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Perceptions of adolescent 'simulated clients' on barriers to seeking contraceptive services in health centers and pharmacies in Mexico

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A R T I C L E I N F O

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A B S T R A C T

Objective: To examine adolescent simulated clients' perceived barriers to quality care as they sought information on contraceptives in public-sector healthcare facilities and pharmacies in Mexico.
Study design: We used a qualitative research design and conducted semi-structured interviews with eight young women who posed as simulated clients at health centers and pharmacies in Mexico City. Grounded Theory was used to analyze the transcripts.
Results: Barriers to receiving information about contraceptives included healthcare professionals who gave administrative pretexts to avoid providing services. Simulated clients also felt judged by healthcare professionals and reported a lack of simple, understandable and pertinent information. Healthcare professionals did not ensure clients understood and had no further questions about using contraceptives, which resulted in clients' poor perceived self-efficacy, as well as a lack of confidence in the healthcare system to help them.
Conclusions: When healthcare professionals fail to provide services according to the World Health Organization's five basic criteria of adolescent friendly care, adolescents perceive important barriers in their access to contraceptive methods. Quality of sexual health care in Mexico would benefit from efforts to improve healthcare professionals' knowledge, attitudes and skills related to adolescent friendly service delivery.

Introduction

The World Health Organization (WHO) establishes five criteria for quality health services for adolescents: that they be equitable (all adolescents can use the services available), accessible (adolescents are able to obtain available services), acceptable (adolescents are willing to use available services), appropriate (services provided are those that are needed) and effective (services make a positive contribution to adolescents' health) [1]. Failure among healthcare professionals to adhere to the WHO guidelines when providing sexual and reproductive healthcare affect all individuals, but can result in significant barriers to contraceptive access among adolescents because of the emotional, psychological and physical changes that occur in adolescence and which can impede or disrupt utilization of healthcare services.

Contraceptive use among sexually active adolescents in Mexico is low with 16.5% of men and 36.8% of women reporting not having used any contraceptive during their last sexual encounter [2]. In a recent national survey to health professionals, 80% recognized the importance of providing reproductive and sexual health counseling for adolescents, yet only 67% offered general contraceptives to adolescents and 21% offered emergency contraception [3]. Importantly, the survey did not gather information on the quality of provider-adolescent interactions. In a nationally representative sample from Mexico, adolescent women (ages 15–19) report receiving a lower quality of family planning services in public sector facilities compared with young adult women (ages 25–29) [4]. "Interpersonal relations" was reported as the poorest of five indicators of quality. Deeper understanding of *how* relationships and other factors affect the quality of contraceptive counseling and delivery in the context of public sector healthcare facilities and pharmacies is needed.

Recent Mexican official norms on adolescent health care[1] establish

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[1] Standard Official Mexicana NOM-047-SSA2-2015, for attention to the health of the age group of 10 to 10 years of age. (2015). Retrieved from http://www.dof.gob.mx/nota_detalle.php?codigo=5403545&fecha=12/08/2015.

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the right to receive medically accurate and comprehensive information on contraceptives as well as free access to the full range of contraceptive choices. A quantitative study using simulated client methods found more than 20% of women who sought contraceptive information in healthcare facilities or pharmacies did not receive the information they requested [5]. The study did not explore how these young women perceived their experiences or the reasons why they felt they did not receive contraceptive information. We used a qualitative research design to examine the perceived quality of the simulated clients' experiences as they sought information on contraceptives in public-sector healthcare facilities and pharmacies, particularly looking at perceived barriers to quality care. Simulated client methodology is a globally recommended and innovative strategy given the advantage of assessing quality of care from a user perspective and avoiding the inherent bias of quality reports offered by healthcare professionals [6]. Our study adds depth to how the presence (or absence) of the WHO criteria for quality health services for adolescents influence the experience of contraceptive counseling from the perspective of the user.

Methods

Fifteen young women posed as simulated clients at a sample of 434 pharmacies and 327 public-sector, primary-care healthcare facilities in Mexico City. To assess equitability of services, simulated clients were selected to represent two groups of age (younger and older than 18) and having an indigenous appearance or not. Each of the 15 simulated clients was assigned approximately 50 facilities. The simulated client visited each of the 50 assigned facilities once during the eight weeks of data collection. At every visit, the simulated client followed a script in her encounters with healthcare professionals. After each visit, the simulated client reported her observations on a standardized abstraction form to assess quality of care when seeking contraceptive information according to the WHO criteria for quality health services for adolescents. Additional information on the protocol simulated clients followed is found in de Castro et al. [5]. Prior to data collection, the simulated clients participated in multiple practice sessions with the field coordinator and conducted 10 pilot visits with pharmacies and healthcare facilities in order to refine the script and modify the standardized abstraction form, as needed. The final script incorporated "every day adolescent language" which was reviewed and confirmed by a group of adolescents.

Each simulated client had two profiles she took on, depending on the type of contraception she sought. When seeking general contraception, the simulated client provided the following background to the healthcare professional as part of the script: she became sexually active a year ago, has intercourse with variable frequency, and does not have a steady partner. She is in good health, is a sporadic smoker, does not use drugs, and drinks alcohol occasionally. She does not like oral contraceptives because she is worried she will forget to take them and does not want to get pregnant or risk HIV. When seeking emergency contraception, the simulated client provided the following information: she had intercourse two days ago without using protection and would like help so she does not get pregnant. If asked to provide specifics, she gave the same background as those seeking general contraception.

For the current study, we conducted semi-structured, one-on-one, one-time interviews with eight of the simulated clients. The inclusion criteria included having participated as a simulated client and accepting the invitation to be interviewed after hearing the study's aim. Of the 15 total simulated clients, two simulated clients declined to participate and another five simulated clients were not available on the day the interviews were scheduled. The study was approved by the ethics committee of the National Institute of Public Health in Mexico City.

Three female interviewers conducted 20- to 45-min interviews in Spanish with the eight participants. Interviews were audio-recorded with participants' written informed consent; if under 18 years, parental consent was obtained. The interview guide was designed to cover the WHO's five criteria for quality health services for adolescents: that services be equitable (referring to age and indigenous traits), accessible (referring to the wait times, the need for appointments versus walk-ins, hours of service, and cost), acceptable (referring to the demeanor and approach of healthcare professionals and the attractiveness, comfort, and cleanliness of healthcare facilities), appropriate and effective (referring to the understandability of information provided and it being able to target and address the need, respectively). To initially elicit information, we asked each participant to talk broadly about a "good" visit and a "bad" visit (referring to the treatment they experienced by healthcare professionals, including pharmacists, pharmacist assistants, nurses, doctors, and others at healthcare facilities, and whether they received the information requested). This opening question prompted rich conversation upon which the interviewers built to ask more in-depth information and cover the concepts in the interview guide.

Given that the interviews were held immediately following completion of participants' 50 assigned visits, we are confident that their general experiences were still fresh in their memory. We did not ask for information specific to one visit apart from another. Rather we brought up a topic, such as wait times, and asked for her reflections based on the breadth of her experience as a simulated client. At the end of the interview, the participants completed a short socio-demographic questionnaire; the participants' names were not recorded at any time, neither on paper nor on the audio recording. After each interview, the audio recording was uploaded to a password-protected laptop and a number was assigned to each interview to ensure participant anonymity. Interviews were transcribed verbatim in Spanish and exemplar quotes were later translated into English for this manuscript.

We used a constructed grounded theory approach to analyze the transcripts in Spanish [7]. First, each transcript was read for general understanding. Next, the second author conducted line-by-line analysis where each sentence was coded and then categorized as addressing one or more of the five WHO criteria, depending on its content: (1) accessibility, (2) acceptability, (3) appropriateness, (4) equitability, or (5) effectiveness. The second author identified emerging ideas from the data categorized in each of the five WHO criteria and recorded her thoughts in analytic memos. The emerging ideas helped with the development of focused codes, which were used to better describe the content within each category. We developed focused codes through the process of both coalescing and collapsing line-by-line codes as well as drawing distinctions between groups of codes. Lastly, the third author reviewed the focused codes, and the second and third authors developed theoretical codes that aimed to explore relationships between the focused codes and integrate them into a coherent whole. We developed theoretical codes to define possible relationships among as well as integrate and give structure to the focused codes in order to explain the largest portions of data [12].

In the results, we present the theoretical codes most relevant to each WHO criteria for quality health services for adolescents. We did not address equitability as a WHO criterion in the results because another manuscript comprehensively addressed this topic [11] and our qualitative data revealed little insight. We also did not include effectiveness as a WHO criterion in the results because it was difficult to untangle nuances between effectiveness and appropriateness in the data; thus, the categories were subsumed into one. This is similar to what was done in de Castro et al. [5,11].

Results

Accessibility (Administrative pretexts act as a barrier to service)

Many of the participants reported barriers to accessing information at pharmacies and healthcare facilities. In some cases, the barriers were straightforward, such as hours at healthcare facilities that were not convenient or well posted. In other cases, participants perceived