



Health care providers' perceptions of family planning and contraception education for adolescents in Kampala, Uganda – A qualitative study



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ARTICLE INFO

Keywords:

Adolescents
Family planning
Contraception
Reproductive health

ABSTRACT

Objectives: Unsafe abortions are a reproductive health problem in low-income countries, but can be prevented by decreasing unintended pregnancies. The objective was to describe health care providers' (HCPs) perceptions of family planning and contraception education for adolescents in Kampala, Uganda.

Study design: A qualitative study with a semi-structured interview guide was used for individual face-to-face interviews. Eight participants from two different Non-governmental organisations were interviewed. Qualitative content analysis was used to analyse the data.

Results: Data analysis resulted in three main categories of HCP perceptions: counseling, education and availability; peer-educators and community leaders; and stigma, inequality and myths. The providers emphasized the importance to discuss and eradicate the myths and misconceptions among adolescents regarding family planning methods by giving information, preferably at early ages. Peer-educators and community leaders were the most successful methods for accessing and involving the community. Approaches mentioned for reaching out to adolescents included involving parents, using social media, and offering education in schools. Furthermore, the providers highlighted to involve the males in family planning.

Conclusions: Health care providers emphasized the importance to discuss and eradicate the myths and misconceptions among adolescents regarding different family planning methods by education in school and information in sexual and reproductive health.

Introduction

Unintended pregnancies are common globally; an estimate is that about 44% of all pregnancies are not planned [1]. In a low-income country as Uganda an estimated 32% of all pregnancies are unintended, and among young women under the age of 20, more than 40% are unintended. Although the total fertility rate in Uganda has declined to 5.4 children per woman, teenage pregnancy and early motherhood is a major health concern. The median age at first birth is 19.4 years and 25% of women age 15–19 have begun childbearing [2].

Unintended pregnancies are leading to unplanned births, unsafe abortions and maternal mortality. Every year, almost 25 million unsafe abortions are performed worldwide and cause the highest maternal mortality in sub-Saharan Africa [3]. These unsafe abortions can be prevented through comprehensive sexuality education and prevention

of unintended pregnancy through the use of effective contraception [4]. Increased efforts are needed, especially in low-income countries, to ensure access to contraception and safe abortions [3].

Family planning includes the capability to foresee one's sexual and reproductive health and to allow spacing of pregnancies and delay pregnancies in young women at increased risk from early childbearing. Thus, family planning prevents unintended pregnancies and enables women who wish to limit the size of their families. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion [5]. As women and couples wish to have smaller families and control the timing and spacing of births, investments in health-care programs are needed to address the growing request for family-planning [1].

There is a need of youth-friendly services that offer reliable reproductive health counseling and information as well as family

Abbreviations: HCP, health care provider; IEC, information, education and communication; NGO, non-governmental organisation; SDGs, sustainable Development Goals; STI, sexually transmitted infection

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<https://doi.org/10.1016/j.srhc.2019.05.001>

Received 26 September 2018; Received in revised form 24 April 2019; Accepted 8 May 2019

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planning methods to adolescents in Uganda. There is also a need of affordable and available family planning services that offer sufficient education to choose the best contraceptive method. [6]. Informed choice indicates that women are informed about the advantages with family planning methods and also what to do if they experience side effects, and about other methods to use. However, adolescents struggle when it comes to their right to be provided with the contraceptive of their choosing and need. Many providers showed negative attitudes to contraceptive use by unmarried and those without children, even though the national reproductive health policy had no such limitations [7].

The unmet need for family planning in Uganda, is 28% of married adolescents and even higher among unmarried adolescents, about 32% [2]. The Government of Uganda committed to increase age-appropriate information, access and use of family planning among young people (10–24 years) and to reduce the unmet need for family planning to 10% and increase the contraceptive use to 50% by 2020 [8]. However, the national guidelines for sexual and reproductive health and rights were not launched as planned [9]. Consequently, the United Nations Sustainable Development Goal (SDG) 3.7 by 2030; to ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs will be delayed [8,10].

For reproductive health-care in a low-income country like Uganda, it is crucial to identify successful methods for reaching out and educating in order to avoid unintended pregnancies among adolescents. Thus, the objective of this study was to describe health care providers' perceptions of family planning and contraception education for adolescents, in Kampala, Uganda.

Methods

Study design

The methodological approach was qualitative design with semi-structured individual face-to-face interviews.

Participants and setting

The participants in this qualitative study were providers of family planning and contraception education for adolescents. The individuals included in the study were selected through purposive sampling. Participants included in the interviews were HCPs who were actively involved in family planning education and service provision, and who offered counseling on contraceptive use among adolescents and young people in an urban setting. The participants had lived in Uganda at least five years or, alternatively, had worked with reproductive health in a low- or middle-income country for at least two years, with a total of 2–20 years of experiences. Eight participants were included: two midwives; one nurse with a Master's degree in public health; one social worker; one counselor; one assistant project officer; and two peer-educators. In Uganda, peer-educators can be peer-mothers, adolescent mothers who previous have received counseling and support from the teen centers and now offer support to other teenagers facing similar challenges. Peer-educators and HCPs not working with young people in the specified age group were not included.

Two NGOs were identified and contacted before the participants were recruited and interviewed. The first clinic was Naguru Teenage Information and Health Center (NTIHC), established in 1994 and located about 6 km outside the capital city of Kampala. NTIHC is providing youth-friendly adolescent sexual reproductive health services and information primarily to young people age 10–24 years [11]. The services they provide include STI screening, diagnosis and treatment, pregnancy testing, prenatal services, postnatal care, family planning, and post-abortion care. Family planning services include information

about contraceptive methods, such as the male or female condom, contraceptive injections, the progesterone-only pill, the combined pill, the contraceptive implant, the intrauterine device (IUD) or the calendar and cycle beads method. They also provide HIV counseling and testing, promote condom use, and offer general counseling. The second clinic was one of the 17 branches of Reproductive Health Uganda (RHU), located in Bwaise, about 3 km from Kampala city center [12]. This organization provides family planning services to the public, including young people aged 15–24. Both clinics serve young people, and offer integrated services to encourage them to access the services. At both facilities, family planning methods were provided free of charge.

Data collection

Individual face-to-face interviews were conducted in English, using open-ended questions from the semi-structured interview guide. Interviews were audio-recorded and transcribed verbatim. Occasional probing questions were asked when the interviewers needed further information. Primary questions were asked on topics such as identifying the HCP's preference of family planning method of, assessing adolescents' preferences of contraception method according to the HCPs, and successful methods for reaching out to and educating adolescents in order to avoid unintended pregnancies. The first interview conducted was a pilot interview; it was considered successful and was thus included in the study. No repeat interviews were conducted. Permission was sought from the managers at both NGOs to conduct the interviews before the data collection began.

Procedure

The participants were recruited during February 2017 from the two NGOs, and the individual interviews were conducted at each facility. The interviews lasted 20–55 min (mean 33 min), and were conducted in English while being audio-recorded. Before each interview the study was verbally explained to the participant, and written information was presented on the consent form. Each participant was informed verbally and in writing that all data collected from the interview would be handled confidentially. Participants were asked to sign the consent form before the interview started. Ethical approval was sought from the School of Public Health Higher Degrees, Research and Ethics Committee (Protocol 466), Makerere University, before the study began.

Data analysis

The interviews were analyzed using qualitative content analysis [13]. After careful reading of the transcribed interview, the text was divided into meaning units. A meaning unit is a piece of text with a specific content that relates to the aim of the study. All meaning units were then condensed; a process of shortening the text while still preserving the core content, into condensed meaning units. The condensed meaning units were further shortened into codes; a labelling that allows the data to be understood in relation to the context. Codes were then grouped into categories depending on similarities and differences in content. No software package was used. As an alternative, documents for each category were made, containing related codes, condensed meaning units and meaning units, to make it easy to return to the original statement and keep track of progress when writing. The codes were independently identified before categorization started. When the analysis process required, a discussion between the co-authors took part in discussing the categories and the interpretation of data until consensus was reached. Quotes were included for trustworthiness of the analysed data.

Results

The data analyses resulted in three main categories: counseling, education and availability; peer-educators and community leaders; and stigma, inequality and myths. Excerpts from the interviews are presented below, labeled with the participants' profession or occupation.

Counseling, education and availability

Among the HCPs it was described that counseling can play an important part in reducing unintended pregnancies:

“if we begin early and give them information of the basics they should need before having sex and I think it would be able to help out on the unwanted pregnancies” (Midwife)

“The rate of teenage pregnancies is shooting up and we need to do something about it. That something starts with information” (Peer-educator)

HCPs declared that in order for them to be able to provide the right method of family planning, the adolescent must be listened to in order to explore the problem and determine what he or she might need. It is only after the HCP knows that the adolescent has the necessary information and can give informed consent that the chosen method can be administered. To be able to answer adolescents' questions, the HCPs described that they need to be well equipped with knowledge in order to explain why the adolescents need to protect themselves against pregnancy. Part of the counseling involves alleviating their fears and ensuring that they trust the HCPs, as well as supporting their right to safe sex and then establishing that the adolescents will contact them if they have any issues. A fear of unsafe abortion due to unintended pregnancy can push an adolescent to visit the clinic, although according to the HCPs there are also those who do not take precautions. In the counseling rooms, the HCPs use comprehensive counseling rather than focusing on a particular problem. It was also mentioned that there is a need for a communication strategy to give the right information and tailor it to the appropriate age bracket. According to the HCPs, the counseling and family planning should not only be comprehensive but also be available in many different approaches, such as information, education and communication (IEC) materials. IEC materials can be found in the waiting areas and counseling rooms, including charts and videos that can be used as a substitute for counseling:

“It should be a multiple – a multiple approach because when you look at the different methods (...) they are all very important and for young people it is tricky, you may not find them at the facility - you find them in the community; if you do not find them at the community, maybe at the school” (Midwife)

Another approach the HCPs suggested for attracting adolescents was through entertainment. For example, music can divert their attention while treatments and tests are being administered. According to the HCPs, outdoor and indoor activities were used, and considered more effective than classroom settings for introducing and sharing information with adolescents;

“And then we entertain them of course that is the easiest way to capture the adolescent's attention – give them some music then they would be able to go for service, as they are having fun here they are actually having services – they are getting injections, they are getting treatment, testing and all of those things” (Peer-educator)

The HCPs claim that if the adolescent have fun while they learn they will more likely understand and remember the information than if they are in class settings;

“So it is more like having all this information that you can sit and get in a class setting but you are having it in a more fun environment because we are going to talk to you about your bodies, how your

body's changes but probably we are going to use a game and at the end of the day when you remember that game you will understand” (Peer-educator)

The HCPs mentioned that they use radio stations to achieve better coverage, in order to reach adolescents who have difficulty accessing family planning services. There are tailor-made radio programs to address issues about family planning. Another way to increase availability and reach adolescents involves using social media, such as Facebook or WhatsApp. The HCPs claimed that good counseling leads to continuity, which they encourage and which is important when it comes to services like depot injections:

“so we try to reach to those adolescents that cannot directly benefit from our services, this is through the radio stations” (Counselor)

“The most popular program, I think it is interaction, when you are face to face (...) whatever way you want, but as long as you are interacting with the young person it is the best way” (Nurse with MSc in public health)

The HCPs also mentioned the daily health talks in which the providers provide information at the clinics and/or in the community. They regarded these talks as major discussions in which clients' experiences can be shared. The aim of these talks is to sensitize the people who attend them. They explained that outreach efforts like the health talks can be offered as reproductive health education in both schools and communities:

“Wherever they choose to go, you have to follow them” (Nurse with MSc in public health)

A health talk normally lasts about 30–45 min, in order not to bore or lose the interest of the adolescents. The talk, or education, can span many topics, from life planning skills to STIs. It is an interactive session between the provider and the clients. When going out into the communities the HCPs offer a service delivery package, including medical services and HIV testing, along with counseling and behavioral change activities. According to the HCPs, medical services and educational activities are often combined to ensure that the adolescent receives more information. The HCPs claim that the medical services will act as a catalyst to attract adolescents, since information is not their first priority. When located in the community, due to congestion it can prove difficult to provide proper counseling and the client will be referred back to the clinic. Advertising medical services will get the numbers up and they can start providing information and family planning services. The HCPs reported that they were in the pilot stage of establishing outreach efforts; if these efforts work, they can be implemented in other areas. Adolescents change quickly, and this was something the HCPs were aware of. They mentioned that it was important to adapt the services as well as increase their availability;

“If you are giving an adolescent friendly service to them and you accept them you - do not judge them (...) you are able to keep the confidentiality of the young person, they can always come in. It is very key, even more than the family planning method itself because when they are free with you they can come and access the service easily” (Nurse with MSc in public health)

Peer-educators and community leaders

The HCPs mentioned that once a week about five adolescents are chosen to go out in the community with fliers and talk about certain topics involving family planning, and to promote the clinics and their services. The HCPs explained that “university champions” were students the clinics chose from the universities to train in methods of family planning in order to teach and refer fellow students to the clinics. Village health teams and village health workers provide information by going out in the community, and were considered efficacious by the

HCPs as they believed people usually accept these. According to the HCPs, one of the peer-educators' duties is to refer the client to a clinic; this is part of the basic counseling peer-educators' exercise. As specified by the HCPs, basic counseling by the peer-educators is meant to create awareness about sexual and reproductive health, mobilize adolescents for outreach efforts, and advocate for adolescents' rights. Peer-educators also have the benefit that the communities and community leaders know them, according to the HCPs. As the HCPs suggest, massive approaches that go deeper into the communities would be an effective way of creating awareness among the adolescents;

“I think basically since this organization is linked with – linked and working with the communities the most important thing and most effective way of sensitizing these young people about family planning services is to have massive sensitization being done in the communities. Because we are getting few young people coming here for services and very few are coming for family planning services the majority of the young people are in the communities. So if we can have massive approaches in going deeper into the communities and sensitizing these young people about family planning services it will work very well it will be an effective way of creating factual information to them. Me I believe that is the most effective way” (Counselor)

They also mentioned that going door-to-door reaches only ten homes a day, and that this needs to be facilitated. A megaphone with loudspeakers on a vehicle achieves this, according to the HCPs. As an entire zone is too large to cover, the HCPs believed more peer-mothers are required. As peer-mothers are adolescent mothers who previous received counseling from the teen centers, they now offer support to other teenagers facing similar challenges to what they have been faced with. According to the HCPs, peer-educators know which areas needed help. To reach out to the young people, the HCPs suggested that the first order of business would be to make the community aware and have a serious mobilization of the adolescents. The HCPs stressed the importance of approaching and asking for the community leaders' permission to talk to their teenagers in order to mobilize them. The peer-mother is the one to approach the leaders because she knows them. The provider is allowed to talk for 10–15 min at a village-level meeting. The topics of these talks can change depending on the request of the adolescents, but sometimes the requested topic is too vast for the peer-mother and is instead scheduled for later, when the peer-mother can get help from the clinic:

“It is me who approaches the leaders because I am within, I know all the leaders, that one is not a problem for me. I just go and introduce myself and say I am so and so I have to do that and that then they allow me” (Social worker)

The HCPs explained that demonstrating how to use different contraceptives like condoms and IUDs will result in better practical use. They also mentioned that some peer-mothers have been educated in family planning through their own experience of being a client. Peer-mothers are equipped with the vouchers and a data tool in the community. HCPs explained that vouchers given from peer-mothers out in the community can later be used in different facilities to access different services free of charge. Mentioned was also that adolescents think age-to-age information is appropriate, as peer-mothers and peer-educators are usually in the same age as their clients:

“Because when a peer-mother goes to the young ones, at least they can listen because it is the same age; they can listen to you more than the older person” (Social worker)

Stigma, inequality and myths

According to the HCPs there is a stigma surrounding family planning that can cause the community to believe you are sexually active if

you are using a family planning method:

“If I go to the Center and request for family planning these people will maybe say I have started sex and they will judge me” (Peer-educator)

It was implied that adolescents may fear that their community and the HCPs will judge them. According to the HCPs there is a stigma that family planning is something for adults, and this adds to adolescents' already uncomfortable feeling about accessing family planning services. The HCPs also mentioned that a lack of information among the adolescents encourages myths and misconceptions, which negatively affect the use of family planning services. The most common myth, according to the HCPs, is the misconception that if an adolescent has not given birth and uses a family planning method she will become infertile. Adolescents who might be ready to start a family planning method may develop feelings of doubt if they hear misconceptions and myths from their communities. If adolescents believe, for instance, that they will not be able to get pregnant later in life, or that it will cause cancer or affect their blood system, they may become afraid and might avoid the family planning services:

“Because if someone tells you that when an IUD coil is inserted it will actually rust so you are supposed to tell them the truth: that an IUD coil does not rust when it is in a system” (Peer-educator)

The HCPs also mentioned the importance of discussing the side effects of the family planning methods, in order to lessen the chances that the girl will decide to discontinue using the method. The HCPs suggested that informing adolescents about side effects will help them be aware and be able to cope. Instead of feeling the urge to discontinue, they can have the opportunity to change to another method. According to the HCPs certain side effects, like excessive bleeding or changes in the female's sexual libido, can affect the boyfriend or husband, which in some cases can lead to gender violence at home;

“Because there's also other issues due like if I talk about over bleeding, okay. If the boyfriend doesn't know about and he's also asking why are you always bleeding? There's so many questions. So you tell them, that if we tell your boyfriend about the side effects, he's able to understand. You'd be able to deal with it as a couple” (Midwife)

The HCPs pointed out that information about reproductive health is the key. Among the HCPs was a belief that there is an uneven distribution between the adolescents who visit the centers, the suggested reason for which is that many girls are driven to know the truth about misconceptions and myths, while boys take things for granted. Most of the adolescents prioritize accessing the method but not always the information about it; especially boys were mentioned in this regard. Another explanation was that boys previously did not get the information and were separated from the girls, who did receive reproductive health education. The HCPs expressed that this had led to a feeling among the boys that sexuality education is not important, and that some of this feeling still lives on;

“I think in my own perspective the issue it could be we as guys we need to be pushed to go for services whereas women most times they really want to know the truth so they are compelled to go to the health centers for services, whereas we boys we just sit back and we take things for granted” (Counselor)

The HCPs mentioned that, to discourage adolescents from being sexually active, the government had recently decided to ban sexuality education in schools and claimed that the information given to children can encourage them to have sex;

“they actually put a stop to sex education in schools because it was being called comprehensive sex education and they felt that information being given to children in school was not conducive for

them” (Peer-educator)

The HCPs disagreed with the ban, because most of their clients with unintended pregnancies were 14–16 years old. The HCPs argued for the importance of giving information as early as possible, regardless of whether or not they are sexually active. According to HCPs, it is mostly 18- and 19-year-olds want family planning because they are starting to be sexually active. In addition, young mothers need access to family planning and information on contraceptives in order to space their children, because some of these women do not know about family planning services.

The HCPs claimed that if they can reach out with information before adolescents have sex for the first time, they can reduce unintended pregnancies. Encouraging males to practice family planning was an ongoing project, but according to the HCPs it needed to be extended more. They described that sometimes the male partner has to remain at work because their managers are not understanding, making it difficult for the male to be involved in couple counseling. Male services need to be incorporated, for example including prostate screening. If the education starts early, adolescents will have the chance to make an informed decision when the time comes.

Parents were considered the main obstacle for some adolescents, as they do not want their parents to know they are using a family planning method; this leads to limited options for family planning services. The HCPs explained that it can happen that a client cannot risk their mother knowing they have an implant, which leaves them with the option of three monthly depot injections. Some other adolescents, according to the HCPs, have the opposite problem: they are forced by their parents to go for family planning even if they do not desire it. Even though it can be a challenge when parents interfere with the adolescents’ family planning, the HCPs stress the importance of involving parents in order to reach out. They describe that parents should know how to participate and provide information and empowerment:

“So if a parent is open enough to share this information with a child, probably give them a clue or some ideas, it makes them able to understand that, okay, I need to do something” (Peer-educator)

According to the HCPs there is a problem of adolescents not showing up for follow-ups. One reason the HCPs claimed to be important involves distance: if an adolescent cannot get transport to the center and it is too far to walk, they will miss their refill or follow-up appointment. The HCPs mentioned a toll-free phone service that allows anyone to call and receive supported from a counselor. As some adolescents do not have a phone, the HCPs cannot call to remind them about this possibility, while other girls give the phone number to their husband, which the HCPs say can cause problems;

“But still, there are those who can give phone numbers of their husbands not theirs so when you call the husband, the husband does not want a family planning method, it can break confidentiality, so those are some of the issues” (Nurse with MSc in public health)

Discussion

Counseling, education and availability of family planning, as information about different contraceptives were mentioned among the health care providers as ways to inform and empower adolescents. Providers presented interactive counseling, group counseling, group discussions in the form of health talks, several adolescent-friendly approaches, various IEC materials such as videos and charts, door-to-door knocking, social media, and radio as their methods. Several HCPs pointed out that empowering adolescents and informing them of their rights was an important part of counseling. Empowerment is an important part of successful sexuality education already in school avoiding unintended pregnancies and the transmission of STIs [14]. Social and mass media entailed another way of solving issues of

reaching out to adolescents, according to the HCPs. However, other studies show that adolescents are uncomfortable with sexual health education through social media like Facebook and Twitter [15,16]. On the other hand, most adolescents were comfortable accessing information about sexual health via websites [16], whereas other studies show that the information on the web may not always be factual and comprehensive [17]. Entertainment was stressed by the HCPs as one of the effective ways of reaching out to the adolescents, consistent to a study stating the importance of involving entertainment and humor in education about contraceptives and STIs for adolescents [15].

Peer-educators and community leaders were the most successful methods for accessing and involving the community, according to the HCPs. Thus, in approaching the community leaders for permission, it was beneficial to be known within the community and by its leaders. They also described the importance of approaching adolescents without judgement in order to create trust and show themselves to be dependable. Hence, the HCPs suggested teaching the community by training the adolescent peer-mothers at the facilities. This would serve to spread information and counsel other adolescents, as these peer-mothers are people they will listen to. This would not only be cost-effective; according to the HCPs, adolescents listen better to their peers. Peer-educators are suggested to be engaged and supportive in increasing the knowledge and empowerment of young people [8].

Stigma is a problem that accompany trust in myths and misconceptions from the communities, and were repeatedly mentioned by the HCPs. Using family planning services as an adolescent, and perhaps before marriage, can be difficult because of the stigma associated with it [6]. The HCPs mentioned the importance of information in order to dispel the myths. One suggested strategy was to share true stories and their own experiences with the family planning method in order to make the information feel more trustworthy to the adolescents. However, the use of contraceptives are affected by myths and misconceptions even among HCPs in Uganda, rather than evidence-based knowledge and national guidelines. Most providers had misunderstandings about contraceptives, negative attitudes toward providing contraceptives to young women, and imposed age restrictions and consent requirements on adolescents, although there were no such national guidelines restrictions [18]. The HCPs in this study suggested, to avoid misconceptions, that if the adolescents understand the side effects they will have an easier time coping or will be more likely to ask to change method instead of simply discontinuing use. Women are more likely to discontinue the use of contraceptives if they are not informed about their side effects and alternative methods [18]. Difficulty making it to one’s appointments and follow-ups, was another issue brought up by the HCPs, claimed to be due to distance and transportation. As a solution to this, the HCPs mentioned the toll-free phone service whereby one can call and receive support from a counselor. Given this being a new service offered to the adolescents, more research within this field is needed.

Education and information is the key to sexual and reproductive health, according to the HCPs in this study. To include the boys in sexuality education in school and in family planning, was considered essential, as they had no information and were separated from the girls, leading to that males considered the sexuality education of no importance. Furthermore, an approach to decrease the unmet need for family planning is to promote male involvement in family planning. Thus, decreasing male disapproval of use of contraceptives by their female partners and misconceptions about side effects [19]. The HCPs also emphasized the importance of involving parents in order to provide information and empowerment. Involving parents in the adolescent life, may reduce risk-taking among adolescents and with involved parents they may be more aware of the consequences of early initiation of sexual debut [20]. Thus, this information has to start in early adolescence, to enable access to more accurate information and avoid many of the misconceptions and incorrect information that surround sexuality [21].

A ban on sexuality education in schools in Uganda in 2017, mentioned by the HCPs, made it difficult to address these issues and reach out to a great number of adolescents. Reaching out with information at early ages might be easier if HCPs were allowed to educate and demonstrate among the young people in schools. However, the ban on sexuality education was lifted, after a national sexuality education framework was launched in 2018 [22]. This will be the first guidelines to promote and facilitate the sexuality education in Uganda. Sexuality education is important to empower young people with information and life skills that are age appropriate, cultural and religious sensitive, and to enable to make safe and healthy life choices [22]. This national framework will promote and facilitate the development of sexuality education in Uganda and support the achievement of the SDGs by 2030, such as access to family planning, information and education [8,10,22].

A qualitative design was used to describe HCPs perceptions of family planning and contraception education for adolescents in Kampala, Uganda. A strength of this method was the opportunity to explore issues related to unintended pregnancies and low contraceptive use by interviewing HCPs about their experiences in this field. The participants were collected through purposive sampling at two different facilities with a spread of different professions. However, the recruitment of facilities in this study was made by an administrator and may be affected of some level of selection bias. Quotes were presented to substantiate the content, but also to give the reader the opportunity to interpret some of the findings, to strengthen the credibility. However, a limitation of the study was that, even though the interviewer and interviewees spoke English, there were moments when the English vocabulary and skill were inadequate. This means that the researcher may have influenced the answers to some questions due to communication issues. If a statement relevant to the purpose of the study was difficult to interpret, the interviewee was asked to clarify through the use of further questions regarding the statement. Another limitation was the small sample size, even though a larger sample size may achieve similar results. Therefore, findings in this qualitative study may not be transferable to other populations and/or settings due to the explorative incentive. The extent of the transferability of the results to other populations and settings depends on cultural and traditional similarities or differences. Furthermore, when using a qualitative design the aim is not to generalize, but to offer new insight from the providers' perspective and to encourage further research within sexual and reproductive health and family planning.

Conclusion

The providers emphasized the importance to discuss and eradicate the myths and misconceptions among adolescents regarding family planning methods by giving information, preferably at early ages. They identified obstacles, and gave examples of potential improvements to develop family planning and contraception education for adolescents. Peer-educators and community leaders were the most successful methods for accessing and involving the community. Approaches mentioned for reaching out to adolescents included involving parents, using social media, and offering education in schools. Furthermore, the providers highlighted to involve the males in sexual and reproductive health care services and information for their support of family planning.

Declaration of Competing Interest

No conflicts of interest declared by the authors

Acknowledgements

We are grateful to Carl Voghera and Tove Hedberg for help in collecting data and to Lydia Kabiri, for the help to identify the facilities where collecting the data.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.srhc.2019.05.001>.

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