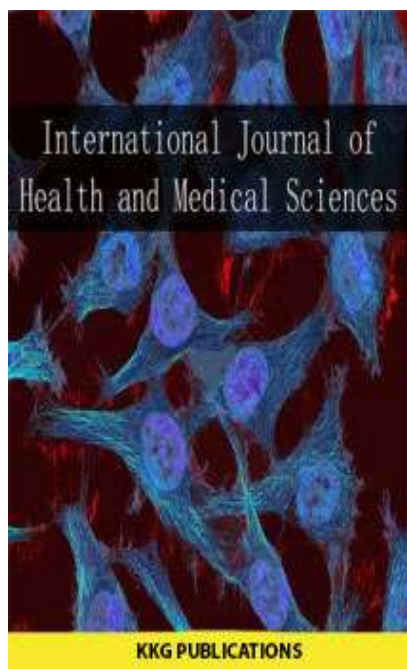


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EVALUATION OF CLINICS ON THE PROVISION OF YOUTH FRIENDLY SERVICES IN THE ETHEKWINI METRO OF KWAZULU NATAL

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Abstract. Many barriers prevent young people from accessing health services that are pertinent and friendly to them. The objective was to determine if the selected clinics provided youth-friendly services and if barriers existed at these clinics for young people to access health care. A descriptive cross-sectional study using anonymous questionnaires was conducted amongst young people visiting two primary health care clinics and one community healthcare center in the eThekweni Metro of KwaZulu Natal. Of the 152 participants, two-thirds were females, the majority being between 18-24 years. Over 42% (n=64) stated that the waiting periods were too long ($p < 0.05$), while fifty-three respondents (35%) complained of the short consultation times. Forty-two percent felt that the staff was judgmental towards them when they sought reproductive health services, while (15%) felt discriminated against. Twenty-one percent felt their privacy was not honored. A third of the participants stated that no awareness programs/group discussions existed within the clinic to inform them about HIV/AIDS, STI, though (73%) responded that educational materials on HIV are available. Only (8%) were treated by a doctor, but (87%) preferred treatment by a doctor and to be seen by the same person every time they came to the clinic. A small percentage of (16%) rated the clinic services as excellent. The study has highlighted characteristics that contribute to clinics not offering youth-friendly services.

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INTRODUCTION

In South Africa young people comprise 40% of the population countrywide, with the majority being in developing areas [1]. Many significant obstacles exist that prevent young people from obtaining information and services related to health, such as laws and policies, which may prevent young people from accessing reproductive health services, being embarrassed at being seen at a clinic, and social stigma [2], [3], [4]. Often clinics are designed for adults, thus making younger people uncomfortable when receiving reproductive health services, especially unmarried young people [5].

In addition to this, negative community attitudes or perceptions towards unmarried young people accessing reproductive services bias by service providers, social stigma, and a concern that their privacy and confidentiality will not be respected, could deter young people from accessing health services [5]-[3]. It is important to provide youth friendly health care services and to remove any obstacles that prevent access. Youth friendly service delivery is about providing services based on a comprehensive understanding of what young people in that particular society or community want, rather than being based only on what providers believe they need [3]. 'Youth friendly health services need to be 'accessible', 'equitable', 'acceptable', 'appropriate', 'comprehensive', 'effective' and efficient [6].

In a study done in South Africa the participants highlighted the need for adolescent sexual and reproductive health services to be revised in order to make them more youth-friendly, thus preventing stigmatization generated by community healthcare workers [7]. Other factors such as providers who are not trained to work 'competently', 'sensitively' and 'respectfully' and are judgmental of young people, and services that are not confidential, or private, also pose barriers to young people using these health care centers.

In many societies, adults have difficulty accepting teen sexual development and young people wanting to access health care facilities may be embarrassed and may even refuse to return to the facility if the staff asks personal questions loudly enough to be overheard by others [8].

In South Africa within the context of re engineering Primary Health Care the priority is to establish youth friendly services in all PHC facilities by 2014, therefore it is important to evaluate whether clinics are providing such youth friendly services [9].

Currently, a limited number of studies have been done in KwaZulu Natal (KZN) to evaluate whether clinics provide youth friendly services.

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Aim and Objectives

The study was conducted to evaluate whether the clinics provided youth friendly health care services and to determine what barriers existed that prevented young people from accessing health care services in the local clinics.

The specific objectives were to determine the perceptions of young people towards staff attitudes, the extent of provision of health care information, their preferred choice of health care professionals, the waiting periods experienced at the clinic, if privacy and confidentiality were honored, the availability of youth specific reproductive health services and their perceptions of the infrastructure, services and convenience of operational times.

Ethics Approval

Gatekeeper's permission to conduct the study was obtained from the Department of Health and Ethics approval was obtained from the University, (SHSEC028/12) before the start of the study. The study was explained to the participants, and those willing to participate signed a consent or assent form. Confidentiality and anonymity was ensured by coding all questionnaires.

METHODS

Design, Setting and Study Population

A descriptive cross-sectional study was conducted, in two primary health care clinics and a community health care centre in the eThekweni Metro of Kwa Zulu Natal. These facilities provide a comprehensive health package which included reproductive health. The PHC clinics and community health centre were chosen based on the accessibility to the researchers and the clinics' location ie there was one PHC clinic from an urban area, one from a suburban area and the community health centre from a township area. The facilities were also chosen to ensure that there was racial mix of participants. Permission was obtained from the Department of Health to conduct the study in these facilities. Even though the facilities are busy the ratio of young people to older patients are disproportionate with the one facility recording forty young people 10-24 years per week, and in another facility, it was stated that (40%) comprise of young people, but the total number attending was not known.

The study population included all young people between the ages of 10-24 years that visited the clinic between the opening and closing times (8am -4pm). There was no predetermined sample size as all young people fitting the criteria were to be administered the questionnaire if consent was obtained.

Instrument

An anonymous closed ended questionnaire, available in English and IsiZulu, was administered. The questionnaire had both closed and open ended questions. It was divided into three

different sections containing variables on demographics and the objectives and a few open ended questions which was optional. The questionnaires were coded to avoid duplication. The codes corresponded to the date of birth of the youth and their initials. Variables in the questionnaire included: barriers to obtaining sexual health care, perceptions regarding: the attitudes of the clinic staff, privacy and confidentiality, waiting periods as determined by the respondents, clinic operational hours, and the provision of health care information. On completion, the questionnaires were pilot tested with fifteen university students and subsequently amended.

Data Collection, Capture and Analysis

The questionnaires were accompanied by a consent form or an assent form together with an information sheet, which briefly described the study. The data was collected over two weeks. One week was chosen during normal schooling hours as defined by the KZN school term calendar, whilst the second week was chosen during the school holiday. After the data was collected and cleaned, the codes on the questionnaire obliterated to ensure there was anonymity before capturing the data onto the computer. The data was analyzed using SPSS version [9]. Chi-square and frequencies were utilized in the statistical analysis. A *p* value of (< 0.05) indicated significance.

Possible responses to questionnaires were 'Yes', 'No' and 'NA'. Yes in the questionnaire was credited with a binary number of 1 whereas No and NA were credited with binary numbers 0 and 2 respectively, forming the bases of the analysis.

RESULTS

A total of 152 youth responded by completing the questionnaires.

Demographics

The majority of the respondents were females 64% (n = 97). The overall mean age of the respondents visiting the clinics was 20.26 years (SD of 3.02) (n=152).

Breakdown of respondents into age groups 10-18 had shown that of the total of 40 young people that visited the clinic and participated in the study, all were between the ages of 12-18 and none in the age group 10-11.

Of the 40 respondents, 9 (22.5%) visited during term time and 31(77.5%) visited during the school holidays.

The majority of the respondents (112) were in the age group above 18 that visited the clinic and participated in the study.

Over (57%) of the participants visited the clinic during the school holidays.

Staff Attitudes

Table 1 shows the percentages of young people who felt discriminated against and judged across the clinics with greater prevalence in Clinic A and Clinic C.

TABLE 1
PERCEPTIONS OF RESPONDENTS ATTENDING THE FACILITIES TOWARDS STAFF ATTITUDES

	No. Seen at Clinic	Discriminated Against		Judged	
		N	%	N	%
Clinic A	57	11	19.3	23	40.4
Clinic B	38	2	5.3	15	39.5
Clinic C	57	10	17.5	26	45.6
Overall	152	23	15.1	64	42.1

percentages

n=152, $p = 0.373$ (Discriminated), $p = 0.397$ (Judged)

Fourteen respondents (9%) stated that the staff were both judgmental towards them and that they felt discriminated against. The majority of the respondents felt that the staff were efficiently trained to assist them with their problems, with the percentage

being higher in clinic B.

The majority of the respondents who felt judged and/or discriminated against was female respondents (Table 2).

TABLE 2
GENDER DISTRIBUTION ON PERCEPTIONS TOWARDS STAFF ATTITUDES

		Discriminated Against		Judged	
		N	%	N	%
Male	55	4	7.3	15	27.3
Female	97	19	19.6	49	50.5
Overall Percentage	152	23	15.1	64	42.1

n= 152, $p<0.05$ (Judged), $p<0.05$ (Discriminated)

Waiting Period. (n=72)

This was an open ended question and was labeled optional, hence all participants did not answer this question. Of the respondents that answered this question, a significant finding ($p<0.05$) was that over (88%) of the respondents felt that the waiting period as determined by themselves was long. The responses varied from 2-4 hours as being long waiting time.

Adequate Time with Health Care Provider. (n=150)

Across the clinics, (35.3%) of the respondents felt that they did not have adequate time with health care provider. Thirty seven percent of the participants (n=138) who were treated by the nurse felt that they did not have adequate time during the consultation whilst over (83%) of participants (n=12) treated by the doctor felt they had adequate time with provider. This

question was related to patients' perceptions, hence no predetermined definition was provided.

Comparison of Clinics A, B and C

Table 5 shows the comparison of clinics A, B and C with regard to selected variables. These possible barriers to accessing health care seem to be consistent across the clinics, however lack of privacy and confidentiality was more prevalent in clinic A, whereas inconvenient operating hours, poor staff attitude and unavailability of educational material were more prevalent in clinic C. Over a third of the respondents (51) reported that there were no group discussions and/or awareness programs available to inform them about HIV/AIDS, STI etc. Forty three (28.3%) of the participants felt that the health care system in the country was not good, with Clinic C recording a significantly higher percentage of respondents who felt this way.

TABLE 3
RESPONDENTS PERCEPTIONS ON STAFF TRAINING

Clinic	Staff efficiently trained			Total
	No	Yes	N/A	
A	8	48	1	57
B	(14%) 1	(84.2%) 36	(1.8%) 1	38
C	(2.6%) 12	(94.7%) 43	(2.6%) 2	57
Total	(21.1%) 21	(75.4%) 127	(3.5%) 4	152
	(13.8%)	(83.6%)	(2.6%)	

$n=152, p = 0.138$

Preferred Health Care Professional

A majority of respondents preferred a doctor over a nurse for their consultations. Of the (92%) respondents treated by the nurse,

(86%) to be treated by a doctor and of the (8%) that were treated by the doctor only 1 respondent preferred to be treated by a nurse (Table 4).

TABLE 4
HEALTHCARE PROFESSIONALS PREFERRED BY RESPONDENTS

Respondent's Preference		Number (%) treated by		Total
		Nurse	Doctor	
Respondent's Preference	Nurse	19(14%)	1(8%)	20(13%)
	Doctor	119(86%)	11(92%)	130(87%)
	Total	138(92%)	12(8%)	150(100%)

$n=150, p = 0.59$

TABLE 5
COMPARISON OF CLINIC A, B AND C

Variables	Clinic A – 57		Clinic B – 38		Clinic C – 57	
	N	%	N	%	N	%
Lack of Privacy and confidentiality	16	28.0	9	23.7	14	24.6
Inconvenient operating hours	15	26.3	15	39.5	27	47.4
Poor Staff Attitude	23	40.4	15	39.5	26	45.6
Unavailability of Educational Material	12	21.1	4	10.5	12	21.1
Poor Health Care System	11	19.3	11	28.9	21	36.8

$n=152, p = 0.817$ (Privacy and confidentiality), $p = 0.063$ (Inconvenient operating hours), $p = 0.397$ (Poor Staff Attitude), $p = 0.211$ (Unavailability of Educational Material), $p = 0.025$ (Poor Health Care System)

DISCUSSION

Barriers do exist for young people to access youth friendly healthcare services in the eThekweni region.

The finding that more young women than young men attended the clinics, is consistent with another study where it was found that only eight percent were males that visited the nurse for health services, whilst the young people that came for reproductive health services were females [5] with the males seeking services from other sources [10]. It was evident that a greater percentage of the school going young people visited the clinics during the school holidays than during school term. This could be due to the times of opening and closing of the clinics, which may be inconvenient during school term, by the early closure of the clinics in the afternoon. Inconvenient operational hours are a barrier to accessing health services, generally as evidenced by other studies. A study done in the Western Province found that clinic times were inconvenient for school going children, hence it was recommended that operational hours are more flexible [11]. Whilst in the other age group, a total of over (25%) of the respondents in two of the clinics and over (47%) in the third clinic stated inconvenient operating hours. In one study youth visited the health centres, but found them closed and added that the hours were not convenient for them [10]. A study done in Burkina Faso, Uganda, Malawi and Ghana found that adolescents preferred public clinics, but with a strong emphasis on accessibility [3]. An article on ways to improve access to health care by young people recommended that special hours should be set aside for young people to visit the clinics after school, evenings and Saturdays [12].

A significant finding was the negative attitudes of the health care workers where respondents felt judged and discriminated against. For young people considering sexual activity or are already sexually active, health care workers play a vital role in the provision of contraceptives and counseling, thereby having a significant impact on young peoples' sexual decision making and behavior [13]. Youth friendly staff is the single most important criteria for setting up youth friendly health services [14] and one of the major barriers that adolescents say they face is the negative attitude of providers [15]. The most important qualities in services for young people are friendly staff who are not judgmental [10]. The study conducted in Ghana, Malawi, Uganda and Burkina Faso found the fear of being chastised, stigmatized, embarrassed or punished for sexual involvement a great barrier to accessing health services [3]-[4] whilst another study demonstrated negative attitudes toward young unmarried women who are sexually active [15]. In Burkina Faso a study was done which showed that when young people accessed information on reproductive health services, it was supported by adults, however, these adults were less supportive if the young people accessed the actual services [2]. The negative attitude of staff could be related to a lack of counseling skills, confidence and training in dealing with young people [14].

Having specially trained staff to work competently with young people is essential for establishing youth friendly services [14].

The majority of the respondents were treated by a nurse, however, when asked for preference, (86%) stated that they preferred to be treated by a doctor. This finding is consistent with another study where patients preferred the doctor for medical aspects of care, whereas for educational and routine aspects of care few clients preferred the nurse [16] and [17].

With respect to the waiting time, only 72 responses were received to this optional question, and of these responses 64 (over 88%), stated that the waiting periods were too long ($p < 0.05$). The responses varied from 2-4 hours as being a long waiting period, whilst some also complained of short consultation times. Long waiting periods and the short consultation times have been quoted in other studies as a barrier to young people accessing health services [18]-[9]-[3]. The possible reasons in this study extrapolated from other studies could be due to insufficient staff, lack of interest of the healthcare provider in assisting the youth, and lack of clinics in the area resulting in one clinic servicing a large population [18].

Clinic C appeared to be performing the poorest with respect to waiting periods, staff attitudes, and inconvenient operating hours; hence it was no surprise to find that almost (50%) rated the health service in this clinic as poor, in comparison to clinic A and B where about (25%) rated the services poor. Clinic C is situated in a central business district area, which could be contributing to the inconvenient operating times and longer waiting periods as staff have to travel to and from the clinic, whereas clinics A and B are situated in residential areas, a possible walking distance for both patients and staff. A study done in India, identified five reasons why women did not use the public care facilities, they ranged from 'no nearby facility,' 'facility timing is inconvenient', 'health personnel are absent', 'waiting time is too long,' and 'poor quality of care [18]. The findings of this study can be paralleled to the previous study cited.

Various studies have reported that the lack of resources to provide private counseling areas as well as poor infrastructure have contributed to the lack of privacy and confidentiality [3]-[5]-[12]. Privacy and confidentiality should be ensured during counseling sessions and examinations so that young people are comfortable with accessing health services [5]. A study done in India indicated that young people often face the problem of privacy and confidentiality, thereby restricting them from seeking services related to reproductive health [14] hence posing a barrier to accessing health care. Over (70%) stated that educational material was available, however a third of the participants stated that no awareness programs/group discussions existed within the clinic to inform them about HIV/AIDS as well as STIs. Many adolescents do not have adequate information on sexual reproductive health services [4]. Poor knowledge and lack of awareness about sexual reproductive services are the main

underlying factors for adolescents not using health services [5]. Awareness programmes are essential in assisting the youth in making informed decisions, thus impacting positively on their health. A study done in Fiji showed that amongst the reasons quoted for lack of utilization of the clinic was the lack of awareness as well as misconceptions regarding services, this could be due to lack of resources to provide youth with educational material to guide them in making informed decisions regarding their health [18].

LIMITATIONS OF THE STUDY

Participants under the age of 18 were not accompanied by their parent/guardian hence were unable to obtain consent resulting in a poor participant's response in that age group. Secondly adolescents misinterpreted the concept of having to sign a consent form which resulted in poor participation. Thirdly the resulting small sample size limits the generalisability of the data to all young people.

CONCLUSION

It can be concluded that certain barriers to accessing health services by young people as quoted in other studies does exist at these local clinics, and that youth do share some preference in terms of their treatment.

RECOMMENDATIONS

A further study should be done with a larger sample size and more sites to confirm the findings of this study.

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