with the healthcare providers. Positive attitudes are an important component of any program to improve the quality of care rendered. A range of people has an influence on teenagers' access to services and information, including peers and health care providers. Some argue that the most important challenge to care is providers' attitude (International Federation of Gynecology and Obstetrics, 2011).

A study by Holt *et al.,* (2012) documented health care workers' role as gatekeepers to young people accessing sexual and reproductive health services; while they are also blamed for stigmatisation and cruel treatment of teenagers seeking contraceptives. Syed (2014) corroborates this by explaining that teenagers may be sensitive to what they perceive as rude, dismissive or judgmental responses from providers. As a result, providers may fail to discuss the preventive care with sexually active teenagers. The health care practitioner should give information regarding advantages and disadvantages of the different contraceptive methods.

Moreover, information should be given about the effectiveness rate of the different contraception methods (Hockenberry and Wilson, 2007). The reason for some health care providers being reluctant to provide contraceptives is that they think it would encourage teenage sexuality. However, it is not always the case and it is not yet proven. Women's selection of a new contraceptive method is influenced by whether providers recommend specific methods (Harper, Brown, Foster- Rosales & Raine, 2010; Bitzer, Cupanik and Fait, 2013). In a study conducted by Forrest (2009), participants emphasised a need to revise teenage sexual and reproductive health services to make it more youth-friendly in order to avoid stigma generated by community healthcare workers.

A study conducted in Ethiopia, revealed that some health workers were setting up strict rules and regulations against teenage sexuality (Tilahun, Mengistie, Egata and Reda 2010). The decisions by health care provider not providing contraceptives to unmarried teenagers is that it is in conflict with their moral beliefs. Meaning that health care providers put ahead their personal beliefs of the health needs of patients they are meant to serve (Planned Parenthood, 2006).

In this regard, this may reveal that staff may not have the counselling skills and training necessary for dealing with teenagers (Oxfam, 2007). Godia (2010) also states that providers' approach has been identified as a major obstacle as it discourages teenagers from seeking health care services. Han and Bennish (2009) further highlighted that free condoms is delayed by the judgemental treatment teenagers receive from healthcare providers, particularly with some of the clinics that are closed after school hours. Some health care providers' unwillingness to assist young women is based on social norms against teenage sexuality. They view teenage who engage in sexual activities as being immoral. The social norms surrounding teenage sexuality prevent access to sexual health services, which is not aligned with Section 27 of the Constitution of the Republic of South Africa, Act No. 108 of 1996, which promotes reproductive rights and the right to reproductive health care.

In their study, Tavrow, Malarcher and WHO (2010) supported Han and Bennish (2009) by explaining that in Kenya and Zambia almost half of the providers specified that they were unwilling to provide any contraceptives to teenagers. The stigmatisation of teenagers accessing contraceptives results in young girls not using contraceptives. Nalwadda, Mirembe, Byamugisha and Faxelid (2011) reported that most of the providers had a negative attitude towards the provision of contraceptives for teenagers and were not prepared to give contraceptives; as such, they forced consent requirements. In the case of access to female condoms as a method of contraception, it seems to be very difficult for teenage women who have to discuss with the negative attitudes of nurses at local clinics, while social norms prevent them from carrying condoms (Macleod, 2011).

However, Mkhwanazi (2010) disagrees with the findings of Macleod (2011) by arguing that teenagers do not go to the clinics with an open mind, they are the ones who have negative attitudes towards contraception. Holt *et al.,* (2012) posit that service providers report negative attitudes towards teenagers' sexuality and frustration for teenage women for not practicing abstinence, which affect the delivery of information and services of teenagers. This may imply that teenagers are reluctant and have attitudes towards sexual matters and contraception.

Hence they blame health care providers for not displaying positive attitude when providing contraceptives to them. The providers reported feeling that young women should not be sexually active until marriage. The reason why teenagers are afraid is the nurses' attitudes towards giving teenagers contraceptives. Some nurses reported to be uncomfortable about providing teenagers with contraceptives, as they felt they should not be having sexual intercourse at an early age. They responded to request for contraceptives in a manner that was highly judgmental and unsupportive.

Tavrow (2010) posits that many providers hesitate to provide contraceptives to teenagers, believing that to do so would encourage early sexual activity. Biddlecom *et al.,* (2007) as well as Population Action International (PAI) (2014) report that even where there are no legal restrictions to obtain services; teenagers face unfairness and negative attitudes from providers. Nanda, Rogan and Maharaj (2009) also noted that there is evidence that in South Africa, providers are unwilling to mention emergency contraception to teenagers because they think it will lower girls' use of condoms. Emergency contraception is an oral contraception which is used immediately after sexual intercourse. It is anticipated for emergency situations such as unprotected intercourse, contraception failure or rape (Castle and Coeytaux, 2000). It reduces the chances of unwanted pregnancy by 75% to 89% if taken within 72 hours.

Researchers have recognised that health care providers play a critical role in preventing and promoting access for Sexual and Reproductive Health. Health care providers have recognised the fact that they are not well equiped with more knowledge and skills to provide sexual reproductive to teenagers (Mgandi, Fxelid, Swane, Höjer and Ransjo-Arvidson, 2008; Klingberg-Allvim, Nga, Ransjo-Aridson, Johansson and Scand, 2006). For example, a study by Maharaj and Rogan (2011), reported that it is not lack of knowledge that result in underutilisation of emergency contraception, but rather the attitudes of health providers and their hesitancy to provide it. A by Khalema, Ndinda, Bhembe, Makiwane, Vawda, Mahapa, Zondo and Mgcina (2014) revealed that the nature of the interactions between health workers and clients have been highlighted as one of the key factors that discourage teenagers from seeking contraception or health care advice.

Moreover, Mngadi, *et al.,* (2008) also emphasised that a major reason reported to be responsible for the opposition of service providers to provide contraceptive services to adolescents is the belief that it promotes sexual promiscuity. Provider's often-negative attitude and lack of knowledge also remain significant obstacle to Nicaraguan female teenagers. One study revealed that only 13 percent of pharmacists were willing to supply emergency contraceptives to teenagers without parental consent (Ehrle and Sarker, 2011).

In the case of Long Acting Revisable Contraceptives (LARC), scholars such as Dempsey, Billingsley, Savage and Korte (2012) as well as Haimovich (2009) have stressed the frequent need to teach providers on the relevant methods for their clients, since providers have been identified as one of the main reasons why women do not know about LARC methods. Under such circumstances, the client is likely to stop using the contraceptive.

Teenage women trying to access free contraceptives from clinics choose never to return because of the judgment and scolding of clinic staff. Agampodi, Agampodi and Piyaseeli (2008) reported that teenagers preferred to be treated by young service providers and services which could be delivered during the evening, weekend and not combined with maternal and child health services. Furthermore, these teenagers preferred to be treated by a female doctor who could listen and understand their health problems. For example, some teenagers reported that they refused to go to public clinics because of the attitude of the health care providers.

The study conducted by the Medical Research Council of South Africa (2007) showed that the attitude of nurses at the hospitals and other health centers are a barrier to adolescent contraceptive use in South Africa. These attitudes hinder teenagers from seeking protection and it therefore, contributes to teenage pregnancy. The findings from this study demonstrated that most nurses feel uncomfortable to provide teenagers with contraceptives because of their belief system. For example, they feel that teenagerscshould not be having sex at an early age. Recent studies by Holt *et al.,* (2012: 283-294); Flanagan *et al.,* (2013: 259-262) found that 'all healthcare workers in three public clinics in Soweto needed additional training on modern forms of contraceptives in order to provide comprehensive family planning counseling'.

Tuoane, Madise and Diamond (2004) indicated that in Lesotho young women were discouraged by providers' bias, where they would pay more attention to their friends over the rest of them. Langhaugh, Cowan, Nyamurera and Power (2003) posit that teenagers were labelled whenever they sought reproductive health services at a clinic in Zimbabwe.The labelling of teenagers by health care providers makes them to rely on the information of their peers, which mighty be correct or incorrect

Alli, Maharaj and Vawda (2013) also found that, although the majority of teenagers' respondents to exit interviews from sexual reproductive health services in KwaZulu-Natal reported that they were happy with the service, one third felt they did not get all the information they needed and some felt judged or disrespected by clinic staff. Warenius, Faxelid, Chishimba, Musandu, Ong'any and Nissen (2006) found that nurses criticised teenage sexuality, including masturbation, contraceptive use and abortion, and had judgmental attitude towards handling these problems.

The study conducted in Zambia and Kenya substantiated that teenage people are caught between the norms and values of society, and the reality of life (Warenius, 2008). Health care providers considered premarital sex and contraceptive use as sinful and immoral, but on the other hand struggled with sexual feelings and even participated in sex. The attitude of nurses towards teenage sexuality and access to contraceptive is an important aspect as this may deter teenagers to seek contraception. Hence, the attitude that they display to teenagers may also make teenagers to be embarrassed to seek contraceptives.

Furthermore, teenagers have no confidence that the information shared with the service provider would be kept confidential (Warenius, 2008). Health care providers sometimes have conflicting views between their professional responsibility and religious values, such that they fail to provide services to the teenagers (Botswana, 2008).

Health care provider considered premarital sex and contraceptive use as sinful and immoral. However, on the other hand struggled with sexual feelings and even participated in sex. Furthermore, teenagers have no confidence that the information shared with the service provider would be kept confidential (Warenius, 2008). Health care providers sometimes have conflicting views between their professional responsibility and religious values, such that they fail to provide services to the teenagers (Botswana, 2008).

Such attitudes deprive adolescents of safe sex services and predispose them to unsafe or unprotected sex practices. Service providers were observed to discuss only the use of the condom for contraception and did not mention the other methods. In some cases, they refused to prescribe contraceptives for teenagers (Ziyane & Ehlers 2007). Many teenagers often feel unwelcome citing that they encounter providers who are judgmental, who treat them rudely or who deny them access to services (Erulkar, Onoka and Phiri 2005). Corroborated further, it is reported that providers in normal clinics treat teenagers rudely and deny them services (WHO 2009; UNFPA 2016). A normal clinics may refer to a clinic where health care providers wear uniform every day to render health care services to patients.

The negative attitudes of providers have been identified as a major barrier as it discourages teenagers from seeking or returning for care (Godia, 2010). A study by Warenius *et al.,* (2006) among Kenyan and Zambian midwives revealed that reproductive health services are underutilised due to the judgmental attitude of health providers and lack of competence coupled with lack of knowledge in youth friendly service provision irrespective of training. Tangmunkongvorakul, Ruangyuttikarn, Sombatmai and Bipodhi (2006) explored the perspectives of providers in Northern Thailand concerning difficulties with sexual and reproductive health services for unmarried teenagers. Providers were aware that unmarried teenagers were exposed to risky sexual behaviour, yet faced a range of challenges in obtaining appropriate information and services in user-friendly ways. According to Waddington (2007), many of these health care providers are of the view that teenagers should not be engaging in sexual activities.

Biddlecom *et al.,* (2007) found that most teenagers consider confidentiality and privacy to be their center of attraction to the health care providers. This was revealed by their studies in Burkina Faso, Malawi, Ghana and Uganda. Their findings pointed to the fact that teenagers prefer to obtain sexual reproductive health information from service providers who are willing to secure their privacy without linking them to their parents. Once teenagers have identified an attractive separate youth-friendly center and indicated their confidence and trust in the system, they will increase their utilisation and access to relevant information and services.

Hobcraft and Baker (2006) illustrated that health care providers have an arrogant view of teenage clients, assuming to know whatever care and treatment is suitable for them. Furthermore, the country surveys conducted by Godia *et al.,* (2014) revealed that health care providers possess mixed feelings based on cultural and religious values in relation to their professional work. Besides some of the health care providers intentionally deny delivering reproductive health services to teenagers, especially condoms with an attitude that they are not potential clients for such services. The above authors concluded that teenagers seeking reproductive health services might be unreasonably subjected to discriminatory behaviours from health professionals due to age preference and gender.

The study of Richter and Mlambo (2005) revealed that health care providers also contribute to non-utilisation of health care services by the youth, as they were reported to be negative towards youth requesting specific contraceptives. Clients then had to settle for any contraceptive method offered which in turn affected compliance rate. In some instances, teenagers were denied services. Teenagers reported that nurses were rude, short-tempered and arrogant towards them when they tried to obtain contraceptives from state clinics (Maja, 2007).

The findings contrast with those of Goncalves, *et al.* (2011), who indicate that access to contraceptives through the primary health care network is effective as compared to that provided by most pharmacists who will sell the pill without a prescription, which leads to young women using combination oral contraceptives. Ratlabala, Makofane, and Jali (2007) further state that teenagers expressed strong views about the harsh treatment they received from some of the health providers and that this resulted in poor use of the services aimed at preventing teenage pregnancy. These attitudes make teenage girls to be scared of the reproductive health services. Such attitudes also expose them to risk poor decision making in preventing unplanned pregnancies (Maja, 2007; Mudhovozi, Ramarumo and Sodi, 2012).

2.3. The National contraception and fertility planning policy and service delivery guidelines 2012

The National Contraception Policy and fertility planning policy and service delivery guidelines is an important document aimed at reprioritising contraception in South Africa (National contraception and fertility planning policy and service delivery guidelines, 2012) .Contraception is one of the most powerful public health tools for any country. Therefore, providing women with access to safe and effective contraception is a critical element of women's health.

The policy precisely seeks to address the problems faced by teenagers in accessing contraception and protect their reproductive health. However, acknowledging that abstinence is the ideal, the policy recognises that the majority of teenagers sexually active and that pregnancy and HIV can have serious consequences for their lives and futures. Moreover, the policy advocates the provision of adolescent- friendly contraceptive services that are structured in ways that alleviate the barrier to contraceptive access.

From my view, it is clear that by trying to address the demand for sexual and reproductive health care by female teenagers and by trying to incorporating the right to access contraceptives, the South Africa has made a genuine effort to improve the sexual and reproductive health of teenagers.

2.4. Teenagers' challenges on the use of contraceptives.

Various factors can unpleasantly affect the use of contraceptives. Using contraceptives is neither a simple nor a straightforward process, it is complicated and accompanied by many challenges that hamper its effectiveness and sustained usage. This notion is aligned with the literature that states that it is uncommon for contraceptives to be without challenges (Speizer, Hothchkiss and Mgani, 2000). The fear of side effects and the experience of side effects on using contraceptives methods are the most common reasons for non-use or discontinuation of contraceptive (UNFPA, 2013). The experience of side effects may be one of the major challenges in using contraceptives among teenagers.

The perceptions about contraceptive use are influenced by information that teenagers receive from the family, school and the media (Glanz and Kegler, 2002). However, a lot of information about sexuality has been found to be incorrect, unclear and this has a negative impact on sexual behaviour of teenagers (Undie, Crichton and Zulu, 2007). Teenagers rely on the information they receive from anyone regarding contraceptives, which sometimes mislead them from using contraceptives.

2.4.1. Culture

Culture is a means of viewing, acting and knowing oneself in the world; it is a guide that is used to determine someone's ideas, beliefs, practices and values (Andrew and Boyle, 1995).There is a disapproval use of contraceptives among teenagers in rural areas. In some instances, teenagers decide to use contraceptives without the acknowledgement of their parents. Many sexually active teenagers who are afraid from using family planning services (Blidlecom *et al.,* 2007). In this regard, teenagers may regard, they may resist the use of contraceptive in general. The stigma attached to teenage sexuality helpful discussions about sexual related matters among teenagers.

2.4.2. Religion

Religion holds unique importance in people's lives. It is cited as an important factor in Sexual and Reproductive Health. According to Mkangi (2000), many teenagers encounter conflicts between religious values and decision- making surrounding contraception. Religious teaching often view contraceptive use as a sin. Religious teaching often view contraceptive use as a sin. Religion has been detected to play an important role in using contraception. For example, Muslim women have less likelihood of using contraceptive compared to non- Muslim women. Study observed similar patterns. Muslim women are likely to have a lower approval rate for contraceptive (Hussain, 2011).

2.4.3 Lack of knowledge

Study has shown that even when awareness of contraceptive is high, poor knowledge contraceptives methods and their side effects has been associated with poor uptake of contraceptives (Wafula, Obare and Bellows, 2014). Waddington (2007) posits that knowledge and information about sexuality and contraception have been shown to increase contraceptive use particularly among teenagers. Female teenagers appeared to have allowed themselves to be overwhelmed by their perceptions to the point of blaming the nurses for their failure to use contraceptives.

According to Jejeebhoy, Shah and Thapa (2005), inadequate knowledge about contraception and how to obtain health services is one of the reasons why many teenage women in developing countries are very vulnerable. Inadequate knowledge about contraception brings fears, rumours, and myths about family planning methods and can prevent young people from seeking contraception. In contrast, the study conducted by Manena-Netshikweta (2007) amongst secondary school learners in Limpopo Province found that permissive attitudes prevailed towards sex, characterised by casual sexual activities beginning at an early age. This study further found out that few of the female learners knew about contraceptives and the different types of modern contraceptives. In addition, about half of the female learners received contraceptive information from their friends while others received the information from their parents.

Teenagers often do not have adequate information and access to contraceptive methods because of the fear of being humiliated by health care providers. Instead, they try to avoid the use of contraceptives (Eaton, Kann, Kinchen, Ross, Hawkins, Harris, Lowry, McManus, Chyen, Shanklin, Lim, Grunbaum, & Wechsler, 2006). The knowledge on how contraceptives works within the body; the advantages and disadvantage of using each method of contraception. All this should be disseminated in the counselling room or in peer education programs if the community has one.

Poor knowledge about contraception is regularly mentioned as a motive for ineffective use of contraceptives use (Arai, 2003; Bankole, Ahmed, Neema, Ouerdraogo & Konyani 2007; both cited in Panday, Makiwane, Ranchod & Letsoalo 2009). Panday *et al.,* (2009) have shown that many teenagers are well informed about modern methods of contraceptives. Flishera and Aarob (2002) studied the South African literature on the factors that promote sexual risk behaviour. Their findings indicated that lack of knowledge accounted for some of the teenage behaviour. However, proper education and counselling before and at the time of selecting a method of contraception can help these teenagers to address their challenges and make informed choices and voluntary decisions (WHO, 2010). In a study by Harper, Brown, Foster- Rosales and Raine (2010) of the choice of contraceptive method, women reported that provider counselling and their own contraceptive knowledge after the visit was associated with the hormonal method initiated. The same study concluded that more extensive counselling and patient education is important for integration of new hormonal methods.

The main reason for not using contraceptives was that teenagers did not have adequate knowledge about contraceptives and even if they did, they did not know where to access them (Paelete and Saskaio, 2007). As for Waddington (2007), knowledge and information about sexuality and contraception has been shown to increase contraceptive use, particularly among teenagers. Lack of knowledge and negative attitudes towards contraceptive use were some of the motives of contraceptive use failure by teenagers (Mbambo, Ehlers and Monareng, 2009).

A large number of teenagers embrace incorrect information about the use of contraceptives and condoms. Even when teenagers are able to start using contraceptives, lack of comprehensive understanding contributes to high failure and discontinuation rates, hindering teenagers from effectively controlling their bodies and reproduction.

A study by Willian (2013) found that most teenagers had basic knowledge about contraceptives and protection from unplanned pregnancies. However many reported insufficient and incorrect usage as well as limited knowledge on fertility and conception. The implication in this regard is that teenagers' success in avoiding pregnancy depends on having easy access to contraceptives services. The research findings of Ankomah, Anyanti, Adebayo and Giwa (2013); Amoran, (2012); Adedemeji *et al.*, (2007) highlighted that poor knowledge and misinformation about modern contraception contribute to the rate of use and demand. Poor knowledge might be the major reason for not accessing contraceptives by teenagers and this result in unwanted pregnancy.

2.4.4. The experience of side effects

According to Langille (2007), discussions about sexual health issues are rarely initiated by teenage people for whom the process of seeking sexual health advice is a complicated one and who hence may not want to use the services. Teenagers continue to face challenges in accessing reproductive health services (Kamau, 2006). Lack of access to information makes it difficult for teenagers to make informed health choices in their lives. In line with the view of Kamau, (2006) some female teenagers might perceive contraceptives to be inappropriate or even harmful. These opinions could result in unplanned pregnancies.

Etuk, Ikpeme, Kalu, Mkpanam and Oyo-Ita (2004) as well as Mayekiso and Twaise (1992) found that teenagers' contraceptive use was inconsistent and hindered especially before the first sexual intercourse. Other studies have established the fear of side effects to be the major reason for non-use of modern family planning methods (Campbell, Hodoglugil and Potts, 2006; Sedgh and Bankole, 2006). The limited use of condoms by younger people is a function of their perceptions regarding this type of contraceptive

Teenagers experience higher rates of contraceptive discontinuation and contraceptive failure than older women due to insufficient information about side effects, lack of method choice and inappropriate guidelines regarding their use (Blanc, Tsui, Croft and Trevitt, 2009). Other studies reported that teenagers have inaccurate knowledge on the use of contraceptives (Abiodum and Balogun, 2008; Bankole *et al.,* 2007). At the clinic teenagers are offered little choice of contraceptive method and given poor explanations on the side effects and mechanism of action, which contributes to a low uptake of contraception, despite it being free (Wood and Jewkes, 2006).

The effects of contraceptive method on menstruation is also another influential factor that can influence the choice of contraceptive method (Imbuiki, Todd, Stibich, Schaffer and Sinei, 2010). Some women stopped using contraceptives after they experiences what they perceive as side effects of contraceptives (Kabagenyi, Jennings, Reid, Nalwadda, Ntozi and Atuyambe, 2014). From some users when they experience side effects and get they switch from one method to another method, this may also be of the inadequate counselling they receive while accessing contraceptives.

There is an agreement in literature that teenagers are particularly vulnerable to sexual and reproductive health risks due to factors such as their young age, ignorance of matters related to sexuality and reproductive health, lack of factual knowledge about contraception and their unwillingness to use most family planning and health services (Mago, Ganesh, and Mukhopdhyay 2005). When experiencing side effects, many teenagers discontinue the use of contraceptives without seeking advice from nurses or care providers. Clients are advised to talk to their doctors or nurses if they experience heavy or prolonged bleeding (Depo-Provera Information, 2010). Discontinuing all protection during sexual interaction may lead to an unplanned pregnancy (Maja & Ehlers, 2004).

Onyensoh, Govender and Tumbo, (2013); Ramathuba, Khoza and Netshikweta, (2012) also postulate that perceptions such as fears of weight gain due to hormonal contraceptive use and the size of the female condoms had a negative influence on the use of contraceptives amongst teenagers.

In the research findings of (Kirby 2007; Manena-Netshikweta 2007), participants indicated that using contraceptive would cause infertility, make users fat and decreased pleasure in sex often result in the non-use of contraceptives. Misconceptions, fear of side effects and stigma associated with the use of contraceptives as teenagers may be labelled as being promiscuous can be considered as contributing factors for non-contraceptive use (Chonzi, 2000; Paz Soldan, 2000). The fear of side effects and lack of understanding of the full range of contraceptive methods, can also prevent girls from desiring to access contraception (Otoide, Oronsaye and Okonofua, 2001; Williamson, Parkes, Wright, Petticrew and Hart, 2009; The Children's Investment Fund Foundation, 2013).

Specific disadvantages with a given contraceptive can lead to discontinuation of its use if the teenagers are not given adequate information (East, Jackson, O'Brien & Peters, 2007). These perceptions are comparable to those that emerged from studies on factors influencing non-utilisation of contraceptives in rural communities in South Africa (Onyensoh *et al.*, 2013; Ramathuba *et al.* 2012). Therefore, there is a need for teenagers to be provided with adequate information about contraceptives in terms of the advantages, disadvantages and side effects and how to manage the side effects.

Waddington (2007) also emphasised that participants indicated that they did not use the contraceptive pill because of the fear of side-effects. Waddington's (2007) finding is similar to the study findings by Akers, Schwarz, Borrero and Corbie-Smith (2010) which confirmed this as female teenager and their families reported to be very concerned about the protection of menstrual irregularities related with many hormonal contraceptive methods. This concern often results in negative attitude and discontinuation of contraceptive use.

2.4.5. Parents and Partner influence

Some parents are unwilling to discuss contraception with the fear that approving contraception may encourage teenagers to engage in sexual intercourse. Contrary to believes and perceptions, providing adolescents with information about contraception does not result in increased rates of sexual activity, earlier age of first intercourse or a greater number of partners (Jaccard, 2000). Majority of parents or guardians would object to contraceptive use by unmarried teenagers and have negative views of the unmarried teenagers using contraceptives, as a result, parents themselves lack confidence to discuss sexuality issues with young people (Kinaro, 2012). Corroborated further, Glinski, Sexton and Petroni (2014) posit that teachers and parents may be unwilling to discuss sexual matters with teenagers, believing that doing so will encourage them to become sexually active. Casterline, Sathar and Haque (2001) also showed that non-use of contraceptives is determined by inexperience and poor communication among partners. Teenage women are not able to negotiate condom use as they may have perceived as being immoral. In some cases, male partners are unwilling to use condom because it is perceived in reducing sexual pleasure (UNDP/ UNFPA/ WHO/ World Bank, 2002; Imbuiki *et al.,* 2010).

Partners prevent teenage women from using or accessing modern contraceptives (Ankomah *et al.,* 2013; Amoran, 2012; Adedemeji, 2007). Most of the youth choose hormonal methods because their partners would not know that they are using any family planning method to prevent unplanned pregnancies. However, Panday *et al.,* (2009) showed that many teenagers are well informed about modern methods of contraceptives. Some teenagers encounter challenges in negotiating condom use and resort to injectable methods of contraception as access to other options remains limited (Smith and Harrison, 2013; WhipKey, East and Coffey, 2014). Culturally, male partners are dominated as decision makers in sexual relationships. These limit female partners to negotiate the use of contraceptives. For example, in the case of condom use, culture influences the decision of male partners not using condom or any other contraceptive method.

2.5. The accessibility of the clinic that provides contraceptives

According to The Constitution of the Republic of South Africa, Act 108 of 1996, Section 27, 1 (a) the South African government has an obligation to ensure that all health facilities are easily accessible to the people. Accessibility in this study context means the degree to which services or the environment is available to as many people as possible. Access to services can be influenced by factors such as, money, lack of knowledge about available services, infrastructure, equipment and distance to users of such services. Similar to this, the clinic environment is pivotal to patient counselling.

According to Fox, Philliber, McManus and Yurkiewicz (2010) uncomfortable health care services that may lead to a negative experience could be considered as a challenge of seeking health care services. The experience of uncomfortable health care services does not apply to teenagers only; however, it also applies to adults. The problem of accessibility have been documented in public health facilities especially in rural areas.

Teenagers feel embarrassed when going to the public health facilities for information or services pertaining to sex and contraception (Awusabo-Asare, Bankole and Kumi-Kyereme, 2008), because they think that they will be met with an unwelcoming attitude at the facility. (International Planned Parenthood Fedaration, 2008) postulated that element such as adolescent friendly policies, friendly health service providers and support staff, friendly service delivery mechanisms such as convenient opening hours, privacy and comprehensiveness of services have been cited as essential.

In Uganda, underdeveloped logistical systems leading to frequent contraceptive shortages were reported; as shortage of skilled staff, and other health and social concerns competing for the limited resources available (Mukasa, 2009). From Cameroon, Dogmo (2010) reveals that public health facilities devoted to teenagers are limited in scale. Maja (2007)'s findings revealed that inaccessibility of contraceptive services was also reported in terms of inadequate resources where neighbouring health facilities did not have condoms for clients, particularly for teenagers.

Substantiated further Belohlav and Karra (2013) also found that in India, poor access to contraceptives was due to frequent shortages of stocks in clinics, long waiting times for service appointments or counselling, high costs of contraceptives and limited choice of contraceptive methods. The findings of Belohlav and Karra are similar to those of Malini and Narayanan (2014) who found that even when women are aware of the availability of contraceptives, they are not properly informed about various forms of contraceptives and how they work within the body. It is not always the case that teenagers are not informed about various methods of contraception; health care providers cannot inform clients on methods that are not available.

Regmi *et al.,* (2010) content that many clinics find it difficult to keep contraceptive supplies in stock, which make it difficult for young people to get them. Health facilities are dominated by limited contraceptive method, the pill, injection and condoms are the common method one can find in public clinics. The inference in this notion is that some contraceptive methods are not recommended for teenagers.

This is supported by Flanagan *et al.,* (2013) by saying that even when girls do go to clinics, they are fortunate enough to find friendly health care workers and they are often still faced with limited contraceptive options (the injection being most common) and poor counselling. Godia, Olenja, Lavussa Quinney, Hofman and Broek, (2013) emphasised that sexual health for teenagers is based on recognising their sexual rights, sexuality education and counselling and high quality confidential services. According to the UNFPA Cameroon (2012) Report on reproductive health, access to reproductive health care services has always been a concern in Cameroon, given that only some parts of Cameroon's population have access to them. Godia *et al.,* (2013) explained that contraceptive services need to be "youth-friendly" in order to encourage teenagers to seek reproductive health care. Teenagers need youth friendly services to access contraceptives easily and open up for discussions openly.

2.5.1. Lack of Confidentiality

The major reason for teenagers not going to health facilities is the fear about lack of confidentiality and the fear of being recognised in clinic waiting rooms with possible stigma (Kambikambi, 2014). Research conducted by Agampodi *et al.,* (2008) also revealed that lack of confidentiality, youth friendliness and accessibility of available services could be main challenge in accessing contraceptives. Crede, Harries, Constatnt, Hatzell Hoke, Green and Moodley (2010) state that when counselling is done with a patient, it must take place in an environment that is comfortable in a way that it will ensure that a patient can make informed choices in a comfortable environment.

Kamau (2006) found that institutional and structural barriers such as lack of counselling rooms make it difficult to maintain privacy. Therefore, teenagers in many developing countries are unwilling to visit facilities providing contraception because they view them as unfriendly. Cooper, Harries, Myer, Orner and Bracken (2007) support the notion of Kamau by saying that they blame the counselling environment at the health care facilities for not being conducive to open discussions on contraceptives issues, resulting in the low uptake of contraception.

In several studies, confidentiality has been found to be a contributing factor linked with utilisation of sexual reproductive health services among teenagers (Regmi *et al.* 2008; Agampodi *et al.,* 2008 and Swann, Bowe and McCormick, 2003). Research conducted by Agampodi *et al.,* (2008) also revealed that lack of confidentiality, youth friendliness and accessibility of available services could be main challenge in accessing contraceptives. In line with the view of Agampodi *et al.,* (2008), Bankole and Malarcher (2010) postulate that teenagers' need for privacy may be so strong that they are willing to utilise higher costs services or travel long distances to access services at private facilities; this may underline that teenagers tend to avoid public clinics.

The study conducted by Regmi, Van Teijlingen, Simkhada and Acharya (2010) in Nepal revealed that majority of respondents believed that health providers do not keep information confidential, the same study also found that teenagers are not happy with reproductive health services they get. The findings in that study also revealed that most of the rural health facilities were not providing youth friendly services to teenagers. Furthermore, Bearinger, Sieving, Ferguson and Sharma (2007) highlight that all teenagers need to access quality youth friendly services provided by clinicians trained to work with this young people.

Population Action International (2014) reported that teenage people may be deterred from seeking the services they need if they feel they will be ill-treated or judged, or if they are concerned that their privacy will not be sustained. A trained health care provider to work with teenagers is crucial in disseminating information about contraception and sexuality and that teenagers might be able to pay attention, open up for discussions openly.

The National Contraception Policy Guidelines (2012) reported that only around one third of clinics provided contraceptive options to people seeking contraceptives. Thomas, Murray and Rogstad (2006) assert that the belief in confidentiality is important for clients to visit and revisit the health facility. While the structure of health facilities confronts privacy and confidentiality during consultation and prevent teenagers from accessing contraceptive services and information. It is important that health care providers should ensure private and confidential environments to prevent embarrassment when teenager access contraceptive information and services (Wong, 2012).

Clinics are often being designed for adult clients, and service providers are not trained in teenage sexuality and youth-friendly concepts. As a result, young people are neither well received nor comfortable in mainstream family planning clinics (MIET Literature Review, 2011). The lack of confidentiality among health care workers contradict with the health professions ethical practices. The practice of health care professional is based on a relationship of a mutual trust between patients and health care practitioners. When confidentiality is not maintained between health care provider and patient, it therefore contradicts in how health care providers should engage with patients (Health Professions Council of South Africa).

2.5.2. Clinic operating hours

Biddlecom (2007) articulated that inconvenient location and hours of operation of facilities inhibit young people from obtaining sexual and reproductive health services. For example, teenagers may find the clinics' opening hours inconvenient, want separate hours just for teens, or prefer walk-in appointments**.** The findings of Ali, Maharaj and Vawda (2012) findings in a study in Kwazulu- Natal, South Africa, highlighted the effect of inconvenient clinic hours on access to contraceptives services among teenagers. This may highlight that clinic timings are critical for teenagers.

Additionally, a study by Khalaf, Fathieh and Froelicher (2009) indicated that most of the teenagers desired to have a big health facility which could be specific for the teenagers, attractive and accessible even during certain hours Some teenagers have found service operating hours to be restrictive or not suitable (Donelly, 2000; Grifftihs and Gerressu, 2008; Evans and Cross, 2007). In their study Nalwadda *et al., (*2011) also highlighted that waiting times at clinics are often long, which many teenagers report as difficult for them to access health services. This makes contraceptive services to be inaccessible to women as they leave very late in the day when the clinics have closed (Zungu and Manyisa, 2009).

Teenagers find it difficult to access services, as some of them are still schooling. When they go to seek services they find clinics closed. This also hinder their access to contraceptives. Apart from opening and closing times, teenagers are also unhappy about spending long hours waiting for consultation at the clinic (Mayeye, Lewis, Oguntibeju, 2010; Godia, Olenja, Hofman and van den Broek, 2014; Onokerhoraye and Dudu, 2017).

The researcher's view in this matter is that long waiting times might result in dissatisfaction with services provided and can make teenagers unwilling to visit health care facilities for contraceptives.

2.5.3. Distance

The distance to health facilities was identified as a barrier to service utilization. Other studies have shown that longer distance to facilities undermines service utilisation (Baral, Khatri, Schildbach, Schmitz, Silwa and Van Teijilingen, 2013). Lack of confidentiality is another major reason that makes young people reluctant to seek sexual and reproductive health services (Braeken, Otoo-oyortey and Serour, 2007.

Han and Bennish (2009) agree that access to condoms is limited for South African teenagers. Barriers to access include substantial travel time and the cost of travel to sites of condom distribution; the fact that government clinics distributing free condoms are usually closed when learners are out of school; the judgmental and often hostile attitude of providers; and the cost of condoms in shops. Moreover, Michael Bennish, who runs the Mpilonhle programme in rural Kwa-Zulu Natal Province in South Africa, contends that there are serious gaps in access to condoms, especially among rural youth. He states that shops and clinics are rare and that it is expensive and unlikely that learners would go to a clinic just to access condoms (Plus News 2009).

Despite progressive reproductive health policies, young women in South Africa often lack access to contraception and termination of pregnancy services, as well as to HIV protection (MacPhail, Pettifor, Pascoe and Rees, 2007). A welcoming environment can be created by making working hours convenient to teenagers providing appropriate information and educational material, offering privacy and avoiding stigma. Creating a welcoming environment in the reception and waiting area is also very important to reassure teenagers that the services are 'for them' (Department of Health 2009). Teenagers may prefer to buy some contraceptives from shops, rather than going to public health facilities in a way of avoiding stigma. This is supported by Bankole and Malarcher (2010) who indicated that teenagers may utilise higher costs services or travel long distances to access services at private facilities. This may underline that teenagers tend to avoid public clinics.

2.6. The role of Peer influence in accessing contraceptives

Peer influence is the influence exerted by a peer exerted by a peer group in encouraging a person to change his or her own attitude, values, or behaviour in order to conform to the group norms (Stuart (2001). This can be positive or negative influence. Wickert (2002) in agreement, defines peer influence as the influence of a social group on an individual; it can also be positive and negative. Panday *et al.,* (2009) substantiated that in their need of information, teenagers go to their peers for guidance to satisfy their interest. In relation to this, it is not only parents and elders who have difficulties to talk about sex with their teenagers but also the other way around, for this reason teenagers turn to their peers for advice instead.

Macleod and Tracey (2010) shown that peer communication is both a source of positive information and a way of confusing and spreading silence around sex. Peers have a great potential to influence one's behaviuor as they often use most of the time linking to each other. In the case of contraceptives friends influence, each other whether or not to seek and use them.

The findings of Bezuidenhout and Joubert (2008) revealed that when peers are strongly close to each other, they tend to spend long time together; exchange different patterns of behaviour. This reveals that some of these peer relationships play a key role in the social development of teenagers. Han and Bennish (2009) added that teenagers associate with one another and influence one another through the development of group rules. This is supported by the research findings from Hammer and Banegas (2010) which are similar to those of Nwanko and Nwoke (2009) which indicate that the peer groups influence teenagers' behaviour. The findings of Baloyi (2006) also confirm that many teenagers get information related to sexual and reproductive health from one another, and some of this information is often incorrect. Incorrect information may influence risky sexual behaviour among teenagers.

Reddy, James, Sewpaul, Koopman, Funani, Sifunda, Josie, Masuka, Kambaran and Omardien (2010) emphasised that people do not only change on account of new information, however they change when others around them change. Many teenage people approach adulthood with conflicting, inaccurate information and messages about sexuality. In most cases, they have inaccurate information about sexuality, reproduction and contraception ((PreslerMarshall and Jones 2012). The information, in turn could be positive or negative. For example, having friends or peers who practice unprotected sexual intercourse can strongly influence one's own behaviour to practice the same behaviour practices by friends. As a result, this may come in a form of negative peer pressure, which may influence one to fit-in with their peers by conforming to their influences.

2.6.1. Access and use of contraceptive by peers

Adams and D'Souza (2009) argue that peers are deeply influenced by negative and inaccurate stories about method of contraception over concern about side effects. For example, weight gain and bad skin. Studies conducted in South Africa, Zimbabwe and Tanzania indicates that most teenagers depend on their friends as the main source of information regarding to the use of contraceptive (Dehne and Riedner, 2005). The peer group pressure affects teenagers because when they find out that their friends are not using contraceptives, they would also not use them too because they want to fit in the group.

A study conducted among teenagers in Nigeria revealed that there are myths that contraception causes infertility, which encouraged teenagers to seek abortion rather than contraceptive services (Stuart, 2009). The myths that are heard from peers and partners, whose influence on contraceptive demand and uptake obtained is well documented in Kenya (Wafula, Obare and Bellow, 2014; USAID Wambui, Eka and Alehagen, 2009). Teenagers without knowledge of contraceptive use usually rely on the experience of their peers, implying that peers influence reproductive behaviour of many teenagers. This is because peers provide teenagers with models, support and identity (Ochieng, Kakai and Abok, 2011).

During adolescence, teenagers often feel the pressure to make friends and fit in with their peers. Stevens and Cloete (2009) suggest that functions that are fulfilled by peer influence provide friendship; facilitate knowledge and information about the sex activities and weakening of the emotional bond between child and parents so as to conform to peer group influence. On the other hand, Yee and Simon (2010) found that the opinions of friends, mothers and sisters were considered more valuable or more “true” than the recommendations of clinicians.

On the other hand, Yee and Simon (2010) found that the opinions of friends, mothers and sisters were considered more valuable or more “true” than the recommendations of clinicians. Nzouankeu (2010) postulated that young women often think of contraception either as 'the pill' or condoms and have little knowledge about other methods. This is due to being heavily influenced by negative, second-hand stories about methods of contraception from their friends and the media.

Kruger (2011) explains that there is a great deal of disinformation about reproductive anatomy and physiology in relation to the use of contraceptives. The result is that contraceptives, when they are available, are not used correctly. Morake (2011) revealed that teenagers appear to be ignorant about issues such as puberty, pregnancy and contraception. Ignorance motivated by cultural taboos to discuss sex with one’s parents, combined with perceived peer group pressure to engage in sexual activities, cause unnecessary heartache for many teenage women. Sharry (2004) contends that the teenagers’ value judgments are often influenced by fear of rejection by the group.

Advocate for Youth (2007) highlighted that some of the obstacles to use contraceptives among teenagers in the United States are peer pressure from partners and friends. In that way, teenagers are marked by significant psychosocial transformation and recognition in their social life, spending more time with peers and socialising with a larger, more varied cohort with strong desires to be acceptable to both their close friends and larger groups (Mason, Tanner, Piacentini, Freeman, Anastasia and Batat, 2013).

A study conducted by the Human Research Council (HSRC) in 2008 concerning sexuality and reproductive issues found that parents are reluctant to discuss these issues with their children (Panday *et al.,* 2009). The study focused on children of the age group 12-17 years and the respondents indicated that they obtain most of their information about sexuality and reproduction from their friends at school. It was, however, established that friends have the correct or complete information about these issues. Some teenagers are well informed with correct information about contraception by their parents, nurses and peers.

Ahman and Shah (2004) point out that lack of sexuality education from parents makes peers and the mass media the usual sex educators for teenagers, resulting in teenagers being misinformed. This was supported by Okonufia (2005), who indicated that lack of communication between young people and their parents as a cause of concern, as it leads to teenagers having inaccurate information regarding sexuality, contraceptives and pregnancy. Peer influence have an effect on teenager's decision to use contraceptives.

Some matters that could not be discussed with teenagers' parents might be freely discussed with peer group members, for example, personal problems, sexuality issues, contraceptives, drugs and alcohol. However, sexual information that peers provide might be incorrect or inadequate. Thus, incorrect information received about sex from peers might contribute to unwanted pregnancies (Bezuidenhout 2013). It is not always the case that peers provide one another with incorrect information, sometimes they share important aspects related to sexuality and encourage one another on positive behaviuors. Peer pressure is also widely assumed to be a significant causative factor in the initiation of habits, such as smoking, drug use and sexual involvement among teenagers. Steinberg and Monahan (2007) indicated that peers influence teenagers' decisions and behaviours. The impact of peer pressure increases during periods of uncertainty and can be either positive or negative with unknown consequences (Vladas, Robert and Noah, 2008).

2.7. The Department of Health and Basic Education stance on contraceptive distribution in schools

The provision of contraceptives to learners in schools is still a controversial issue among the educators and health department. Some educational officials perceive that the provision of these contraceptives will promote sexuality among teenagers. The Department of Basic Education and Department of Health collaborated in the adoption of the Integrated school health policy (ISHP, 2012). The aim of (ISHP) is to reinstate health care programmes in public schools and to ensure that schools become inclusive of learning, care and support that assist in the protection and realisation of the educational rights of all children. The (ISHP) also address the immediate health problems of learners as well as interventions, which will assist in the promotion of their health and well-being.

The campaigns of safe sex has been taking place in several schools of South Africa. This clearly shows that the Department of health and Education are working together in the promotion of good sexual behavior in schools. Although such policy is, implemented in schools the provision of condoms as method of contraception is still a controversial issue in many schools. Some educational officials perceive that the provision of this contraceptive will promote sexuality among teenagers. Peltzer and Promutassanon (2003) emphasise that the availability of condom in school did not increase the sexual activity of teenagers.

2.8. Summary

From the literature obtained, it is evident that all factors that prevent teenagers from accessing contraceptives have also surfaced such as teenagers' perception on the use of contraceptives, the accessibility of the clinic that provides contraceptives, the health care providers' attitude towards the provision of contraceptives and the role of peer pressure in accessing contraceptives. The findings revealed that discontinuing all protections during sexual interaction might lead to an unplanned pregnancy (Maja and Ehlers, 2004).

Onyensoh, Govender and Tumbo, (2013); Ramathuba, Khoza and Netshikweta, (2012) postulate that perceptions such as fears of weight gain due to hormonal contraceptive use and the size of the female condoms had a negative influence on the use of contraceptives amongst teenagers. The findings from the literature revealed that the perception is one of the factor that influence the use of contraceptives among teenagers. Mbambo, Ehlers and Monareng (2006) also reported that the lack of knowledge about contraceptives and negative attitudes towards the use of contraceptives were some of the reasons for failure to use contraceptives by teenagers.

Lack of knowledge was identified as a major challenge on contraceptive use. On the factor of health care providers, it was found that provider have negative attitudes towards teenagers seeking emergency contraceptives and they are often bias when discussing the type of contraceptive method given to clients. It seems to be very difficult for young women who have to discuss with the negative attitudes of nurses at local clinics, while social norms prevent them from carrying condoms (Macleod, 2011). Mkhwanazi (2010) disagree with the findings of Macleod (2011) by saying that teenagers do not go the clinics with an open mind, they are the ones who have negative attitudes towards contraception. This notion reveal that the attitude of health care providers is less significant in access of contraceptives, teenagers are the ones who do not go to the clinic with open mind to discuss reproductive health with their health care providers. Teenagers should display positive attitude while visiting the clinic for contraceptives. Findings from Panday *et al.,* (2009) concluded that in their need of information, teenagers go to their peers for guidance to satisfy their interest. It was observed that friends influence each other in the use of contraceptives and discuss some of the correct and incorrect side effects about contraceptive, thus peer influence may expose positive and negative impacts. Clinic environment was more significantly in accessing contraceptives because most of the teenagers seeking contraceptives at public facilities.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

This chapter focuses on the methods which were employed in the study. It provides a description of methodology; research design, study site, population, sampling, data collection tools and method of data analysis. Ethical considerations and significance of the study is also described in this chapter.

3.2. Study site

Byldrift clinic is a government public organisation. It is a primary health care facility providing HIV and AIDS and TB related treatments, care and support services. The clinic also have home based care services and also offer treatment for opportunistic infections and maternity services. The Byldrift clinic provide services for children, teenagers and adults. Malatane Village was founded by Seloane. Seloane is the first son of king Matlebjane II of Batau (Census, 2011). The population of Malatane was estimated to 1690 in 2011 (Census, 2011).

3.3. Methodology

The study adopted a qualitative method. Qualitative research is often defined as a naturalistic, interpretative approach, concerned with exploring phenomena from the interior (Flick, 2009) and taking the perspectives and accounts of research participants as a starting point. The method allowed the researcher to get close to the data and provide opportunities to derive their concepts from the data gathered. Qualitative research methods are often used to gain better understanding of social phenomena.

A qualitative approach is a multi-perspective approach that seeks to understand participants in their natural setting by interpreting a social phenomenon in terms of the meanings participants attach to it (Denzin and Lincoln, 2011). In other words, the key goal in qualitative research may be to gain in-depth understanding of people's actions and expression of words. Babbie (2013) refers qualitative research as a paradigm that pursues to gather full in-depth data from participants. A qualitative methodology is based on the certainty that knowledge of human beings is subjective as it is socially constructed (Chilisa and Kawulich, 2012).

Creswell (2009) emphasises that qualitative studies permit the researcher to develop a complex picture of the problem. The qualitative methodology was applicable to the study because the study aimed to explore the challenges faced by female teenagers in accessing contraceptives, which pursues in- depth information from the research participants. Furthermore, qualitative methodology was suitable to gain deeper as there are no documented studies conducted in the area about challenges to contraceptives access.

3.4. Research design

Research design is the structural framework or blueprint of the study (Burns and Groove, 1997). The research design of this study was a case study. Case study research through reports of past studies, allows the investigation and understanding of complex issues. There are several types of case studies. Yin (1994) notes three types of case studies namely; exploratory, descriptive and explanatory case studies.

This study utilised the exploratory case study design. Exploratory case study design is used where little is known about the research problem (Neuman, 2011). The chosen design assisted the researcher in gaining more knowledge and understanding of challenges to contraceptive access by teenagers.

Burns and Groove (2005) further supported the articulation by indicating that exploratory research is conducted for development of new ideas and knowledge of a phenomenon. In using this design, the researcher intends to provide an in-depth understanding of the perspective and experiences of the participants (Babbie, 2010; Hennink, Hutter and Bailey, 2011). The research knows little about the challenges facing female tenagers in accessing contraceptives, therefore, the researcher found the exploratory research design to be suitable for the study.

3.5. Population and Sample

A population is defined as an entire group of elements or objects that meet the study criteria (Denzin and Lincoln, 2005). The population of this study consisted of female teenagers accessing contraceptives at Byldrift Clinic.

3.6. Sampling and sample size

In non- probability purposive sampling suitable participants are selected according to preselected criteria relevant to a particular research topic (Mack, Woodsong, MackQueen, Guest and Namey, 2005; Laher and Botha, 2012). Purposive sampling was used to select units of analysis. Purposive sampling is used when the units are selected according to the researcher's own knowledge and opinion about which the researcher thinks would be appropriate to the topic area (Rubin and Babbie, 2013). This simply implies that researchers purposefully choose the participants who in their view are relevant to the study. The researcher chooses the technique in order to have relevant participants with specific characteristics that are relevant to the study. Anney (2014) further contend that purposive sampling is a technique used in naturalistic inquiry studies. The sample consisted of (10) female teenagers who access contraceptives at Byldrift Clinic.

Qualitative research typically require a small sample size**.** There are no specific rules when determining an appropriate sample size in qualitative research, however they may determine by the time allocated, resources and the study objectives. Participants were purposively selected. Criteria for selection of participants included the following:

Participant must be a female;

Participants must be a teenager;

Parents must have consented in writing for their daughters to take part in the study.

3.7. Data collection

Data was collected through an interview guide which was developed in English and translated into Sepedi. This enhanced quality issues as it allowed the interview to be easy and understandable to the participants. The Semi- structured face to face interviews were conducted with female teenagers in their homes. The choice of semi-structured interviews offers sufficient flexibility to approach participants differently while exploring emerging issues (Noor, 2008; Rubin and Babbie, 2010). The use of semi- structured interview assisted to gather deeper information from participants and allowed the formation of new ideas during the interviews.

3.8. Data Analysis

In qualitative research, data analysis starts during data collection, and it is a process of examining and interpreting data in order to get meaning and gain understanding (Grove, Burns and Gray, 2013). The interviews were conducted individually and each interview took 30 minutes. The data was analysed manually following Braun and Clarke;s (2006) six phases of conducting thematic analysis. The translations were done after the completion of all interviews with the participants.

The researcher followed Braun and Clarke's (2006) six phases of conducting thematic analysis, which are:

Phase 1: Becoming familiar with the data

The initial phase involved familiarising oneself with the data, by reading and rereading the data in order to become familiar with what the data entail, paying specific attention to patterns that occur and noting down initial ideas (Gibbs, 2007).

Phase 2: Generate initial codes

This is the logical way of organising and gaining meaningful parts of the data called coding and relating it to the study objectives (Terre Blanche, Durrheim and Painter, 2006). This also involves making inferences about what the codes mean.

Phase 3: Searching themes

The researcher collated all the relevant coded data extracts within the identified themes.

Phase 4: Reviewing themes

The researcher checked if the themes make sense and account for all the coded extracts in the entire data. The researcher checked the data to find if something was missing on the data.

Phase 5: Defining and naming themes

The fifth phase involves generating clear definitions and names for each theme, describing aspects of captured data in each theme. The researcher defined the themes that were presented for analysis and analysed data with them.

Phase 6: Producing the report

The final phase involves detailed analysis and producing a written report, after the final themes had been reviewed (Terre Blanche *et al.*, 2006). The researcher provided a brief report of the data. Only responses that were considered important were included and the emerged themes were discussed as major themes.

3.9 Quality criteria

3.9.1. Credibility

Credibility refers to the confidence that can be placed in the truth of the research findings (Holloway and Wheeler, 2002; Macnee and McCabe, 2008). Cope (2014:89) define credibility as the truth of data, in other words it is the participant's views, and the interpretation of these views by the researcher. The implication here is that the researcher must not manipulate the views of the participants and the interpretation must be true to confirm credibility.

Qualitative research data collection requires the researcher's self- to engage him or herself in the participants' world (Bitsch, 2005). Credibility was ensured by extending the time of the interview to improve trust with the participants. The extended time of the interviews was important as participants volunteered to give more sensitive information regarding their challenges in accessing contraceptives. The extended time of the interview helped the researcher to gain an insight into the context of the study.

3.9.2. Corfirmability

Confirmability is "concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination, but are clearly derived from the data" (Tobin & Begley, 2004). Additionally, confirmability refers to the degree to which the findings of an investigation could be confirmed by others (Kumar, 2011:185; Anney, 2014). The researcher enhanced confirmability by documenting all the procedures used for checking the data throughout the study and also by checking the original source in transcripts.

3.9.3. Dependability

According to (Bitsch, 2005), dependability refers to the stability of the findings over time. Dependability involves participants assessing the findings, interpretation and recommendations of the study to make sure that they are all supported by the data received from the informants of the study (Cohen, Manion and Morrison, 2011; Tobin & Begley, 2004). The researcher discussed the research process and findings with the research participants. According to Bitsch (2005) and Krefting (1991), peer examination helps the researcher to be honest about his or her study and peers contribute to his or her deeper reflexive analysis. In addition, colleagues help to identify the categories not covered by the research questions or help to identify negative cases.

3.9.4. Transferability

The transferability of the study is the extent to which the findings of a study can be applied in other related contexts (Botma, Greef, Mulaudzi and Wright, 2010). Transferability was ensured by the use of purposive sampling to select participants and by providing a detailed description of the study to the participants.

3.10. Ethical considerations

The researcher got the ethical clearance from the University of Limpopo Turfloop and Research Ethics Comiitee (ULTREC). Permission to conduct the study was received from the Department of Health (Limpopo Province). Female teenagers who were recruited by the researcher at Byldrift Clinic were interviewed through the consent of the parents as some of them were under the age of 18 years.

This procedure was followed according to (Children's Act 38 of 2005), which emphasises that parental consent is mandatory to all participants below the age of 18 years. Participants were given full description of the study without deception; participation in the study was voluntary. To maintain anonymity, the researcher did not use names of the participants but used codes, for example participant 1.The researcher did not disclose participants' information. Information was used for academic purposes only.

3.11. Significance of the study

Various factors such as attitude of health care providers, challenges on contraceptive use, clinic accessibility and the role of peer pressure provided an insight and understanding on challenges faced by female teenagers in accessing contraceptives. The study is significance in the sense that it helps in establishing appropriate ways of health care providers in working with teenagers. The study also provides understanding of the challenges experienced by female teenagers in accessing contraceptives at rural clinics. The study findings will also inform the Health Department on the unmet need of contraceptives among teenagers.

CHAPTER FOUR: PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.1. Introduction

This chapter presents the findings and interpretation of empirical findings on **Challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic, Malatane Village, Capricorn District of Limpopo Province.** The study was qualitative in nature. The research design of this study was a case study, which allowed the exploration and understanding of complex issues like challenges in accessing contraceptives. The sample consisted of ten (10) female teenagers. In-depth information was collected until a point of saturation was reached on the 10th participant. Participants were selected purposively; criteria for selection of participants included the following:

participant must be a female;

participant must be a teenager; and

parents must have consented in writing for their daughters to take part in the study.

The interview guide was developed in English and translated into Sepedi. This enhanced quality issues as it allowed the interview to be easy and understandable among participants who all spoke Sepedi. Female teenagers who were selected by the researcher at Byldrift Clinic were interviewed after the consent of their parents. Data was collected through semi-structured face to face interviews. Data was analysed thematically. Themes and sub-themes were identified in relation to the study objectives.

Ethical clearance was granted by the University of Limpopo Turfloop and Research Ethics Committee (TREC). Permission to conduct the study was granted by the Department of Health (Limpopo Province).

4.2. Description of the sample

Table 1: Age and Educational level of participants

Age of participants	**Total Number**
15 years old	1
16 years old	2
17 years old	3
18 years old	2
19 years old	2
Total	**10**
Educational level	
Grade 10	2
Grade 11	4
Grade 12	4
Total	**10**

The study comprised of ten female participants. One (1) participant was 15 years old. Only two participants were 16 years old. Three (3) participants were aged 17 years. Two (2) participants were 18 years old and the other two were 19 years old. Teenagers experiences challenges during their teenage period and need information, skills opportunities and services to make healthy choice (Save the Children, 2007). Without sufficient knowledge and skills, teenagers cannot be able to make informed choices about their bodies.

With regard to some of the challenges teenagers' experiences, Flanagan *et al.,* (2013) posits that teenagers in rural areas are not happy about contraception access. Corroborated further, Baloyi (2006) specified that teenagers face specific vulnerabilities that are unique to their age group, including difficulty in accessing contraceptives.

With regard to educational level, the researcher noted that the ten (10) participants were still schooling. Two (2) participants were in grade 10, while four (4) participants were in grade 11. The other four (4) participants were in grade twelve (12). The notion by Riyani *et al.,* (2004) emphasise that education gives teenagers autonomy to make informed choices about their bodies. In the context of high unwanted pregnancies and the high rate of unmet need for contraception, education seem to play a major role in influencing teenage women to access contraceptives so that they can delay unwanted pregnancies.

4.3. Themes and Sub- themes

During the analysis of data, four (4) themes and six (6) sub themes emerged. The themes and the sub-themes are discussed in relation to the literature and the research objectives underpinning the study. The themes and sub-themes are confirmed by direct quotations of the responses attained from the participants during the interviews.

The following themes and sub-themes were identified:

Table 2: Theme and sub-themes

Themes	Sub-themes
Attitude of health care providers	Feelings of teenagers on the attitude of health care providers
Challenges on contraceptive use	Understanding of contraceptive on access influence
	List of contraceptives
Clinic accessibility	Influence of accessibility on contraceptive
Role of peer influence in accessing contraceptives	Teenager’s discussions of contraceptives with friends
	Influence of peers’ discussions on access to contraceptives

4.4 Theme 1: Attitude of healthcare providers

Holt *et al.,* (2012) documented health care worker’s role as gatekeepers to young people accessing sexual and reproductive health services; while they are blamed for stigmatisation and cruel treatment to teenagers seeking contraceptives. Cruel treatment may include the use of verbal abuse of words or physical abuse towards someone. Syed (2014) added that teenagers might be sensitive to rude and judgemental responses from health care providers. This evident from literature indicate how the attitude of health care providers influence access to contraceptives by teenagers.

Most participants explained the negative attitude of health care providers and few explained the good attitude of health care providers. Participants described the attitude of healthcare providers in this way:

“They are very rude, judgmental and aggressive people. I do not feel comfortable to share my health problems with them because I know that the whole community will know about my health problems. They also do this with older people, they tell other people about their patient’s information.” (Participant: 2)

“Sometimes the health care providers are very angry, so they might treat you badly or tell you to come another time.” (Participant: 3)

“They always shout at patients especially young people.” (Participant: 5)

It is assumed that health care providers have judgmental attitudes towards young people who are sexually active. Teenagers in this study appeared to have more concern on the negative attitude of health care providers. The reason being that, these young people are sometimes treated impolitely or not given the services they need (WHO, 2009). Tavrow *et al.,* (2010) indicate that in Kenya and Zambia almost half of the health care providers specify that they were unwilling to provide contraceptives to teenagers.

The beliefs that society hold about teenage sexuality prevent teenagers from accessing contraceptives, as a result teenagers engage in sexual activities without knowledge of using contraceptives. Moreover, with regard to confidentiality, Thomas *et al.,* (2006) connote that the belief in confidentiality is vital in order for clients to visit and revisit the health facilities. Most teenagers have the fear of that health care providers do not maintain confidentiality; it is not always the case to find that health care providers do not maintain confidentiality. Some health care providers are better trained to work with teenagers.

Teenager’s need for confidential services is important as it influences access to contraceptives. It is important for health care providers to guarantee privacy and confidential environment to teenagers accessing contraceptives (Wong, 2012). From the societal level of Social Ecological Model, the beliefs that some societies have on teenagers accessing and using contraceptives determine the likelihood of

teenagers to use contraceptives and prevent unwanted pregnancies and sexually transmitted diseases. The concerns from teenagers about confidentiality, for example might be addressed by a trustworthy relationship between health care providers and clients so that teenagers may feel empowered and take the advice of the health care providers.

The fact that teenagers are labelled as young people, their rights to confidential services are being violated by societal norms surrounding sexuality, and contraceptives prevent contraceptive access and use. This may result in discontinuation of contraceptives use by teenagers.

"We are being criticised by nurses for being sexually active and using

contraceptives at an early age." (Participant: 4)

"Ijooo, their attitude is so bad. They will tell you that they are on lunch time when it is our turn to get in and when you tell them your problems they tell other people. They do not respect our privacy." (Participant: 6)

Research conducted in South Africa by Medical Research Council (2007) showed that the attitudes of health care providers at health facilities is a challenge to teenagers using contraceptive. Moreover, a major reason reported to be responsible for the opposition of health care providers to providing contraceptive services to teenagers is the belief that it promotes sexual immorality (Mgadi *et al.,* 2008). Their attitudes and beliefs about teenage sexuality appears to discourage teenagers from seeking contraceptives and contribute to high teenage pregnancy. In contrast, Mkhwanazi (2010) said that teenagers do not go to the clinic with an open mind and that they are the ones who have negative attitudes towards contraception as a result they transfer the blame to health care providers. Corroborated further, Adra (2007) concurs that teenagers are shy to access health services. The researcher's opinion in this regard is that the blame should not be directed to healthcare providers only, however even to teenagers as well.

On the other hand, the issue of confidentiality among health care providers is also a challenge among teenagers. Positive interactions between the client and the health care providers is essential. A recent study conducted in KwaZulu-Natal by Khalema *et al.,* (2014) revealed that the nature of interactions between health workers and clients have been highlighted as one of the key factors that discourage teenage people from seeking contraception. The involved relationships between health care worker and client is delayed as teenagers view the healthcare providers' as rude and judgmental; teenagers may be less inclined to listen to the healthcare worker's advice. Other participants explained the attitude of the health care workers in this way:

"Their attitude is very good, because I feel comfortable to share any health problems with them and I get advice and more clarification on the method of contraceptive I use." (Participant: 7)

"I am always treated well by our nurses when visiting the clinic for contraceptives, they are friendly." (Participant: 8)

"They are so understanding when you explain yourself and your health needs to them openly." (Participant: 10)

This also confirms what Mngadi *et al*., (2008) said; that teenagers need to go to the clinics with open minds. The above responses of participants might reveal that some healthcare providers have received counselling skills and training for dealing with teenagers as Oxfam (2007) asserts that health care workers who have negative attitudes towards teenagers seeking sexual and reproductive health may not have counselling skills and training necessary for dealing with teenagers.

Health care workers in public clinics needed additional training on modern forms of contraceptives in order to provide comprehensive family planning counselling (Holt *et al.,* 2012; Flanagan *et al.,* 2013). The comments may imply that healthcare providers at Byldrift Clinic are committed and prepared to work with teenagers to ensure easy access and quality family planning. Teenagers can be empowered by

the healthcare providers to access and use contraceptives consistently; however, health care providers need to display positive attitudes towards teenagers.

4.4.1. The feelings of teenagers on the attitude of health care providers

Participants described the feelings of the attitude of health care providers in a negative and positive way. The researcher found it useful to start with the negative feelings described by participants and followed by positive feelings. The oral transcripts below illustrate how teenagers feel about the attitude of healthcare providers:

"Their attitude makes me feel bad and embarrassed, even if I want to ask for more explanation I do not ask because I feel uncomfortable with their rude behaviour. I could not ask further questions, because I felt uncomfortable with their rude behaviour." (Participant: 1)

"I just feel ashamed, but we don't challenge them. Sometimes you may challenge them and find that you use words which may hurt them. Then the next time you go there, they refuse to help you." (Participant: 2)

"They make me feel discouraged, every time I look at my return date; I obviously know that they will not help me without shouting. I am used to their louder voice but sometimes I also get angry and shout at them." (Participant: 3)

Godia (2010) posits that the approach of the health care providers has been identified as a major challenge as it discourages young people from seeking health service. This is in line with the findings of Maja (2007) who found that teenagers were harassed by nurses who were rude, short-tempered and arrogant towards them when they try to obtain contraceptives from public clinics.

Mudhovozi *et al.* (2012) posit that the attitudes make teenage girls fearful of the reproductive health services and these expose them to risk poor-decision making in preventing unplanned pregnancies. Teenagers are being discouraged from using contraceptives. Holt *et al.* (2012) highlighted that service providers report

negative attitudes towards teenager's sexuality and frustrate teenagers for not practicing abstinence, which affect the delivery of information and services of young people. Some participants raised their positive feelings regarding the attitude of health care providers in this manner:

"I am treated well by our nurses and I am satisfied with the services they provide to us as teenagers." (Participant: 8)

"I feel happy, because they educate us and motivate us to make informed choices regarding our health." (Participant: 10)

Patient satisfaction with the health care provider and continuity of care has a significant impact on compliance behaviour (Goodman and Gilman, 2006). When teenagers are satisfied about the attitude of health care providers, they will access and use contraceptives. Corroborated further, Peterson *et al.,* (2004) are of the view that counselling with motivational discussions may be a possible means of improving contraceptive compliance. Therefore, providers have the potential to positively influence women's ability to use contraceptives.

The researcher's inference in this matter is that talking to teenagers in a friendly manner makes them feel free for discussions with the health care providers. Positive attitudes are important components programmes to improve the quality of care rendered. Effective staff attitudes are crucial for improving the quality of care rendered to teenagers. Blanc *et al.,* (2002) point out that the quality of family planning care is a vital display of continuing using contraceptives and improve good care by sustaining clients' needs and improving their services.

4.5. Theme 2: Challenges on contraceptives use

Various factors can unpleasantly affect the use of contraceptives. Using contraceptives is neither a simple nor a straightforward process, it is complicated and accompanied by many challenges that hamper its effectiveness and sustained usage. The notion above is aligned with the literature that states that it is uncommon for contraceptives to be without challenges (Speizer *et al.,* 2000). The fear of side effects and the experience of side effects on using contraceptives methods are the most common reasons for non-use or discontinuation of contraceptive (UNFPA, 2013). Participants cited the experience of contraceptive side effects as a major challenge on contraceptive use. Participants highlighted this:

"For the first time, I used the three- month injection, I stopped seeing my periods. I did not feel happy at all I then stopped using it and now I am using the two- month injection. My other challenge is my mother; she always shouts at me when I tell her that I am going to the clinic because she knows that I am using contraceptives." (Participant: 1)

"I used pills before, it is easy to forget them, as they have to be taken daily and if you miss one pill you are pregnant. I then stopped using the pill and decided to use the two- month injection and I am ok with it." (Participant: 2)

Some individual factors that influence teenagers to use contraceptives are teenagers' knowledge about contraceptives and attitudes towards using contraceptives. For example, a teenager who experiences side effects like seeing no periods may believe that the contraceptive method is responsible for seeing no periods and she may stop using it, like the other participant who stopped using the three- month injection and used the two-month injection.

Contraceptive methods sometimes challenge the bio-cultural beliefs for example, women in some societies believe that it is healthy to menstruate monthly and therefore refuse to use a pill or injectable contraceptive (Makundi, 2001). In the case of using pills, teenagers discontinued the use of contraceptive pill due to difficulties in adherence as they have to be taken daily.

On the other hand, parents are also reported as a challenge on the use of contraceptives by teenagers. Kinaro (2012) posits that majority of parents' object to contraceptive use by unmarried teenagers and have negative opinion of unmarried teenagers using contraceptives and as a result, parents lack confidence to discuss sexuality issues with the young people.

Another participant said this:

"Pills make me feel dizzy and damage my eggs. I might not have a baby of my own when I am an adult. Lack of knowledge is also my challenge because some of the information we get from friends is incorrect and it discourages continued use of contraceptives." (Participant: 6)

The perception that contraceptives causes infertility may indicate that teenagers do not have sufficient knowledge on the advantages and disadvantages of the contraceptive method they use. From the individual level as the centre of the Social Ecological Model, personal factors such as attitudes and beliefs influence contraceptives use and motivation to use contraceptives. The inappropriate guidelines and the misconceptions of side effects from teenagers need interventions designed to affect an individual's behaviour such as educational training and counselling (Powell *et al.,* 1999). In this regard, there is a need to give teenagers adequate information about contraceptives in terms of their side effects and how to manage the side effects.

"I once experienced over bleeding when I was on the three- month injection. Without being counselled, I just decided to change to two -month injection without asking a nurse about how to manage the side effects. I also gained weight from using injection contraceptive." (Participant: 4)

Contraceptive users are advised to see and talk to their doctors or healthcare providers whenever they experience heavy or prolonged bleeding as it can be treated (Depo-Provera Information, 2010). The experience of over bleeding by a participant who switched to another contraceptive method without asking the health care providers about how to manage side effects might reveal that teenagers are shy to ask for clarity on the contraceptive method they use due to the bad attitude of healthcare providers.

"Seeing no periods for a couple of months is my major challenge on using contraceptives. We are Christians at home, my parents told me that using contraceptives is against our Christianity, this affect me because I have to obey my parents and I also have to protect myself from unwanted pregnancy." (Participant: 5)

"My challenge on contraceptive use is my partner; he often claims to be sick from the injection I am using. We sometimes fight because he even told me to stop using it."(Participant: 3)

In most countries, religious affiliation is totally prohibiting contraceptive use among young people as they are not expected and encouraged to engage in sexual relations. Casterline *et al.,* (2001) have shown that non-use of contraceptives has been determined by inexperience and poor communication among partners. Most of these youth choose hormonal methods because their partners will not know that they are using any family planning method to prevent unplanned pregnancies. However, their partners end up knowing that they are on contraception.

4.5.1 The influence of contraceptive understanding on access

Under this sub-theme, participants were asked how their understanding of contraceptive influence them to access contraceptive. Participants emphasised that:

“The little knowledge I have always encourages me to access contraceptives to avoid unwanted pregnancy.” (Participant: 2)

“Whatever understanding I have and get from friends, I will always access contraceptives until I am older enough to fall pregnant” (Participant: 6)

“I do not have enough knowledge on contraceptives. Because of my little knowledge I am motivated to go to the clinic after two months to access contraceptives so that nurses can give me more information” (Particpant:9)

“I already have two children; whether I experience unpleasant side effects that make me feel uncomfortable I will always use contraceptives.” (Participant: 10)

According to Wood and Jewkes (2006) at the clinics, teenagers are offered little choice of contraceptive method and given poor explanations of the side effects, which contributes to a low uptake of contraceptive. In the past, studies have shown that a high percentage of young people are getting sexually active in early adolescent stages and as a result most of them use contraceptives without much knowledge about them (Kenya, National Bereau of Statistics, 2010). Proper education and counseling before and at the time of selecting a method of contraception can help teenagers address their problems as well as make informed and voluntary decisions (WHO 2010).

4.5.2. List of contraceptives

Pill, injection and condoms were mentioned as common types of contraceptives known by participants. Participants said that:

"I know a pill, two and three- month injection and also a condom. I do not know if a condom is classified as a contraceptive. I also heard about the implant that is inserted under the arm from a friend." (Participant: 1)

"I know depo, nustrate, condoms and pills." (Participant: 2)

Knowledge of different types of contraceptives methods and their effectiveness is important in awareness of the expected advantages and disadvantages of each method and reflection of correct usage. Knowledge about contraception has been shown to increase contraceptive use, particularly among teenagers (Undie *et al.,* 2007). Most participants mentioned the pill, injection and condoms.

A pill and an injectable contraceptive remains the most used and recommended methods of contraception (Tuone *et al.,* 2004). The evidence is that teenage women encounter challenges in negotiating condom use and see injectable methods of contraception as an option (Smith and Harrison, 2013; Whipkey *et al.,* 2014). The pill and the injection remain the popular known methods of contraceptives among these teenagers. The knowledge of contraceptives was however, limited in one participant who mentioned a condom and stated that she does not know if a condom is classified as a contraceptive.

4.6. Theme 3: Clinic accessibility

According to The Constitution of the Republic of South African , Act 108 of 1996 Section 27, 1 (a) the South African government has an obligation to ensure that all health facilities are easily accessible to the people. For the purpose of this study, accessibility means, the degree to which services or the environment is available to many people as possible. Access to services can be influenced by factors such as money, lack of knowledge of services available, infrastructure, equipment and distance to users of such services.

Participants explained their experience of the clinic when accessing contraceptives in this way:

"Privacy is my major experience because the clinic is so small."

(Participant: 1)

"The clinic is not attractive to us teenagers. That is the reason why teenagers refer to clinic as for older people. The most people I found at the clinic are older people who come for treatment and nurses spend a lot of time with them than with us teenagers. The clinic does not have enough equipment like blood pressure machine." (Participant: 2)

Infrastructure is one of the factors that can influences accessibility. Lack of proper infrastructure may reveal that the privacy of clients will not be protected. Denno and Riedner (2005) also agree that challenges that lead teenagers not to use health services is the fact that young people are being served in the same health facilities with older people which can make them feel embarrassed. In Cameroon Dongmo (2010) reveals that public health facilities devoted to teenagers' health are limited in scale.

Participants emphasise that the clinic is not attractive. This may reveal that teenagers want a user-friendly clinic. They also want to have their own clinic specifically for teenagers only. The availability of family planning infrastructure and equipment in local clinic increased the use of modern contraceptives (Blanc *et al.,* 2002). Lack of counselling rooms as lack of infrastructure make it difficult to maintain confidentiality (Kamau, 2006). Khalaf *et al.,* (2009) indicated that most teenagers desired to have a big health facility which could be specific for them only, attractive and accessible.

Other participants explained their experiences at the clinic as follows:

"The clinic closes early. I find it difficult to miss classes in the morning so that I can go to the clinic. I normally go after school and sometimes the nurses will tell you that they are closing." (Participant: 7)

"Sometimes when I go to the clinic I wait for hours to be helped and this affect me badly as I am still at school. I think that more staff members need to be employed to deal with young people during weekends as most of us are free.'' (Participant: 8)

"I experience long queues because of shortage of staff." (Participant:10)

Teenagers have found the operating hours of services are not suitable (Donelly, 2000; Grifftihs & Gerressu, 2008; Evans & Cross2007). Biddlecom *et al.* (2007); WHO (2012) articulated that operating hours at health facilities inhibit young people from obtaining sexual and reproductive health services. Timing of services is not convenient for them as they are at school at the opening time.

Teenagers may find clinic's operating hours inconvenient and want separate hours just for them because they find it difficult to access health services as some of them are still schooling and when they go to seek services, they find clinics closed (Biddlecom *et al.,* 2007).

In their study Nwaladda *et al., (*2011) also highlighted that waiting times at clinics are often long, which many teenagers report as difficult for them to access health services. This makes contraceptive services to be inaccessible to these women as they leave these places very late in the day when the clinics have closed (Zungu and Manyisa 2009). Agampodi *et al.* (2008) also noted that teenagers preferred to be treated by young services providers. This is also in line with the notion of Bearinger *et al*. (2007) who contended that all teenagers all teenagers need access to quality youth friendly services provided by clinicians who are trained to work with teenagers. However, based on observation this is not surprising because many health facilities are understaffed; this situation limits young women to access contraceptives. Services must always be available to users at any time when they need to utilise them. The institutional level of the theory used in this study, involve policies and rules that hinder access to health services, for example the operating hours of the clinic impede access to contraceptives for teenagers as some clinics close early while they are still attending classes.

4.6.1. Influence of accessibility on contraceptives use

Two (2) participants said that the clinic is accessible, while eight (8) participants said that the clinic is not accessible. The reason for participants citing the clinic as accessible is because the two participants live closer to the clinic and they do not walk a long distance, while the other (8) live far from the clinic. The researcher even observed that the distance some participants have to walk to get to the clinic is long. WHO (2008) posits that when the accessibility of the clinic providing contraceptives is compromised in any way, the need for contraceptives in the community remains unmet with high rate of unintended pregnancies. Flanagan *et al.* (2013) viewed the unmet need for contraceptives and noted that teenagers in rural areas are not satisfied about contraception access. Moreover, eight (8) participants also indicated that they were not happy about the accessibility of the clinic, whereas two (2) participants said that they were happy about the accessibility of the clinic.

"I live at the new stands (Potlaka Section) I have to walk a long distance, I sometimes take a local taxi to get to the clinic and if I do not have money I have to walk." (Participant: 1)

"It is far, you have to go early so that you can easily get help because is the only clinic we have here." (Participant: 10)

The eight (8) participants indicated that the clinic is far from their home and they are not happy about the distance they walk to get to the clinic, only two (2) participants said that is not far from their homes and they are happy about the distance they walk to get to the clinic. Some studies have shown that longer distances to get to health facilities undermines service utilization (Baral *et al.,* 2013). This is aligned with the view of Tladi (2014) by stating that most teenagers from rural areas normally walk long distances to reach a health facility. In contrast, the views of the above stated authors is not aligned with the findings of the study, the motive being that (2) participants indicated that they live closer to the clinic and they are happy about the distance of the clinic from their homes. Tuone *et al.,* (2003) added that women who stay closer to the clinic are more likely to use contraceptives than those who have to travel hours to get to the service point. Greater access to health care has been related to better health care including the use and access of contraceptives among teenagers.

4.7. Theme 4: The influence of peers in accessing contraceptives

Peer influences as one of the interpersonal level of the social ecological model, involves relationships between teenagers and their friends. Stuart (2001) defines peer influence as, "the influence exerted by a peer group in encouraging a person to change his or her own attitude, values, or behaviour in order to conform to the group norms." This can be positive or negative influence. Wickert (2002), in agreement, defines peer influence as the influence of a social group on an individual; it can also be positive or negative. The findings of Macleod and Tracey (2010) also revealed that peer influence is both a source of positive information and a way of confusing around sexuality.

All participants interviewed agreed that they discussed contraception with their friends. This is in line with the view of Panday *et al.* (2009) stating that in their need for information, teenagers go to their peers for guidance to satisfy their interest. Stevens and Cloete (2009) further suggested that functions that are fulfilled by peer influence provide friendship; facilitate knowledge and information about sexual activities. The reason for teenagers trusting information from peers might be that most parents have difficulty with communicating with their teenagers about sexual matters; which results in teenagers seeking help somewhere else. Teenagers can be negatively affected by peer influence if parents are not involved in the sexual education of their children. For this reason, teenagers turn to their peers for advice. Participants explained their discussion on contraceptives with their friends as follows:

"We give each other advice and encouragement to continue using contraceptives so that we may not fall pregnant at an early age." (Participant: 3)

"Being pregnant at early age is disturbing, we want to finish school and go to varsity, and contraceptives are the only means to help us achieve this."

(Participant: 5)

"We discuss a lot of things related to sexuality, contraception and problems we face as teenagers, but we end up arguing with each other because of lack of knowledge on contraceptives.'' (Participant: 10)

When peers are strongly close to each other, they tend to spend a long time together and interchange the wide patterns of behaviour (Bezuidenhout and Joubert, 2008). This may also reveal that peer relationships play a key role in the social development of teenagers. In the case of contraceptives use, Han and Bennish (2009) posit that friends influence one another in seeking and using contraceptives. Considering the negative and positive influence of peer pressure Steinberg and Monahan (2007) indicated that peers influence teenagers' decisions and behaviours. The participants seemed to have taken into consideration on the discussions and views they share with their friends regarding contraceptives.

One participant also indicated the following:

"We discuss and argue on how a contraceptive works within the body and how it may affect future fertility among us as teenagers. We end up arguing because everyone thinks that their ideas are true while some of them are just incorrect information related to contraceptives." (Participant: 6)

According to Stover and Ross (2010), over 1.4 million teenagers give birth each year with 12, 8 births occurring in developing countries. The fertility rates of these teenagers as reported by the Population Reference Bureau (2017) is 71% in South Africa among teenagers aged 15- 19 years. The perception over the fear of infertility among teenagers might be heard and influenced by the discussions they have with their friends which are sometimes correct and incorrect.

4.7.1. The influence of Peers discussions on access to contraceptives

Many teenagers approach adulthood facing conflicting, inaccurate information and messages about sexuality. In most cases, teenagers have incomplete information about sexuality, reproduction and contraception (Presler-Marshall and Jones, 2012). Baloyi (2006) also found that many teenagers get information about sexual matters and reproductive health from each other, and this information is often incorrect. Under these sub-theme participants emphasized the following:

"I started using the two-month injection after a friend of mine told me that she is also using it. My friend went with me to the clinic to get contraceptives; sharing things with her really influenced me to access contraceptives." (Participant: 1)

"It influences me negatively and positively, because sometimes we argue a lot and end up being confused. One day we asked each other about how contraceptives can affect fertility among teenagers because we use contraceptives at an early age and what will happen to us when we are older enough to have children. We could not answer each other because we do not know what to say about it." (Participant: 2)

"My friends told me that contraceptives are meant for older people, and I took their advice and now see, I am the mother of two children before the age of 21. I learned my lesson after my second baby because this did not make my parents happy at all while they cannot discuss sexuality and contraception with me." (Participant: 10)

These responses from participants clearly prove that peer influence has a positive and negative influence on teenager's decision to use contraceptives. Reddy *et al.* (2010) are of the view that people do not only change with information, but they change when others around them change. The change in behaviour can be traced back to the interpersonal level of the Social Ecological Model, which explains that the closed social circle like peers has the potential to shape an individual's behaviour (Dahlberg and Krug, 2002).

Peers as indicated fall within the interpersonal level by providing social identity and role definition. It is clearly from the participants that parents lack parental guidance on sexual matters and contraception. Parents should find a way of approaching their children about contraception and sexual matters, so that their children are able to make informed choices.

When teenagers are supported by their parents and have open communication about contraception, chances are that they may use or access contraceptives. Conversely, if they are not supported by their parents they may not use or access contraceptive.

Other participants highlighted the influence of peer's discussions on contraceptives this way:

"I am strongly influenced to access contraceptives because of the discussions we have with friends and it really helps a lot, although sometimes we give each other incorrect information because of lack of knowledge on contraceptives." (Participant: 3)

“It sometimes influences me negatively to access contraceptives because we do not have enough knowledge on contraceptives.” (Participant: 9)

Mago *et al.,* (2005) accentuated the lack of factual knowledge about contraception. Wafula *et al.,* (2010) as well as USAID (2009) also explained that the myths that are heard about contraception from peers, which influence contraceptive use is well documented in Kenya. The myths that are heard from peers can be due to lack of knowledge about contraceptives among these teenagers. Moreover, participants were asked if their friends use contraceptives. Six (6) participants said that their friends used contraceptives, while others said that they did not know if their friends used contraceptives. Some participants indicated that:

“My friend use contraceptives and I also use them, but we do not have more knowledge on contraceptives. Nurses do not give us enough counselling on the type of contraceptive we use.” (Participant: 4)

Research has shown that teenagers were not satisfied with the contraceptive counselling they were given (Kero and Lalos, 2005). (Pathfinder International, 2005) also notes the reason why teenagers are not happy about contraceptive counselling by saying that lack of confidentiality and poor relations with health staff are their concerns over access to reproductive health services. Lack of knowledge about methods of contraception discomfort during interactions and about how to raise certain issues (Akers *et al.,* 2010). Lack of knowledge among teenagers impede on asking questions to health care providers providing contraceptive counselling and these leave teenagers unsatisfied with the contraceptive counselling they receive.

Oxfam (2007) added that staff might not have the counselling skills and training necessary for dealing with teenagers. Even these young girls go to the clinic; they are often faced with limited contraceptive options and poor counselling (Flanagan *et al.,* 2013). Therefore, it should be noted that effective contraceptive counselling is pivotal as it encourages consistent use of contraceptives. Other participants highlighted this:

"Yes, my friend told me that she is using the two -month injection."(Participant: 1)

"I know that she is using injection, and I am also using it, I even saw her card, we go to the clinic for contraceptives on the same date."

(Participant: 2)

Peers sharing with each other on their use of contraceptive is a positive influence to contraceptive use. Young women were more likely to use friends as preferred sources of information about contraception (Yee and Simon, 2010). Simon (2010) found that the opinions of friends were considered more valuable. Most teenagers depend on their friends as the main source of information regarding the use of contraceptives (Denne and Riedner, 2005).

The following extracts are from participants who said that they do not know and they are not sure if their friends use contraceptives.

"I am not sure, because you might not know what other people do when we are not with them" (*Participant*: 6)

"I know everything about my friends, but when coming to who uses pills and injection we are secretive. We don't tell each other what we use exactly to prevent unwanted pregnancy." (Participant: 7)

"I do not know if they use them, others may feel embarrassed that if they openly tell their friends the type of method they use, their friends will reject them and they will feel ashamed." (Participant: 5)

The intention of being secretive by teenagers not telling each other that they use contraceptives is not a new thing. Researchers contend that teenager's important judgements are often influenced by the fear of rejection by the peer group (Sharry, 2004). Nalwadda *et al.,* (2011) revealed the stigmatisation of teenagers accessing contraceptives. In this case, teenagers feel uncomfortable to tell their friends that they use contraceptives because they fear to be rejected if their peers do not use the same method as their peers.

Lastly, participants were asked if there were anything else they would like to say about the challenges faced by teenagers in accessing contraceptives. Only one participant highlighted that her parents do not discuss contraception with her.

"Our parents do not discuss contraception with us; if they discuss this thing with us we will access contraceptives and use them to avoid unwanted pregnancy." (Participant: 10)

Majority of parents or guardians object to contraceptive use by unmarried teenagers and have negative opinion of unmarried teenager using contraceptives, as a result parents lack confidence to discuss sexuality issues with the young people (Kinaro, 2012). Other participants did not say anything related to challenges faced by female teenagers in accessing contraceptives; however, they mention suggestions and recommendations to make contraceptives easily accessible to teenagers.

"I think it is better for the Department of Health to provide schools with contraceptives, so that teenagers like me who are shy to visit the clinic can access them easily." (Participant: 2)

"Government must build us a big clinic for teenagers and youth in our community." (Participant: 3)

"Our nurses must be friendly to us so that we can freely discuss our health problems with them." (Participant: 4)

Policies should be implemented to support the availability of contraceptives at school as a component of comprehensive education. On the other hand, parents will still be afraid that if their children are given contraceptives they will engage in sexual activities. As Peltzer and Promtussananon (2003) explained that the fear that school condom availability programmess will lead teenagers to promiscuity is probably unfounded since various studies concluded that, the availability of condom in school did not increase the sexual activity of teenagers. Critics of school condom availability have argued that the increased availability of condoms will lead to an increase in sexual activity. However, to date, no studies have shown such an increase. Moreover, several studies suggest that condom availability programmess may be associated with a decrease in recent sexual activity or delayed onset of sexual activity (Furstenberg *et al.,* 1997; Blake *et al.,* 2003; Charania *et al.,* 2011).

Although there are policies meant to focus on school health services (Department of Health, 2003; Department of Health and Department of Basic Education, 2012), they are not yet being implemented in all districts, especially schools in rural and informal settlement areas. The need for a big health facility for teenagers might reveal that teenagers are not comfortable to be served in the same health facility with older people. It is therefore essential for the creation of confidential environment to prevent embarrassment when teenagers access contraceptive information and services (Wong, 2012). It is also necessary for health care providers to display positive attitude when working with teenagers and adults as well, hence teenagers also must display positive attitude towards health care providers. Teenagers should display a positive attitude while visiting the health facilities for contraceptives.

4.8. Discussions of Empirical Findings.

The health care providers, majority of participants complained about the judgmental and often bad attitude. While few explained health care providers as hard working people who motivate them to make informed choices to avoid unwanted pregnancy. Young people are often treated rudely or denied services. There is still a major problem about health care providers as some of them are not prepared to give teenagers contraceptives. Health providers had negative attitudes towards the provision of contraceptives for young people and were not prepared to give contraceptives. This study revealed that healthcare providers react negatively towards teenagers using contraceptives. Research findings also showed that health care providers treated teenagers rudely. This highlights gaps in some health care providers' knowledge and personal beliefs on how to work with young people. However, some participants explained that they are treated well by health care providers. This is an indication that some health care providers are well trained and have skills to deal with young people. Participants also articulated how they felt about the attitude of health care providers, some participants felt embarrassed and discouraged while some felt motivated and seemed to be satisfied by the attitude of the health care providers. The societal level of the social ecological model emphasises that the societal norms of society by health care providers towards sexually active teenagers, hinder access and use of contraceptives among teenagers.

Most participants cited the experience of unpleasant side effects as a major challenge in using contraceptives. The study found that teenagers do not have adequate knowledge on the type of contraceptives they used and the expected possible side effects. Some were reluctant and shy to ask health care providers on how to manage side effects. Pills and injection were reported to be common known contraceptives by teenagers. This indicates knowledge gaps among teenagers on condoms as a contraceptive due to lack of access to comprehensive contraceptive information. On the other hand, it could mean that young people are mainly interested in pills and injection. From the findings, it was found that personal factors such as attitudes and beliefs influence the use of contraceptives.

The clinic was found to be not attractive and teenagers referred it as clinic for older people. Clinic infrastructures were also an issue, as participants highlighted that it has few consulting rooms and shortage of nurses. Lack of accessibility was cited as problematic as the study revealed that young people do not want neighbours to see them entering or leaving the clinic. The study revealed that most participants do not travel long distances to get to the clinic. Long waiting times was also cited as a challenge in accessing contraceptives among teenagers as a distraction to access health services. Participants found the operating hours inconvenient as they are still schooling. Operating hours is influenced by the distance teenagers travel to get to the clinic.

Peers have a great influence on access to contraceptives. They influence each other to make good and wrong choices throughout their exploratory stage of adolescence. This study noted that teenagers rely on the views of their peers when discussing contraceptives. Most of the teenagers discussed contraception with their friends and again the discussion seems to have promoted and encouraged contraceptive use among teenagers. Literature substantiates that teenager’s behaviour is influenced by the behaviour and ideas of their peers. This study also revealed that teenagers lack knowledge about contraceptives to make informed choices over their sexual and reproductive health. Peers being secretive on the type of contraceptive used was also cited. Teenagers felt that if they open about using a specific type of contraceptive, their friends will discriminate them and they will fell rejected from their peer groups.

Participants recommended that the schools and the Department of Health need to work together in ensuring easy access to contraceptives by teenagers. Others suggested that health care providers should be friendly so that teenagers can freely discuss their health problems with them. It was highlighted that parents should acknowledge that their children are grown up; hence, parents find it difficult to discuss contraception with their children.

4.9. The re-statement of the aim and objectives of the study

4.9.1. Aim of the study

The aim of the study was to explore the challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic, Malatane village, Capricorn District, Limpopo Province.

4.9.2. Objectives of the study

The study pursued the following objectives:

- **To ascertain the health care provider's attitudes towards the provision of contraceptives to teenagers**

Literature specified that health care providers were not willing to provide contraceptives to teenagers (Tavrow *et al.,* 2010). Medical Research Council of South Africa (2007) also showed that the attitudes of health care providers at health centres is a challenge to teenagers using contraceptives. The objective was achieved because participants were able to describe the attitudes of the health care providers and explained how they felt about the attitudes of the health care providers. Participant's responses were divided on the attitude of health care providers' attitudes. Others were positive, saying that the healthcare providers treat them well and motivate them, while others were negative, explaining that health care providers were judgmental and have negative attitudes towards teenagers using contraceptives at an early age.

- **To determine the teenagers' challenges on the use of contraceptives**

The literature confirmed that it is rare for contraceptives to be without challenges (Speizer *et al.,* 2000). The findings of the empirical study also confirmed that there are challenges experienced while using contraceptives. The objective was attained as participants provided challenges they experience while using contraceptives.

- **To examine the accessibility of the clinic that provides contraceptives**

Access to services is influenced by a number of factors. In this study it was found that most participants found the clinic to be inaccessible, citing that they walk long distances to get to the clinic. The operating hours were inconvenient as they are still schooling. The infrastructure of the clinic was cited as unattractive by participants. Participants cited lack of confidentiality among health care providers as a challenge for them to access contraceptives. The objective was achieved as participants shared their views and concerns on accessibility of the clinic.

- **To examine the role of peer pressure in accessing**

Contraceptives.

The literature and empirical findings of this study demonstrated that peer pressure is one of the most influential factor that influence contraceptives access. This objective was achieved because teenagers discussed contraceptives with their friends and accessing contraceptives because of the discussions they have with their peers regarding contraceptives.

4.10. Summary of Findings from Empirical Findings

The following is a summary of the findings from empirical findings:

- The attitude of health care providers is significant as it determines access to contraceptives among participants.
- Participants reported the experience of side effects as a challenge on the use of contraceptives.
- Partners, parents and religion were also reported by participants as challenges to use contraceptives.
- Parents do not discuss contraception with their children.

- Parents object to contraceptive use by unmarried teenagers

- Participants pointed out that the clinic is not accessible, as some of them have to walk long distances to get to the clinic and experience long waiting times due to shortage of staff. This simply implies that the operating hours of the clinic is not convenient for them.

- Participants in this study were influenced by the attitudes and actions of their friends.

- Some participants travel a lot to get to the clinic.

- The infrastructure of the clinic was also cited as a challenge as participants highlighted that the clinic has few consulting rooms and this impact on their privacy.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the conclusion, recommendation and recommendations for further research. The aim of the study was to explore challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic. Teenagers engage in sexual activities at an early age with lack of knowledge on contraceptives. Teenagers in rural areas were not satisfied about contraception access (Flanagan *et al.,* 2013). The Social Ecological Model focused on the individual, interpersonal, community, institutional and societal level which affects access to contraceptives by teenagers. These levels influence an individual's behavior. The study was qualitative and used case study research design. Participants were purposively selected. Semi structured face to face interviews were conducted with the female teenagers accessing contraceptives. Thematic analysis was used to analyse data. Health care providers' approach has been identified as a major obstacle as it discourages young people from seeking health care services (Godia et al., 2010). The literature demonstrated that it is uncommon for contraceptives to be without challenges (Speizer *et al.,* 2000). Regmi *et al.,* (2010) contend that teenagers are not happy about reproductive health services. They highlight that most of the rural health facilities are not providing youth friendly services. Teenagers get information about sexual matters and reproductive health from each other, and this is often incorrect (Baloyi, 2006).

5.2. Conclusion

From the findings of the study, the following conclusions can be drawn:

Some health care providers are rude in providing contraceptives to teenagers, whilst others do not have positive attitude in distributing contraceptives to them. Some teenagers feel discouraged and some felt motivated about the attitude of the health care providers. Nurses do not provide enough information on the types of contraceptives. The issue of confidentiality among is still a challenge among healthcare providers. Teenagers walk long distances to get to the clinic.

Parents do not discuss contraceptives with their children and that they discourage unmarried teenagers from using contraceptives. It is therefore noted that parental involvement in sexual matters play a key role in helping teenagers to establish and maintain healthy sexual and reproductive lives. It is very important for parents to take into account on matters of contraceptives and to discuss sexuality with their children.

Teenagers have found the operating hours of the clinic to be inconvenient, as most of them are schooling. Teenagers are not happy to be mixed with elderly people at the same clinic. Poor infrastructure remains a challenge as participants mentioned that the clinic does not have enough consulting rooms, this result in their right to confidential services being undermined. This is evident that teenagers do face challenges in accessing contraceptives.

Peer influence is a significant factor on access to contraceptives. The study made poignant findings, such as that peer influence is positive and negative; also that it influences access to contraceptives services. Peers are not open to one another about contraceptive method they use. Peer education may play a major role in shaping teenagers to make healthy and informed choices.

5.3. Recommendations for Intervention

Based on the study results and conclusions on challenges experienced by female teenagers accessing contraceptives at Byldrift Clinic. Easy access to contraceptives services would improve the life chances of these young women; therefore, the study recommends the following:

- Health care providers should provide more education on the effectiveness rate of the contraception method and ways to manage side effects. This can be done by giving counselling and education on contraceptives.

- There is a need to educate health care providers on patient confidentiality. Health care providers should be trained in how to serve young people and provision of provision of contraceptives should be accompanied by adequate information. Operating hours must be convenient to teenagers who are still schooling.

- Health facilities need to be more user friendly. This can be enhanced by making waiting times at the clinic short and the friendliness of the all the staff members working at the clinic.

- Teenagers should seek alternative source of information from counsellors and trained personnel on sexual and reproductive matters. When seeking information about contraceptives; it is important for teenagers seek contraceptive information from nurses, rather than their friends or family members.

- Schools and the Department of Health need to work together in ensuring easy access to contraceptives by teenagers. The two department should make use of the school health policy to ensure that teenagers are provided with the Sexual and Reproductive health they need. Schools should be used as a distribution points for contraceptives. Policies must be implemented to support the availability of contraceptives at school as a component of comprehensive education.

5.4. Recommendations for further research

While conducting the research, and compiling the report, it became apparent that further research is required about:

- A similar study on a larger scale should be carried out in various parts of the Limpopo Province to confirm the findings as the present study only focused on Byldrift clinic.
- The influence of family on contraceptive use. The family play a huge role in the socialization of teenagers, therefore investigating family role in use contraceptive will be influential to determine barriers hindering contraceptive use.
- Investigation of the side effects of contraceptive methods among teenagers and their partners. Some of the side effects resulting from contraceptives are unknown, hence exploring more on this issues will familiarise health stake holders to ensure that more education programmes regarding contraceptives are well implemented in the public health facilities.
- Reasons why peers keep the type of contraceptive secretive. This may be achieved by exploring the peer education programs as it would enable teenagers to be open to their peers regarding contraceptive use.
- Ways of encouraging parents to get involved on issues of teenage sexuality. The social norms that deter parents from involving themselves in the sexual matters of their children should be explored as to find some reasons and solutions on how parents can be involved in sexuality matters of teenagers.
- The theoretical elements that could be enhanced is the interpersonal level of the Social Ecological model as it involves the relationship that influence peoples' behaviour; peers, partners, family members and social networks. The relationships that teenage people engage in have an influence on the behaviour.

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APPENDICES

Appendix A: Interview Guide (English)

Section A: Personal information

1. Age ___________

2. Educational level ____________

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

3.1. How do you feel about the attitude of the healthcare providers?

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives.

4.1. How does your understanding on contraceptives influence you to use contraceptives?

4.2. List some of the contraceptives that you know.

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		
B. Are you happy about the clinic's accessibility?		
C. Is the clinic far from your home?		
D. Are you happy about the distance of the clinic from your home?		

Section D: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends?

6.1. If so, what do you discuss regarding contraceptives?

6.2. How does the discussion influence your access to contraceptives?

6.3. Do your friends use contraceptives?

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

THANK YOU FOR YOUR PARTICIPATION

Appendix B: Interview Guide (Sepedi)

Karolo ya A: Tša bophelo bja gago

1. Mengwaga _____________

2. Tša dithuto _____________

Karolo ya B: Mokgwa wa Bašomedi ba tša tlhokomelo ya tša maphelo go šomišweng ga dithebela pelegi.

3. A o ka hlaloša maitshwaro a mohlokomedi / mošomedi wa tša maphelo/ baoki nakong ya ge o etetše ka kliniking?

3.1. A o ekwa bjang ka maitshwaro a bahlokomedi / bašomedi ba tša maphelo?

Karolo C: Ditlhohlo tša moswa go šomišeng ga dithibela pelegi

4. A o nka mpotša ka ditlhohlo tšeo o hlakanago le tšona ge o šomiša dithibela pelegi.

4.1. Kwišišo ya gago e go huetša bjang go šomiša dithibela pelegi?

4.2. Efa dithibela pelegi tšeo o di tsebago.

Karolo ya D: khwetšo ya kliniki yeo e thušago ka go fa bana ba basetsana dithibela pelegi

5. A o ka abelana ka maitemogelo a gago ge o etetše kliniki go ya go hwetša dithibela pelegi?

5.1 Dipotšišo tše di latelago di swanetše go arabiwa ka Ee goba Aowa.

Khwetšo ya kliniki	Ee	Aowa
A. A e ka ba kliniki e a hwetšagala naa?		
B. A o a thaba go ya ka moo kliniki e hwetšwago ka gona naa?		
C. A kliniki e kgole le wena naa?		
D. A o kgahlwa ke bokgole bja go ya kliniki go tšwa ga geno naa?		

Karolo ya E: Karolo ya kgatelelo ya bokgotsi go hwetšeng ga dithibela pelegi.

6. A o kile wa hlalosetšana le mogwera wa gago ka ga dithibela pelegi naa?

6.1. Ge go le bjalo, a o hlaloša eng mabapi le dithibela pelegi?

6.2. A e ka poledišano ya gago e huetša bjang go hwetšeng ga dithibela pelegi?

6.3. A bagwera ba gago ba šomiša dithibela pelegi naa?

7. A e ka ba go na le seo o nyakago go se bolela mabapi le ditlhohlo tšeo bana ba basetsana ba kopanago le sona ge ba hwetša dithibela pelegi naa?

KE A LEBOGA GE O TŚERE KAROLO

Appendix c: Informed Consent form (English)

Dear participant.

Thank you for your willingness to participate in the study. The purpose of the study is to investigate challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic. If you agree to participate in this study, the information you provide will not be disclosed to any person but only be useful to academic purpose and for the purpose of the study.

Participation in the study is voluntary and you have the right to withdraw from the project at any time without hostile consequences. To the best of my knowledge, there are no actual and potential risks that may result from your participation. Should you have questions please feel free to ask. I kindly request you to sign the consent form attached to confirm your consent to participate in the study.

CONSENT

I voluntarily consent to participate in the study and I fully understand the purpose of the study as explained to me.

I am aware that I am under no obligation to participate in this study and I may withdraw at any time without negative consequence to me.

Signature of participant ______________________________

Date ______________________________

Signature of the researcher ______________________________

Date ______________________________

Appendix D: Informed Consent form (Sepedi)

Thobela motšeakarolo

Ke leboga matsapa a gago a go tšea karolo ka gare ga nyakišišo. Bohlokwa bja nyakišišo ye ke go nyakišiša ditlhotlo/ ditšhitišo tšeo bana ba basetsana ba kopanago le tšona ge ba hwetša dithibelapelegi kliniking ya Byldrift, motseng wa Malatane.

Ge o dumela go tšea karolo, tseba gore tshedimošo yeo o neelanang ka yona e ka se phatlalatšwe ka mokgwa wa bošaedi, e tlo šomišwa fela go mabaka a thuto le bohlokwa bja nyakišišo.

Go tšea karolo ke maithaopo goba boithaopo bja gago, o na le tokelo ya go emiša go tšea karolo nako le nako ge o se sa nyaka go tšwela pele. A gona le ditlamorago tša go kweša bohloko, go ya ka tsebo ya ka. O a amogelwa go botšiša dipotšišo.

Ke kgopela gore o saene ge o dumela go tšea karolo mo nyakišišong ye.

TUMELELO

Ke ithaopa go tšea karolo ka gare ga nyakišišo ye, ebile ke kwešiša bohlokwa bja nyakišišo ye. O ka saena mo ge o dumela go ba motšeakarolo

Mosaeno wa Motšeakarolo _________________

Tšatšikgwedi __________________

Mosaeno wa monyakišiši ____________________

Appendix E: Parental consent form (English)

Dear Participant

I am a master's student intending to conduct a study on Challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic, Malatane village, Capricorn District of Limpopo Province.

In terms of the children's Act 38 of 2005, parental consent is mandatory to all participants below the age of 18 years. To that end, you consent for your daughter to take part in this study is requested.

Please note that participation in this research is voluntary and the identity of the participants will be protected. Also note that you are at liberty to withdraw your daughter's involvement and participation in this project at any time during the project, should this be desirable. Such a decision and action will not be held against you and your daughter.

If you decide you want your daughter to take part in this study, please complete and sign the following section:

I, parent/ guardian's full name and surnames

____, hereby grant consent for my daughter's full names ___________________________________to participate in this research study.

Parent/ guardian's signature	(Date)
___________________________	____________________
Researcher's full name and surname	Date
_________________________________	_____________________

APPENDIX F: Parental Consent form (Sepedi)

Thobela motšeakarolo

Ke nna moithuti wa Masters yo a nyakago go dira mabapi le ditlhotlo/ditšhitišo tšeo bana ba basetsana ba kopanago le tšona ge ba leka go hwetša dithibela pelegi kliniking ya Byldrift, motseng wa Malatane, Seleteng sa Capricron, Profentsheng ya Limpopo.

Go ya ka molao (Children's Act 38 of 2005), tumelelo ya motswadi e ya nyakega/ hlokega go batšeakarolo kamoka ba ka tlase ga mengwaga e masome seswai

(18). Go feleletša seo, tumelelo ya gago gore ngwana wa gago a tšeakarolo e ya hlokega.

Go tšea karolo ke maithaopo ka gare ga nyakišišo e. Tseba gore maina a ngwana wa gago a tla šireletswa. Gape ngwana wa lena o na le tokelo ya emiša go tšea karolo nako le nako ge a se sa nyaka go tšwela pele. Sephetho se ka se somšwe kgahlanong le ngwana wa lena.

Ge o tšere sephetho sa gore ngwana wa gago a tšee karolo nyakišišong ye, ka kgopelo tlatsa le go saena karolo ye e latelago:

Nna motswadi/mohlokomediwangwana _____________________

(maina ka botlalo) ke dumelela ngwana waka go tšea karolo ka gare ga nyakišišo e

(Maina a ngwana kabotlalo) ___________________

(Saena leina la gago mo)__________________

Tšatšikgwedi ________________________

Maina a monyakišiši ka bobotlalo ________________

APPENDIX G: Turfloop research ethics committee clearance certificate

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

TURFLOOP RESEARCH ETHICS
COMMITTEE CLEARANCE CERTIFICATE

MEETING: 03 November 2016

PROJECT NUMBER: TREC/217/2016: PG

PROJECT:

Title: Challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic at Malatane Village, Capricorn District of Limpopo Province
Researchers: Ms KA Mothogoane
Supervisor: Prof SL Sithole
Co-Supervisor: N/A
School: Social Sciences
Degree: Masters in Sociology

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council. Registration Number: REC-0310111-031

Note:
i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX H: Department of Health approval letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650) Ref:4/2/2

Kagiso AM
University of Limpopo

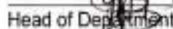
Greetings,

RE: Challenges faced by female teenagers in accessing contraceptives at Byldrift Clinic at Malatane Village, Capricorn District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
    - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
    - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
    - In the course of your study there should be no action that disrupts the services.
    - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    - The above approval is valid for a 3 year period.
    - If the proposal has been amended, a new approval should be sought from the Department of Health.
    - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.



Head of Department

16/03/2017.
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

The heartland of Southern Africa – *development is about people*

APPENDIX I: Interview transcripts

INTERVIEW GUIDE (ENGLISH)

Participant: 1

Section A: Personal information

1. Age: 15 years' old

2. Educational level: Grade 10

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

They are very rude people and they are also loudly. They will tell you that you are still young to chase after men.

3.1. How do you feel about the attitude of the healthcare providers?

Their attitude makes me feel bad and embarrassed, even if I want to ask for more explanation I do not ask because I feel uncomfortable with their rude behaviour. I could not ask further questions, because I felt uncomfortable with their rude behaviour.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

For the first time, I used the three- month injection, I stopped seeing my periods. I did not feel happy at all I then stopped using it and now I am using the two- month injection.

My other challenge is my mother; she always shouts at me when I tell her that I am going to the clinic because she knows that I am using contraceptives.

4.1. How does your understanding influence you to use contraceptives?

My understanding on contraceptive influence my positively to access and use contraceptives, even if we are not given enough counselling on the method of contraceptive we use.

4.2. List some contraceptives that you know.

I know a pill, two and three month injection and also a condom, I do not know if is classified as a contraceptive.

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

Privacy is my major experience because the clinic is so small.

5.1. The following questions must be answered by Yes or No**.**

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

I live at the new stands (Potlaka section) I have to walk a long distance, I sometimes take a local taxi to get to the clinic and If I do not have money I have to walk.

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? *Yes*

6.1. If so, what do you discuss regarding contraceptives?

We motivate each other to use contraceptives to prevent unwanted pregnancy because we are still at school.

6.2. How does this discussion influence you to access contraceptives?

I started using the two-month injection after a friend of mine told me that she is also using it, my friend went with me to the clinic to get, sharing things with her really influenced me to access contraceptives.

6.3. Do your friends use contraceptives?

Yes, my friend told me that she is using the two -month injection

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Not, but I have a suggestion, parents must encourage us and discuss contraceptives and sexuality with us and stop shouting at us for being sexually active, discussing this issues with us will help us a lot.

Participant: 2

Section A: Personal information

1. Age: 16 years' old

2. Educational level: Grade 10

Section B: The healthcare providers' attitude towards the provision of Contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

They are very rude, judgmental and aggressive people, I do not feel comfortable to share my health problems with them because I know that the whole community will know about my health problems. They also do this with older people, they tell other people about their patient's information.

3.1. How do you feel about the attitude of the healthcare providers?

I just feel ashamed, but I do not challenge them. Sometimes you may challenge them and find that you use words which may hurt them. Then next time you go there, they refuse to help you.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

I used pills before, it is easy to forget them, as they have to be taken daily and if you miss

One pill you are pregnant. I then stopped using the pill and decided to use the two- month injection and I am ok with it.

4.1 How does your understanding influence you to use contraceptives?

The little knowledge I have always encourage me to use contraceptives to avoid unwanted pregnancy.

4.2 List some contraceptives that you know.

I know depo, nustrate and pills. I also know sterilization, but I do not think is recommended for younger people like me. Because if they sterilize you are no longer going to fall pregnant in future.

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

The clinic is not attractive to us teenagers that is the reason why teenagers refer to clinic as for older people. The most people I found at the clinic are older people who come for treatment and nurse spend a lot of time with them than with us teenagers. The clinic does not have enough equipment like blood pressure machine.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

I am not happy about the clinic' accessibility because we wait for a long time to be helped.

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? *Yes*

6.1. If so, what do you discuss regarding contraceptives?

Contraceptives prevent unwanted pregnancy and other sexually transmitted disease if they are used properly.

6.2. How does this discussion influence you to access contraceptives?

It influences me negatively and positively, because sometimes we argue a lot and end up being confused. One day we asked each other about how contraceptives can affect fertility among teenagers because we use contraceptives at an early age and what will happen to use when we are older enough to have children. We could not answer each other because we do not know what to say about it.

6.3. Do your friends use contraceptives?

Yes, I know that she is using injection and I am also using it, I even saw her card, we go to the clinic for contraceptives on the same date.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

I think it is better for the Department of Health to provide schools with contraceptives, so that teenagers like me who are shy to visit the clinic can access them easily.

Participant: 3

Section A: Personal information

1. Age: 16 years' old

2. Educational level: Grade 11

Section B: The health care providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

Sometimes the healthcare providers are very angry, so they might treat you badly or tell you to come another time. They are always shouting they even shout older people.

3.1. How do you feel about the attitude of the healthcare providers?

They make me feel discourage, every time I look at my return date, I obviously know that they will not help me without shouting. I am used to their louder voice but sometimes I also get angry and shout at them.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

My challenge on contraceptive use is my partner, he often claims to be sick from the injection I am using. We sometimes fight because he even told me to stop using it.

4.1. How does your understanding influence you to use contraceptives?

My understanding influence me to use contraceptives because I do not want to fall pregnant at an early age.

4.2. List some contraceptives that you know.

I know pills that have to be taken daily, (two- month injection (nustrate) and three-

Month injection (depo).

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

I experience shortage of staff when accessing contraceptives because we wait for long time to get in.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

It is far, I walk 25 minutes to get to the clinic.

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? Yes

6.1. If so, what do you discuss regarding contraceptives?

We give each other advice and encouragement to continue using contraceptives so that we may not fall pregnant at an early age

6.2. How does this discussion influence you to access contraceptives?

I am strongly influenced to access contraceptives because of the discussions we have with friends and it really helps a lot, although sometimes we give each other incorrect information because of lack of knowledge on contraceptives.

6.3 Do your friends use contraceptives? *Yes.*

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Government must build a big clinic for teenagers and youth in our community.

Participant 4

Section A: Personal information

1. Age: 17 years' old

12. Educational level: Grade 11

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

We are being criticized by nurses for being sexually active and using contraceptives at an early age.

3.1. How do you feel about the attitude of the healthcare providers?

Their attitudes make me to feel sad every time I visited the clinic.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

I once experienced over bleeding when I was on the three- month injection, without being counselled I just decided to change to two -month injection without asking a nurse about how to manage the side effects. I also gained weight from using injection contraceptive.

4.1 How does your understanding influence you to use contraceptives?

My understanding on contraceptive also influence my attitude on the use of contraceptive, because I have negative attitude towards the use of condom and I do not use them.

4.2 List some contraceptives that you know.

The two and three- month injection, pills and condoms

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

Nurses cannot maintain confidentiality.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?	×	
B. Are you happy about the clinic's accessibility?	×	
C.Is the clinic far from your home?		×
D. Are you happy about the distance of the clinic from your home?	×	

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? *Yes*

6.1. If so, what do you discuss regarding contraceptives?

We discuss if contraceptive can cause infertility,

6.2. How does this discussion influence you to access contraceptives?

I access contraceptives, however when I think of what we discussed with friends I have doubt if I should continue using them or not

6.3 Do your friends use contraceptives?

My friend use contraceptives and I also use them, but we do not have more knowledge on contraceptives. Nurses do not give us enough counselling on the type of contraceptive we use.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Our nurses must be friendly to us so that we can freely discuss our health problems with them.

Participant: 5

Section A: Personal information

1. Age: 17 years' old

2. Educational level: Grade 11

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

They always shout at patients especially young people.

3.1. How do you feel about the attitude of the healthcare providers?

I feel very nervous to look at them when I am at the clinic.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

Seeing no periods for a couple of months is my major challenge on using contraceptives. We are Christians at home, my parents told me that using

contraceptives is against our Christianity, this affect me because I have to obey my parents and I also have to protect myself from unwanted pregnancy.

4.1. How does your understanding influence you to use contraceptives?

My understanding on contraceptive influence me make sure that I go to the clinic on the return date I was given by the nurse to access contraceptives.

4.2. List some contraceptives that you know

I know Depo, Nusertrate and pills

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

My privacy is not protected at the clinic by our nurses, they often tell other people they know about their clients of which is not good.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?	×	
B. Are you happy about the clinic's accessibility?	×	
C.Is the clinic far from your home?		×
D. Are you happy about the distance of the clinic from your home?	×	

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? Yes

6.1. If so, what do you discuss regarding contraceptives?

Being pregnant at early age is disturbing, we want to finish school and go to varsity, and contraceptives are the only means to help us achieve this.

6.2. How does this discussion influence you to access contraceptives?

It influences me positively to access contraceptives because I do not want to get pregnant.

6.3. Do your friends use contraceptives?

I do not know if they use them, others may feel embarrassed that if they tell they openly tell their friends the type of method they use, their friends will reject them and they will feel ashamed.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Nurses must stop shouting at us and be friendly.

Participant: 6

Section A: Personal information

1. Age: 17 years' old

2. Educational level: Grade 11

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

Ijooo, their attitude is so bad. They will tell you that they are on lunchtime when it is our turn to get in and when you tell them your problems they will tell other people. They do not respect our privacy

3.1. How do you feel about the attitude of the healthcare providers?

I feel very sad about their behaviour towards patients.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

Pills make me feel dizzy and damage my eggs. I might not have a baby of my own when am an adult. Lack of knowledge is also my challenge because some of information we get from friends are incorrect.

4.1. How does your understanding influence you to use contraceptives?

Whatever understanding I have and get from friends, I will always use contraceptives until I am older enough to fall pregnant.

4.2. List some contraceptives that you know

Condoms, Injection and pills. I am using the two- month injection

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

The clinic has shortage of equipment like blood pressure machine, chairs for patients to sit while waiting to be helped and weight scales.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? Yes

6.1. If so, what do you discuss regarding contraceptives?

We discuss and argue on how contraceptives works within the body and how it may affect future fertility among us as teenagers, we end up arguing because everyone thinks that their ideas are true while some of them are just incorrect information related to contraceptives.

6.2. How does this discussion influence you to access contraceptives?

The discussion influences me negatively sometimes to access contraceptives, because we give we give each other incorrect information and we think is true while it is not.

6.3. Do your friends use contraceptives?

I am not sure, because you might not know what other people do when we are not with them.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Nurses should change their attitude when attending clients.

Participant: 7

Section A: Personal information

1. Age: 19 years' old

2. Educational level: Grade 12

Section C: The health care providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

Their attitude is very good, because I feel comfortable to share any health problems with them, get advice and more clarification on the method I use.

3.1. How do you feel about the attitude of the healthcare providers?

I feel happy about their attitude and motivation on contraceptives counselling.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

My challenge is that since I started using the injection, I eat a lot.

4.1. How does your understanding influence you to use contraceptives?

My understanding influence me to access and use contraceptives correctly to avoid unwanted pregnancy.

4.2. List some contraceptives that you know

Injection, pills and condoms.

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

The clinic closes early, I find it difficult to miss classes in the morning so that I can go to the clinic, I normally go after school and sometimes the nurses will tell you that they are closing

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends?

Yes

6.1.If so, what do you discuss regarding contraceptives?

We discuss about the importance of using contraceptives as to prevent unwanted Pregnancy.

6.2. How does this discussion influence you to access contraceptives?

I am influenced positively by discussion of friends to access contraceptives because I do not want to fall pregnant at an early age.

6.3. Do your friends use contraceptives?

I know everything about my friends, but when coming to who uses pills and injection we are secretive, we do not tell each other what we use exactly to prevent unwanted pregnancy.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

The school should work with nurses in ensuring that all teenagers who are still schooling get counselling on contraceptives

Participant: 8

Section A: Personal information

1. Age: 18 years' old

2. Educational level: Grade 12

Section B: The health care providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

I am always treated well by our nurses when visiting the clinic for contraceptives they are friendly.

3.1. How do you feel about the attitude of the healthcare providers?

I am treated well by our nurses and I am satisfied with the services they provide to us

Teenagers.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

I had a challenge when I told my friends that I am using contraceptives, they laughed at me and I felt very bad.

4.1 How does your understanding influence you to use contraceptives?

Contraceptives prevent unwanted pregnancy; I am positively influenced to access them.

4.2 List some contraceptives that you know *Injection and pills.*

Section D: The accessibility of the clinic that provides contraceptives to the teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

Sometimes when I go to the clinic, I wait for hours to be helped and this affect me badly as I am still at school. I think that more staff members need to be employed to deal with young people during weekends as most of us are free.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends?

Yes, I once tried to tell my friends about contraceptives, they could not listen to me.

6.1.If so, what do you discuss regarding contraceptives?

Not response

6.2. How does this discussion influence you to access contraceptives?

6.3. Do your friends use contraceptives?

I do not know if my friends use contraceptives. I am not sure if they use them because they one laughed at me one day when I told them about contraceptives.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Parents and nurses must educate teenagers about contraceptives so that they can access them at the clinic.

Participant: 9

Section A: Personal information

1. Age: 19 years' old

2. Educational level: Grade 12

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

They are friendly and approachable

3.1. How do you feel about the attitude of the healthcare providers?

I feel motivated and happy about the services they provide to us as young people.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

I have never experience unpleasant side effects since I used the two- month injection. I am satisfied with it.

4.1 How does your understanding influence you to use contraceptives?

"I do not have enough knowledge on contraceptives, because of my little knowledge I am Motivated to go to the clinic after two months to access contraceptives so that nurses can give me more information.

4.2 List some contraceptives that you know *Pills and injection.*

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

The clinic is not big enough to assist the whole community and the nearest communitie.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? Yes

6.1. If so, what do you discuss regarding contraceptives?

We give each other advice and encouragement to continue using contraceptives so that we may not fall pregnant at an early age

6.2. How does this discussion influence you to access contraceptives?

It sometimes influences me negatively to access contraceptives because we do not have enough knowledge on contraceptives.

6.3. Do your friends use contraceptives?

Yes, some of my friends are using pills

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

The school must also take action to ensure that we get education about contraceptives.

Participant: 10

Section A: Personal information

1. Age: 18 years' old

2. Educational level: Grade 12

Section B: The healthcare providers' attitude towards the provision of contraceptives

3. Can you please describe the attitude of health care providers/ nurses during your clinic visits?

They are so understanding when you explain yourself and your health needs to them openly.

31. How do you feel about the attitude of the healthcare providers?

I feel happy, because they educate us and motivate us to make informed choices regarding our health.

Section C: Teenager's challenges on the use of contraceptives

4. Can you please tell me about the challenges you experience when using contraceptives?

Since I used contraceptives I have gained weight, it does not make me feel happy.

4.1 How does your understanding influence you to use contraceptives?

I already have two children, whether I experience unpleasant side effects that make me feel uncomfortable I will always use contraceptives.

4.2 List some contraceptives that you know *Pills, injection and condoms.*

Section D: The accessibility of the clinic that provides contraceptives to the female teenagers

5. Can you please share your experiences at the clinic when accessing contraceptives?

I experience long queues because of shortage of staff.

5.1. The following questions must be answered by Yes or No.

Clinic accessibility	Yes	No
A. Is the clinic accessible?		×
B. Are you happy about the clinic's accessibility?		×
C.Is the clinic far from your home?	×	
D. Are you happy about the distance of the clinic from your home?		×

It is far, you have to go early so that you can easily get help because is the only clinic we have here.

Section E: The role of peer pressure in accessing contraceptives

6. Do you ever discuss contraceptives with your friends? Yes

6.1. If so, what do you discuss regarding contraceptives?

We discuss a lot of things related to sexuality, contraception and problems we face as youth, but we end up arguing with each other because of lack of knowledge on contraceptives.

6.2. How does this discussion influence you to access contraceptives?

My friends told me that contraceptives are meant for older people. And I took their advice and now see, I am the mother of two children before the age of 21 years old. I learned my lesson after my second baby because this did not make my parents happy at all while they cannot discuss sexuality and contraception with me.

6.3. Do your friends use contraceptives?

I am not sure if my friends use contraceptives.

7. Is there anything that you would like to say about the challenges faced by female teenagers in accessing contraceptives?

Yes, our parent does not discuss contraception with us; if they discuss this thing with us we will access contraceptives and use them to avoid unwanted pregnancy.

THANK YOU FOR YOUR PARTICIPATION.