Author's response to reviews

Title: Provision of Youth Friendly Services in rural South Africa

Authors:

Rebecca S Geary (r.geary@imperial.ac.uk)
F. Xavier Gómez-Olivé (xavier@agincourt.co.za)
Kathleen Kahn (Kathleen.Kahn@wits.ac.za)
Stephen Tollman (Stephen.Tollman@wits.ac.za)
Shane A Norris (san@global.co.za)

Version: 2 Date: 13 December 2013

Author's response to reviews: see over
Dear Dr Morrey,

Please find attached our manuscript, “Provision of Youth Friendly Services in rural South Africa” by Geary et al., which we would like to submit for publication as a research article in BMC Health Services Research.

Earlier work identified the YFS programme as an effective approach for implementing a youth-friendly clinic programme within a public health system in terms of pre-defined standards that include: the types of services provided, the clinic environment and policies supporting adolescents’ rights. However, previous evaluations did not investigate barriers and facilitators experienced by healthcare workers’ in its implementation, and no evaluations have been published since the South African Department of Health took over the programme’s management in 2006. In the context of the programme’s handover to the Department of Health and high coverage targets, it is timely to investigate both current provision and healthcare workers’ perceptions of barriers to and facilitators of provision of this programme. This study investigated the proportion of publicly funded primary healthcare facilities that provided the Youth Friendly Services programme in 2011, as well as barriers and facilitators to its provision perceived by healthcare workers in a rural sub-district with high adolescent fertility and HIV-prevalence. In reporting on one of the few youth-friendly health services interventions to have been scaled-up we believe our findings would appeal to the readership of BMC Health Services Research.

This article was previously reviewed by Dr Dagmar Haller and Dr Terryann Clark and whilst it was not accepted for publication at that time we were encouraged by your willingness to consider the manuscript further once all the reviewer’s concerns had been addressed. In the remainder of this letter we will describe how we have addressed the reviewers’ comments.
Reviewer one's report, major revisions:

1. In the introduction, the reader has a good view of the wide agenda for adolescent health and the effect of health behaviours on adolescent health at large. Yet without specifying the restriction, the paper then focuses on the development of youth-friendly REPRODUCTIVE health services. Although understandably reproductive health issues are a priority in South Africa, it is important to clarify why, despite the wide range of problems that affect adolescent health (as detailed in the first paragraph), the services for this age-group appear to focus on reproductive health (or if this not the case, it is important to clarify why all mentioned outcomes are reproductive health outcomes), and not primary care in the wider sense.

In paragraph four, lines 108-116 and paragraph five, lines 124-134, we have clarified this, explaining the focus of the South African Youth Friendly Services programme on sexual and reproductive health, developing as it did from the National Adolescent Friendly Clinic Initiative (NAFCI), which formed part of the national HIV prevention campaign, loveLife.

“The Youth Friendly Services (YFS) programme in South Africa is one of the few youth-friendly health services interventions to have been scaled-up. The Department of Health took over management of this programme from the loveLife non-governmental organization (NGO) in 2006. Between 1999 and 2006 loveLife managed this programme under the name of the National Adolescent Friendly Clinic Initiative (NAFCI) as one component of a national HIV prevention campaign which combined a sustained, multi-media HIV awareness and education campaign with outreach services including youth centres (Y-Centres) and peer educators (known as groundBREAKERS)[1]... In 2006, the DoH agreed to take over the management of a simplified version of NAFCI, comprising training healthcare providers and facility accreditation, under their Youth Friendly Services (YFS) programme[4,5]. The National Department of Health and key stakeholders, including the loveLife NGO, defined a core package of services for the Youth Friendly Services programme (to be implemented in primary healthcare facilities) that aim to improve the sexual and reproductive health of both young men and young women.”

2. If indeed the service development is for reproductive health services, then a discussion of the implications for male health is probably warranted.

In paragraph two (lines 78-89) we have now ensured that the reproductive and sexual health statistics presented represent both genders and have emphasised that the aim of the Youth Friendly Services programme is to improve the sexual and reproductive health of both young men and young women.

“In South Africa in 2011, HIV prevalence among young women (aged 15-24 years) was 12% and 5% among young men[10]. Half of women have given birth by the age of 20 years and two thirds of adolescent (15-19 years) pregnancies are reported as unwanted[11]. Nine percent report having had sex before the age of 15 years, and early sexual debut is associated with increased risk of HIV
infection, other sexually transmitted infections, adolescent pregnancy, forced sex, and an increased number of lifetime partners as well as with decreased use of condoms and other contraceptives[12-22]. Knowledge about sexuality and reproductive health among young men and young women is limited and young people report a need for more information on relationships, pregnancy and sexually transmitted infections (STIs)[23,24]. Fear of judgmental attitudes of healthcare workers has been reported as a barrier to use of a range of health services in[25-29].”

“The National Department of Health and key stakeholders, including the loveLife NGO, defined a core package of services for the Youth Friendly Services programme (to be implemented in primary healthcare facilities) that aim to improve the sexual and reproductive health of both young men and young women.”

3. I suggest making sure the following criteria are all met or discussed (based on: Mills E, Jadad AR, Ross C, et al. Systematic review of qualitative studies exploring parental beliefs and attitudes toward childhood vaccination identifies common barriers to vaccination. J Clin Epidemiol 2005;58(11):1081–8)

This comment has been addressed on lines 196-209. Additional detail is given below.

Was the data transcribed verbatim?

Added on page 8: “Seven of the eight interviews were audio-recorded and the interviewer transcribed recordings verbatim.”

• Were the interview questions pre-defined?

Added on page 7: “Interview questions were pre-defined to address the aims of the study and covered the following topics at each health facility: the services available to young people, opening hours, confidentiality, perceived community support for the provision of health services to young people, provision of the Youth Friendly Services programme or other activities related to youth-friendly health services and reflections on providing health services to young people.”

• Was there saturation?

Added on page 8: “Thematic analysis of the interview transcripts was conducted and data saturation was reached”.

• Were the themes derived from the data

Added on page 8: “A number of broad themes for the analysis were pre-defined based on formative questions relevant to the design of a health-information delivery system for young people in this area, namely: what services are currently available and what are any barriers to or facilitators of, their provision, experienced by healthcare workers. Additional themes emerged from the data.”
• Were the findings analysed by more than one assessor? Were participant answered reviewed for clarification?

Added on page 8: “A second reviewer reviewed the results of the thematic analysis alongside the original transcripts, and any discrepancies were resolved by consensus.”

• Can quotes be presented in the report?

Quotes have been presented throughout the results section. Not all quotes will be detailed in this letter but as an example, on pages 10-11, lines 282-300,

the following quote was included: “All clinics reported maintaining confidentiality for young people, however, breaches to parents emerged in the narratives at two facilities. At one facility in response to a question on whether the clinic provided pregnancy tests to young people the nurse reported: “Of course, we do that. With the mothers’ permission, of course, because most of them are being brought in by the mothers... You know sometimes, the mothers they query the child when the child gets sick and they say uh-huh, let me take the child. They know their lifestyle, of course some of the children they are very naughty, you find that the child is not there in the family maybe during the night and you find that the mother is worried... So immediately the mother comes with the child and tells us that, “no, this child, I think she is sexually active now, may you please do something?”” And then we start counselling the mother together with the child, and we explain to the child that this is the procedure that we are going to do, we are going to check for pregnancy, we are going to test you, as your mother gave us the permission to see if you are not actually (HIV) positive, you are not pregnant, and then after that we give the results to the mother.” (Clinic 2). This quote reveals a lack of confidentiality from parents at this clinic and suggests limited choice on behalf of the young person to refuse an HIV or pregnancy test if their caregiver requests it. Judgmental attitudes among healthcare workers in relation to young people’s sexual activity are evident; these are branded as “naughty”.

It would be helpful if the elements that formed the base for the analysis of the government documents could be made clearer

The document review referred to in the previous version of the manuscript has now been removed for clarity. Any relevant information now simply forms part of the background section (lines 121-140) which we found made the manuscript more focussed and easier to read.

4. Results: It is a good idea to present a summary table of key findings. Yet information is lacking on the actual structure and content of the government documents.

The reviewers were divided on the inclusion of a summary table of results and upon reviewing the manuscript we decided that, in agreement with Dr Clark, this table was not required and it has therefore been removed. As stated above the document review referred to in the previous version of the manuscript has now been removed for clarity. Any relevant information now simply forms part of the background section.
In addition: to what extent were the subheadings proposed to present the results pre-defined? Or did they emerge from the data? Were no quotes presented so as to avoid translation problems? Or any other reason?

The main sub-headings used to present the results reflect the three objectives of this research, as detailed on page 6, lines 153-163: “Objectives were, first, to describe the characteristics of the eight health facilities in the sub-district; second to investigate the proportion of publicly-funded primary healthcare facilities that provided the Youth Friendly Services programme in 2011; and third to examine barriers and facilitators to the provision of youth-friendly health services as perceived by healthcare workers.” As described above, quotes have been included throughout the results section.

5. Discussion: Youth participation is mentioned as a recommendation for future work but it would be useful if the limitation section included a discussion of why this was not done in the present study: how likely is it that other actors in the system (other health workers, youth) would identify some aspects of YFS implementation that the nurses did not identify?

The reasons for not including the perspectives of young people or other healthcare workers in the present study have been described in the first paragraph of the strengths and limitations section, and in the paragraph describing the aim and objectives.

The following was added on page 6, lines 153-163:

“We aimed to investigate provision of youth-friendly health services in a rural former “homeland” (part of the Bantustan system during apartheid) in South Africa with high adolescent fertility and HIV-prevalence[30,31]. Objectives were, first, to describe the characteristics of the eight health facilities in the sub-district; second to investigate the proportion of publicly-funded primary healthcare facilities that provided the Youth Friendly Services programme in 2011; and third to examine barriers and facilitators to the provision of youth-friendly health services as perceived by healthcare workers. Questions involving young people’s perceptions and experiences of the programme will be investigated in further work. This study focused on formative questions relevant to sustained provision of health-information for young people in this and similar rural settings.”
“Issues of perceived barriers to the provision of youth-friendly health services were investigated from the perspective of healthcare workers as they are best placed to describe any barriers or facilitators they experience to providing these services, both of which could be useful for development of a nurse-led health information delivery system in this area. The perspectives of other cadres of clinic staff could also be explored in further work, although the general nature of the barriers and facilitators that emerged from this work are likely to be applicable to other staff. To address important questions relating to young people’s experiences and utilisation (or lack of utilisation) of these services, young people should be involved in research on the design and evaluation of programmes, such as YFS, that aim to improve their health: this will be addressed in further work.”

6. Abstract: it would be easier for the reader to understand the study if much of what is presented in the conclusion was placed in the introduction.

This has now been revised in line with the reviewer's comments on lines 31-38.

Abstract

Background

Youth-friendly health services are a key strategy for improving young people’s health. This is the first study investigating provision of the Youth Friendly Services programme in South Africa since the national Department of Health took over its management in 2006. In a rural area of South Africa, we aimed to describe the characteristics of the publicly funded primary healthcare facilities, investigate the proportion of facilities that provided the Youth Friendly Services programme and examine healthcare workers’ perceived barriers and facilitators to the provision of youth-friendly health services.
Reviewer Two’s Report: Major Revisions

1. I think the question needs to be better refined. The title suggests that this is a case study, but there is no explicit question posed. In the introduction it states “this study investigated the proportion of publicly funded primary health care facilities that provided YFS in 2011 (no space) in a rural former “homeland” with high adolescent fertility and HIV prevalence”. This is not a case study question – rather an evaluative quantitative one, but then it states “it is timely to investigate both current coverage and healthcare workers perceptions of barriers to and facilitators of YFS provision.” There needs to be an explicitly stated aim and objective as I don’t think this clear and this means the rest of the manuscript is difficult to understand or interpret. I wonder whether ‘scale-up’ is the most appropriate description of this study. I was unsure what scale-up meant until I read further. This is really about the implementation and evaluation of youth appropriate services based on an existing model. Fidelity is always an issue with roll-out of such interventions by governmental agencies.

The title of the manuscript has been changed to “Provision of Youth Friendly Services in rural South Africa”

The aim and objectives are now explicit in the seventh paragraph. In addition the terminology has been adjusted throughout to reflect the focus of the manuscript on provision of YFS, rather than scale-up. The following was added on page 6, lines 153-163:

“We aimed to investigate provision of youth-friendly health services in a rural former "homeland" (part of the Bantustan system during apartheid) in South Africa with high adolescent fertility and HIV-prevalence[30,31]. Objectives were, first, to describe the characteristics of the eight health facilities in the sub-district; second to investigate the proportion of publicly-funded primary healthcare facilities that provided the Youth Friendly Services programme in 2011; and third to examine barriers and facilitators to the provision of youth-friendly health services as perceived by healthcare workers. Questions involving young people's perception and experience of the programme will be investigated in further work. This study focused on formative questions relevant to sustained provision of health-information for young people in this and similar rural settings.”
2. This does not appear to be a case study methodology. The methods were not clear. An interview schedule or list of questions utilised when undertaking interviews or criteria for reviewing documents was not included. The methods section appears to have more background information rather than methods undertaken for this study. Thematic analysis was stated with no references or explanations of how this was utilised.

The topics covered by the interview questions are now described on page 7, line 188-194:

“Interview questions were pre-defined to address the aims of the study and covered the following topics at each health facility: the services available to young people, opening hours, confidentiality, perceived community support for the provision of health services to young people, provision of the Youth Friendly Services programme or other activities related to youth-friendly health services and reflections on providing health services to young people.”

The methods section has been expanded and clarified on page 8 (detailed below). This included additional detail on the thematic analysis conducted and references (lines 196-209):

“Seven of the eight interviews were audio-recorded and the interviewer transcribed recordings verbatim. A number of broad themes for the analysis were pre-defined based on formative questions relevant to the design of a health-information delivery system for young people in this area, namely: what services are currently available and what are any barriers to or facilitators of, their provision, experienced by healthcare workers. Additional themes emerged from the data. Thematic analysis of the interview transcripts was conducted and data saturation was reached[32]. Initial coding of interview transcripts was conducted and themes were then visually mapped, with the inclusion of quotes, to provide a detailed picture of the information pertaining to each theme that emerged from the eight interviews. A second reviewer reviewed the results of the thematic analysis alongside the original transcripts, and any discrepancies were resolved by consensus. There was only one discrepancy where a quote had not been included in a relevant thematic map and this was resolved by its inclusion.”

A paragraph of background information has been removed from the methods section and now forms the last paragraph of the background section, lines 165-180.

“This study was conducted in 2011 in the Agincourt sub-district of Bushbuckridge, Mpumalanga Province, South Africa, which borders the Kruger National Park and southern Mozambique. In 2010 Mpumalanga Province had the second highest provincial HIV prevalence among antenatal care attendees in South Africa at 35.1%[30]. While fertility in other age groups in Agincourt declined, adolescent fertility has remained relatively high[31]. The Agincourt sub-district covers approximately 420km², with some 90,000 people living in 27 villages under both traditional and civic leadership[33]. Physical infrastructure
is limited; there is no formal sanitation system, piped water to communal standpipes is erratic and electricity is unaffordable for many. All villages have a primary school and attendance is almost universal. There are several high schools, but half of 20 year olds are still enrolled indicating lagging academic progress. High unemployment contributes to male and female temporary labour migration[33]. The study site has been described in detail elsewhere[33-35]. Health and demographic surveillance was introduced in 1992 and the study area has a strong record of health systems research and development[34,36,37]."

3. Are the data sound? It is unclear if the data are sound. There was little evidence of data in the form of quotes or narrative from the documents examined. It was unclear what documents were examined and how and based on what criteria. The document review referred to in the previous version of the manuscript has now been removed for clarity. Any relevant information now simply forms part of the background section which we found made the manuscript more focussed and easier to read (lines 121-140).

Quotes have been included throughout the results section.

"It was unclear if there were any quality checks regarding validity or relevance by other researchers.

The following has been added on page 8, lines 205-209:

“A second reviewer reviewed the results of the thematic analysis alongside the original transcripts, and any discrepancies were resolved by consensus. There was only one discrepancy where a quote had not been included in a relevant thematic map and this was resolved by its inclusion.”

4. The reporting of data is inadequate and needs work. I think the themes identified are important, and have real implications for improving adolescent healthcare in South Africa, but it is unclear what contributed to these themes.

The following has been added on page 8, lines 197-202:

“A number of broad themes for the analysis were pre-defined based on formative questions relevant to the design of a health-information delivery system for young people in this area, namely: what services are currently available and what are any barriers to or facilitators of, their provision, experienced by healthcare workers. Additional themes emerged from the data. Thematic analysis of the interview transcripts was conducted and data saturation was reached[32].”
The first sentence described the interview participants and facilities and types of services they provide – If it was stated in the aims and objectives that the characteristics of the health facilities will be described this paragraph would make more sense. I think the 8 nurses agreeing to participate should be in the next section on interviews. I don’t think you need table 1 in its current form. I think a table that explained which data came from what sources and examples of data e.g. quotes from interviews or quotes from documents would be useful.

The objectives have now been made explicit on page 6, lines 153-163, including the first objective being to describe the characteristics of the health facilities in the Agincourt sub-district:

“We aimed to investigate provision of youth-friendly health services in a rural former “homeland” (part of the Bantustan system during apartheid) in South Africa with high adolescent fertility and HIV-prevalence[30,31]. Objectives were; first, to describe the characteristics of the eight health facilities in the sub-district; second to investigate the proportion of publicly-funded primary healthcare facilities that provided the Youth Friendly Services programme in 2011; and third to examine barriers and facilitators to the provision of youth-friendly health services as perceived by healthcare workers.”

The sentence on the nurses agreeing to participate has been moved to the section on interviews. ”All eight professional nurses (all female), representing the eight different health facilities, agreed to participate.” (Page 8, lines 212-216)

The reviewers were divided on the inclusion of a summary table of results and upon reviewing the manuscript we decided that, in agreement with reviewer two, that this table should be removed.

Examples of data in the form of quotes have been added throughout the results section.

There is no discussion about limitations of the study apart from briefly (paragraph 5). The interviews being conducted in English will have introduced significant bias and the cultural factors and interpretation are not discussed. Could there have been cultural advisors to help interpret the data and develop themes from their perspectives?

The following has been added on page 8, lines 186-188: “Semi-structured interviews were conducted in English and a local fieldworker attended the interviews to assist with introductions and any communication difficulties between English and Shangaan.”
“Conducting interviews in English rather than the local language of Shangaan could have been a limitation; however, local fieldworkers from the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) “Learning, Information dissemination, and Networking with Community” (LINC) office attended interviews to provide cultural and language interpretations where necessary.”

I like the finding that there was “unprompted enthusiasm to deliver the programme.” I would have liked some quotes about this – as I think this is the key to motivating providers to change, rather than focusing on the problems. Were there any stories of successful implementation and how they managed to negotiate the systems to make them work? Could there be a theme that highlighted the positive factors of influencing this service?

There were unfortunately no clear stories of successful implementation and but one of the eight health facilities in this sub-district provided the YFS programme. However, we have included a sentence on page 15, lines 435-437, to acknowledge the relevance of positive stories of implementation; “future work could identify successful implementation in other clinics outside this sub-district to identify key learning points that could be applied elsewhere.”

5. The discussion and conclusions do relate to the findings but need considerable tidying up. Needs to be more concise and clear. Recommendations need work.

In line with this suggestion the discussion and recommendations have been rewritten to be clearer and more concise.

In particular the following changes have been made:
1) A key findings paragraph has been added on page 12, lines 333-339:

“The key findings demonstrate that scale-up of the Youth Friendly Services programme is limited and below Department of Health targets in this sub-district. The main barriers to the provision of health services to young people reported by healthcare workers were lack of trained staff and the lack of a dedicated space for young people. In addition, at half of clinics, the right of adolescents from 12 years of age to legally access health services, including TOP, HIV testing and treatment and contraceptives, without parental consent did not appear to be being upheld[38].”

2) The recommendations have been refined on page 15 and 16, lines 445-453:

“Based on the results of this work, future training should include an emphasis on young people’s right to receive confidential health services, and the legal right of young people aged 12 years and older to access health service independently in South Africa and the importance of being non-judgmental. The importance of training on youth-friendly health services was emphasised by staff, suggesting that provision of such training would be popular among the nurses-in-charge in
this area. More than one member of staff per facility should be trained to allow for staff turnover and facilitate maintenance of implementation of the YFS programme.”

*Table 2 – (3rd paragraph in discussion) does not exist.*
This cross-reference has been removed.

*Is there an example (reference) for a cascade model?*
Reference added on page 16, lines 453-458: “In 2012 the South African Department of Health released a new National Adolescent and Youth Friendly Health Services Strategy that aims to increase the provision and reach of Youth Friendly Services training by using a cascade model. In this model, within each sub-district, a number of YFS demonstration sites will act as training bases for at least three other facilities, which will in turn act as training sites for a further three facilities[39].”

6. *As previously stated the limitations are not explicit or comprehensive.*
The strengths and limitations section has been expanded, including the following additions on lines 417-433 and line435-437:

“Issues of perceived barriers to the provision of youth-friendly health services were investigated from the perspective of healthcare workers as they are best placed to describe any barriers or facilitators they experience to providing these services, both of which could be useful for development of a health information delivery system in this area. The perspectives of other cadres of clinic staff could also be explored in further work, although the general nature of the barriers and facilitators that emerged from this work are likely to be applicable to other staff. To address important questions relating to young people’s experiences and utilisation (or lack of utilisation) of these services, young people should be involved in research on the design and evaluation of programmes, such as YFS, that aim to improve their health: this will be addressed in further work.”

“Conducting interviews in English rather than the local language of Shangaan could have been a limitation; however, local fieldworkers from the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) “Learning, Information dissemination, and Networking with Community” (LINC) office attended interviews to provide cultural and language interpretations where necessary.”

“Future work could identify successful implementation in other clinics outside this sub-district to identify key learning points that could be applied elsewhere.”
7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished? Not really, but there is a good rationale for undertaking this work.

The background section includes details of previous evaluations of the Youth Friendly Services programme and how the current work adds to this, lines 142-151.

“Earlier work identified the YFS programme as an effective approach for implementing a youth-friendly clinic programme within a public health system in terms of pre-defined standards that include: the types of services provided, the clinic environment and policies supporting adolescents’ rights[4]. However, previous evaluations did not investigate barriers and facilitators experienced by healthcare workers’ in its implementation, and no evaluations have been published since the South African Department of Health took over the programme’s management[40-43]. In the context of the programme’s handover to the DoH in 2006, and high coverage targets, it is timely to investigate both current provision and healthcare workers’ perceptions of barriers to and facilitators of YFS provision.”

An additional sentence clarifying the focus of this study was added on page 6, lines 161-163: “This study focused on formative questions relevant to sustained provision of health-information for young people in this and similar rural settings.”

8. The abstract is too long and overstates findings based on what I read in the content. I was unsure why this is called a case study in the title but it doesn’t really refer to case study in the article or methods.

The title and abstract have been revised to address this as follows:

The title of the manuscript has been changed to “Provision of Youth Friendly Services in rural South Africa.”

The conclusions in the abstract have been made more circumspect (lines 55-63): “Provision of the Youth Friendly Services programme is limited in this sub-district, and below the Department of Health’s 70% target level. Whilst a dedicated space for young people is unlikely to be feasible or necessary, all facilities have the potential to be youth-friendly in terms of staff attitudes and actions, and training and ongoing support should be provided to facilitate this. The importance of such training is emphasised by staff; more than one member of staff per facility should be trained to allow for staff turnover. As one of a few countrywide, government-run youth-friendly clinic programmes in a low or middle-income country, these results may be of interest to programme managers and policy makers in such settings.”

9. Writing needs work to be more concise and straightforward.

This has been addressed throughout.
We would like to thank the reviewers for their insightful comments, which have improved our manuscript. Having made these changes we would like to resubmit it to BMC Health Services Research. We confirm that this manuscript has not been published elsewhere and is not under consideration by another journal. It will not be submitted to any other journal whilst under consideration by BMC Health Services Research. We confirm that there are no prior publications or submissions with any overlapping information. All authors have approved the manuscript and agree with its submission to BMC Health Services Research. We are not aware of any potential conflicts of interest, real or perceived. We confirm that the study sponsor had no role in the study design, the analysis or interpretation of the results or the decision to submit the manuscript for consideration by BMC Health Services Research.

Please address all correspondence to Rebecca Geary at r.geary@imperial.ac.uk or at the address above. We look forward to hearing from you at your earliest convenience.

Yours sincerely,

Rebecca Geary
Citations


