J Community Health
DOI 10.1007/s10900-012-9595-3

ORIGINAL PAPER

Interpersonal Relations Between Health Care Workers and Young Clients: Barriers to Accessing Sexual and Reproductive Health Care

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Abstract Interpersonal relations between health care providers and young clients have long being cited as an important element for improving client up take of services, satisfaction and overall health outcomes. In an era of HIV and AIDS this forms a critical determinant to young people accessing sexual and reproductive health care. This study explores to what extent interpersonal relations form a barrier to young peoples access to and satisfaction of health services. The study draws on data from 200 client exit interviews and four in-depth interviews conducted with university students and university health care staff in Kwazulu-Natal, South Africa. While young people are aware of the importance of utilising STI, HIV and family planning services they experienced barriers in their relationship with providers. This served as a deterrent to their use of the health facility. Adequate training in interpersonal relations for youth-friendly service provision is essential in helping overcome communication problems and enabling providers to interact with young clients at a more personal level.

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Published online: 11 July 2012

Keywords Young people · Health care providers · Interpersonal relations · Sexual and reproductive health services

Introduction

The present generation of youth is among the largest-ever in history, with more than 1.5 billion people, under the age of twenty five years [1]. Over the decades, changing social contexts have contributed to the increasing vulnerability of young people to poor sexual health outcomes including early pregnancy, sexually transmitted infections and HIV [2]. Despite this, even in an era of HIV and AIDS, the major health problems experienced by young people are largely preventable. For a long time, health services for the youth have presented a challenge to health officials in developing country settings. Traditionally, sexual and reproductive health services were offered as a component of maternal and child health services. This served to create barriers to access for both men and youth. Because of the past stigma attached to youth sexuality, access to sexual health services was also restricted for fear of promoting promiscuity among this age group. In many parts of the world, where health services were available, restrictive laws and policies often prevented access to young people [3]. With this emphasis, health care facilities were not perceived to be welcoming to young men and women [4].

Recently, there has been a growing call for the development of youth-friendly services, that is, services which are designed to make use of existing sexual and reproductive health services more acceptable to young people, worldwide [3, 5]. However even though health clinics have expanded to include a broader range of services pertaining to the youth, studies reveal that these services continue to

be largely avoided by them [3]. The nature of the interactions between health workers and clients have been highlighted as one of the key factors that discourage young people from seeking methods of contraception or health care advice [6, 7]. Studies suggest that young people are reluctant to visit health services due to the fear that health workers will scold, be judgmental or ask difficult questions [8]. In addition, the fear of being stigmatized, chastised, or punished for their sexual involvement results in low acceptability of services among youth [2]. Consequently, youth in this context continue to be disproportionately burdened by threats to their sexual and reproductive health [2, 9]. Health care services offer an important entry point to provide young service users with information, counselling and services [6, 10]. However the provision of youth-friendly services to young people is a relatively recent practice in developing countries. Much research is therefore required on the barriers young people face in accessing services particularly those that are vulnerable to specific sexual and reproductive health problems. Interpersonal relations have been shown to strongly influence clients: confidence in their own choices and ability; satisfaction with services; and the possibility of a return visit [11]. The aim of this study is to determine to what extent interpersonal relations form a barrier to young peoples access to and satisfaction of health services. This will be achieved by exploring the experiences and perspectives of service providers and young men and women at a university health care facility in the province of KwaZulu-Natal, South Africa. According to survey estimates, this province has the highest HIV prevalence among young people in South Africa at 15 % [12]. The need for sexual and reproductive health services for young people is therefore strong in this setting.

Context

KwaZulu-Natal is located on the eastern seaboard of the South African coast. According to 2010 mid-year population estimates by province, with approximately 10.6 million people, KwaZulu-Natal has the second largest population in South Africa [13]. HIV prevalence is among the highest in South Africa at 16 % [12]. Young women in particular continue to be disproportionately affected. According to the KwaZulu-Natal Department of Health (2010), approximately 22 % of 15–24 year old women attending state antenatal clinics in the province were HIV positive [14]. The burden of curable STIs is also severe with an incidence rate of 78 per thousand of the population in KwaZulu-Natal [15]. This study focused on young people in the province of KwaZulu-Natal. The sample was restricted to people attending the selected university in KwaZulu-Natal and utilizing the selected health facility. The university sampled has a total student population of approximately 42 000. Student distribution by gender is 56 % female and 44 % male. The study uses a definition of young people to include those aged between 18 and 24 years, since this includes the age range of students and places them in a group at high risk of exposure to HIV, STIs, and unwanted pregnancies [16].

Methods

Information for this study was obtained using qualitative data collection methods including in-depth interviews with staff and exit interviews with young clients. A range of methods was utilized to check consistency of information and also provide a detailed understanding of health service provision from the perspective of clients and providers. In order to gain access to the heath facility, permission was obtained from Durban Health Services.

Four in-depth interviews were held with clinic management and senior clinic staff who were purposively selected. These explored the health providers' experiences at the health facility in addressing the sexual and reproductive health needs of young people. An in-depth interview stakeholder guide was used to guide the interview. Topics explored with providers included: their training and education; information about the health services available to young people; and opinions about how health services are responding to the sexual and reproductive needs of young people. The interviews also generated information on the barriers providers' experienced in the provision of services.

Exit interviews were held with clients between the ages of 18 and 24 years. In total, there were 200 exit interviews conducted at the selected health care facility. This sample size, selected through non-probability purposive sampling, was deemed sufficient for descriptive purposes. Clients were sampled on different days of the week as well as at different times of the day. All clients were approached after they had completed their consultation with the provider and, after being briefed about the purpose of the research, asked if they would be willing to participate in the study. Each interview lasted approximately twenty minutes. Very few refusals were encountered with an overall participation rate of 97 %. The questions asked of clients attending the clinic for family planning and STI services covered clients background characteristics; satisfaction with services; and knowledge, attitudes and behaviours regarding sexual and reproductive health. Family planning clients were asked additional questions regarding the family planning services received.

Both the focus group discussions and in-depth interviews were tape recorded with the permission of the

participants. The researcher assured the respondents that confidentiality, and anonymity would be strictly observed. Ethical approval for the study was obtained from the University of KwaZulu-Natal, Durban, South Africa.

Analysis

The qualitative data obtained from transcribed in-depth interviews and open ended questions in the survey was analysed using thematic analysis. Since the interviews were recorded, a substantial amount of time was spent translating the tapes, reading through the transcripts and categorising the data according to particular themes or recurrent ideas. The themes that emerged from the interviews and open ended questions with respondents were then linked together to form a comprehensive picture of their collective experience.

Results

Providers felt that the interpersonal relationships between staff and young clients were influenced by many factors. One factor that was mentioned by providers as a barrier to young clients was the negative attitudes of staff. Some staff were judgemental about young people utilising sexual and reproductive health services consequently they were impatient and rude with clients. Health workers cited that staff attitudes acted as a deterrent to young people seeking sexual and reproductive services.

> The staff do have increased knowledge of youth-friendly services because we send them to the courses on how to deal with students. It is just that you can give a person education and knowledge but it is difficult to change a person's attitude (Male, age 55, nurse)

Another key concern mentioned by the majority of providers was limited contact time with patients. Staff at the health facility encountered heavy patient loads of up to 100 clients a day. Providers emphasized that due to the lack of staff limited time was spent in consultation with clients. Most providers stated that they dealt as quickly as possible with patients needs under the pressure of long queues. This also presented missed opportunities to provide information and counselling on sexual and reproductive health and services to young people. Providers admitted that they dealt mainly with the curative aspects of services due to the limited consultation time and were not always able to provide young people with enough information or counselling. This is important since providers felt that information and education were key elements in encouraging young users' to utilise the health services as well as in preventing ill-health among young people. For this reason all providers expressed that they felt overworked and frustrated.

> We tend to focus mainly on curative aspects because we are short staffed and when the clinic is full all you are doing is pushing the queue and not giving enough information to the students to prevent the sexually transmitted diseases (Male, age 55, nurse)

> I think institutions are understaffed… staff do not have the time to sit and counsel individual clients and spend a lot of time with them… staff are overworked, they are frustrated (Female, age 56, nurse)

Health care workers also cited communication and cultural factors as barriers to service provision. Health care staff felt that young clients do not always speak openly to providers about health problems due to a variety of factors such as the age and gender of the provider. For instance, providers felt that female clients were more likely to discuss sexual and reproductive health issues with female providers rather than male providers because they would feel more comfortable. Another common belief among service providers was that clients perceive them as mother or father figures since they are much older. Culturally, they may therefore be afraid to discuss sexual and reproductive issues since it could be perceived as disrespectful. For this reason they felt that young people did not always disclose their health problems. This is illustrated in the following quotations:

> The age difference is a barrier. It takes time for a student to get used to me as an adult, to open up to me; they see us as mother and father figures (Male, age 55, nurse)

> I am not saying that we do not interact but there is that fear. They look at us as parents so that becomes a barrier (Female, age 56, nurse)

To determine the nature of the interpersonal relationship between clients and providers, clients were asked to rate their interactions with providers during their time spent at the clinic by agreeing or disagreeing with specific statements. Table 1 shows that with the majority of clients who utilised the health services privacy received the highest number of positive responses at 85 %. A large majority of respondents who attended the health facility also perceived providers as helpful and friendly and felt that they were treated in a respectful manner. Though in general, clients expressed positive feelings towards providers the results also show that a significant number of students cited barriers in interpersonal relations when asked about their dissatisfaction with services. Some of the respondents

Table 1 Number (n) and percentage (%) of clients who agree with specific statements related to health service provision

Statement	n	%
Staff at the clinic were friendly	148	74
Staff made every effort to ensure my privacy	171	85
Staff gave me the opportunity to ask questions about important issues	130	65
Staff were helpful in providing in providing information	139	69
There was sufficient time for me to ask questions	126	63
All my expectations of service delivery were met	131	65

N = 200

stated that they felt judged and disrespected because staff were rude and unfriendly. This is illustrated in the following responses:

> The staff are too tense and not friendly enough. They do not give you advice; it is more like they judge you (Female, age 18, client)

> The staff are too rigid. They should learn to be more friendly and engage with patients (Male, age 19, client)

> Some nurses judge you and speak to us without respect. Some of them are rude and impatient with us (Female, age 19, client)

As suggested by staff, limited consultation time was an issue at the health facility. Only 63 % of students felt that there was sufficient time to ask questions while 65 % felt that they were afforded the opportunity to ask questions about issues they thought were important. In this regard many students also reported not feeling comfortable enough to open up to providers or ask for information because they were unfriendly and intimidating, as reflected in the responses of female students:

> The nurses are terrifying and not friendly so it makes us scared to fully give them information about our illness (Female, age 18, client)

> Nurses are intimidating and not easy to approach. My first time was a horrible experience I could not speak up (Female, age 20, client)

A sizeable minority (30 %) of respondents also felt that they were not provided with all the information they wanted during the consultation. Some respondents reported experiencing difficulties in communicating with providers. For instance, young people felt that the staff did not always explain what was wrong with them or why they were being given certain medication. This is illustrated in the following quotation by a female client:

> They do not communicate with the patient or explain fully what is wrong with him or her. They do not explain why they administer the medication they do (Female, age 20, client)

Another barrier to service provision mentioned by the majority of health providers was the accessibility and availability of the health services. Providers felt that young people may be prevented or discouraged from using the health services because of logistical constraints such as inconvenient hours. In this regard 46 % of clients did not find the opening and closing hours of the clinic convenient. Since the clinic is open only between certain times in the day, young people who are attending lectures or have transport constraints, are not able to access the services.

> With the clinic operation times we close between half eleven and two. Sometimes you find that for a student that is the only time that they are free to use the clinic but cannot because it is not accessible at that time so it becomes a barrier to the student (Male, age 55, nurse)

> I think if they are at university they do not have the time because these services are provided during the day at certain times and if they are in lectures it is probably a time constraint (Female, age 49, nurse)

Effective provision of comprehensive services for youth was also hindered by a host of logistical problems. Common constraints expressed by staff included shortage of human resources, lack of infrastructure and high-case loads. This leads to longer waiting times and loss of clients. Consequently the process of care and support is affected and forms a barrier to young people receiving the quality of care they need.

> With the shortage of staff, clients have to sit here for longer times so some leave before they are seen (Male, age 55, nurse)

Agreeing with the perspectives of the providers, some of the common complaints by clients included the long queues and excessive waiting times that they experienced at the clinic facility. This served as a deterrent to young people utilising the services. Many clients reported having to make appointments to see a doctor on a later date or being referred to other facilities for services as reflected in the statements below:

> The staff is short, so it is always full and sometimes you go back without seeing the nurses (Female, age 19, client)

> I have to sometimes make an appointment to come back later to see a doctor (Male, age 18, client)

Discussion and Recommendations

As indicated in previous studies from around the world, the results show that young people are often unwilling to obtain much needed health services due to the nature of interactions between health care workers and clients [3, 8]. Though in general, respondents described providers as friendly and helpful, many cited problems with interpersonal relations and communication during their visit. In addition, some clients complained that they did not have the opportunity to raise concerns with providers. These findings agree with other research conducted in public health services in the context of South Africa which found that interactions between providers and clients were limited to brief instructions and cursory explanations [17]. One of the key reasons discerned for the relative failure of heath providers at the university health facility to provide clients with much needed information, was a shortage of staff. Staff at the health facility encountered heavy patient loads of up to 100 clients a day. Under the pressure of long queues providers admitted to dealing as quickly as possible with clients immediate needs. Consequently clients received limited consultation time with the providers. These findings are consistent with studies conducted at other health facilities in South Africa which show that due to a shortage of staff providers spend only a small percentage of their time in consultation with clients [18]. Providing young clients with information about contraceptives methods and services is essential in enabling clients to make their own choices, ensuring utilization of services and preventing method discontinuation due to poor understanding of side effects [19]. One possible strategy to increase the time spent in consultation is to lengthen the visiting hours of the health facility. Since the health facility was opened only between certain hours this resulted in an overload of clients between these times reducing the amount of contact time providers had with individual clients.

Cultural factors also emerged as barriers to service provision. Providers felt that depending on the age and gender of the provider clients were less likely to discuss sexual and reproductive health issues for fear of being disrespectful. In this regard studies in South Africa found that providers were particularly antagonistic towards unmarried young women seeking obstetric care because they felt that they were immoral for getting pregnant [7]. The World Health Organisation has found that ensuring providers are trained in youth reproductive health issues and communication, are respectful, have a non-judgmental attitude, and maintain confidentiality and privacy can increase young people's use of services [5]. Numerous studies on the issues similarly conclude that health workers should be trained to address issues related to sexual and reproductive health in an empathetic manner particularly when interacting with young people [3, 5, 8]. From the in-depth interviews it was highlighted that staff at the university health facility were trained on youth-friendly health service provision. In addition staff received refresher courses on a yearly basis. However, the ability to successfully translate this knowledge into practice was lacking. Given that the interpersonal relation between providers and clients influences to a large extent the uptake of services, there is an urgent need for improving this element of service delivery. Since providers training places emphasis on technical issues, the interpersonal aspect of services is often neglected. If providers do not discuss the client's personal issues and concerns, young people may not understand how these issues impact on their sexual and reproductive health. Adequate training in interpersonal relations is essential in helping overcome communication problems and enabling providers to interact with young clients at a more personal level. Increasing utilisation of health services is essential in preventing and reducing negative health outcomes among youth. Studies in developing country contexts show increased utilisation of health facilities by young people were attributed to making health facilities more youth-friendly by addressing staff attitudes and the clinic environment [3, 20]. Adjusting waiting times is also important in increasing utilization since many young people highlighted this as a deterrent. Similarly the opening and closing times of the clinic prevented young people from using the health services with 46 % of clients finding the opening and closing hours of the clinic inconvenient.

As highlighted in the analysis of the health facility and consistent with previous findings, common concerns that have been expressed with regard to programmatic challenges include shortage of human resources, lack of infrastructure and high-case loads [21]. In this context, responding to health needs of young people has therefore become overburdening. Issues of provider bias, motivation and level of preparedness have also been highlighted as crucial determinants undermining comprehensive service delivery [21]. These constraints undermine the expanded role of health care providers and inevitably have a detrimental effect on the quality and pace of services that young people are receiving. With the high levels of STIs, HIV and pregnancy among young people, youth-friendly services provide the opportunity to address problems among youth in a holistic manner. Some recommendations that have emerged in light of these findings include the need for continued investment in youth-friendly services to prevent unwanted pregnancy, STIs, and the spread of HIV among young people. Within South Africa some of the political and economic factors that influence the implementation of comprehensive, youth-friendly services include: reductions in donor funding, as well as separate funding streams for

sexual and reproductive health; policy restrictions relating to funding and activities; and a lack of political conviction by donors and national governments to make youth-friendly services a policy priority [18, 20]. Particularly in the context of developing countries, young people are therefore often not high priority when resources are allocated [2]. Promoting linkages between youth services and general health services therefore provides an important way forward in addressing this issue, in that one can capitalize on the resources available in the wider health system. This should be utilised for strengthening the capacity of health services, improving information systems and monitoring and evaluation of programs which are necessary steps in accelerating our trajectory towards the countries health goals [2, 3]. Country level data illustrates that continued investment in comprehensive approaches to youth sexual and reproductive health has had significant outcomes for the health of young people [2]. University health facilities form the basis for targeting young people since they operate around the basic principles of youth service provision and should therefore be prioritized when resources are allocated.

Conclusion

Policy makers need to incorporate the needs of young clients within sexual and reproductive health initiatives. Ideally young people should be involved in the design and implementation process of comprehensive, youth-friendly health initiatives [3]. This would form a platform for addressing the barriers such as interpersonal relations that hinder health service provision. This would help ensure that health services are tailored to the unique developmental needs of young men and women as well as the context within which they are embedded [5]. To support this, ultimately the key priority should be to ensure that all countries adopt policies that encourage the provision of comprehensive health services which respond to the needs of young people [3].

Acknowledgments We wish to acknowledge the support of the University Of KwaZulu-Natal and thank all participants in the study.

Conflict of interest None.

References

1. United National Population Fund. (2009). Fact sheet: Young people and times of change. Available from http://www.unfpa.org/public/cache/offonce/factsheets/young_people. Accessed on January 10, 2011.
2. Bearinger, L. H., Sieving, R. E., Ferguson, J., & Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention and potential. *The Lancet, 369*, 1220–1231.
3. Tylee, A., Haller, D. M., Graham, T., Churchill, R., & Sanci, L. A. (2007). Youth-friendly primary-care services: How are we doing and what more needs to be done? *The Lancet, 369*, 1565–1573.
4. Senderowitz, J. (1997). Reproductive health outreach programs for young adults. *FOCUS on young adults research series*, 1–45. http://pf.convio.com/pf/pubs/focus/RPPS-Papers/outreach.pdf. Accessed on January 10, 2011.
5. Petroni, S. (2007). Improving youth sexual and reproductive health in the developing world: An evidence-based approach. http://www.summitfund.org/foundation/pdfs/ASRH-findings.pdf. Accessed on January 10, 2011.
6. Askew, I., & Berer, M. (2003). The contribution of sexual and reproductive health services to the fight against HIV/AIDS: A review. *Reproductive Health Matters, 11*(22), 51–73.
7. WHO. (2010). *Social determinants of sexual and reproductive health: Informing future research and programme implementation*. Geneva: World Health Organisation.
8. Smit, J., Beksinska, M., Ramkissoon, A., Kunene, B., & Penn, K. L. (2004). Reproductive health. *South African Health Review, 2003*, 59–81.
9. Marston, C., & King, E. (2006). Factors that shape young peoples sexual behaviour: A systemaic review. *The Lancet, 368*, 1582–1586.
10. Boonstra, H. D. (2008). Despite consensus and mounting evidence, challenges to improved HIV-reproductive health linkages remain. *Guttmacher Policy Review, 11*(4), 7–10.
11. Bruce, J. (1990). Fundamental elements of quality of care: A simple framework. *Studies in Family Planning, 21*(2), 61–91.
12. Shisana, O., Rehle, T., Simbayi, L. C., et al. (2009). *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?*. Cape Town: HSRC Press.
13. Statistics South Africa. (2010). *Mid-year population estimates 2010*. Pretoria: Statistical Release.
14. KwaZulu-Natal Department of Health. (2010). Strategic plan 2010–2014. Available from http://www.kznhealth.gov.za/stratplan2010-14.pdf. Accessed on January 10, 2011.
15. Department of Health. (2003). *District health information system database*. Pretoria: Department of Health.
16. Nshindano, C., & Maharaj, P. (2008). Reasons for multiple sexual partnerships: Perspectives of young people in Zambia. *African Journal of AIDS Research, 7*(1), 37–44.
17. Ndhlovu, L., Searle, C., Miller, R., Fisher, A., Snyman, E., & Sloan, N. (2003). *Reproductive health services in KwaZulu-Natal, South Africa: A situation analysis study focussing on HIV/AIDS services. Horizons Programme. Final Report*. Washington DC: Population Council.
18. Maharaj, P., & Cleland, J. (2005). Integration of sexual and reproductive health services in KwaZulu-Natal, South Africa. *Health Policy and Planning, 20*, 310–318.
19. Berer, M. (2006). Dual protection: More needed than practiced or understood. *Reproductive Health Matters, 14*(28), 162–170.
20. Fleischman, J. (2006). Integrating reproductive health and HIV/AIDS programs. The Center for Strategic and International Studies. Available from http://csis.org/files/media/csis/pubs/060712_hivaids.pdf. Accessed on August 11, 2009.
21. Bharat, S. V., & Mahendra, V. S. (2007). Meeting the sexual and reproductive health needs of people living with HIV: Challenges for health care providers. *Reproductive Health Matters, 15*(29), 93–112.