Perceptions, Barriers, and Challenges of Healthcare Providers in Adolescent Pregnancy Prevention Services: A Scoping Review

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ABSTRACT

***Background**: Adolescent pregnancy remains a significant global health problem due to increased maternal and child health risks, psychological impacts, and socio-economic factors. Efforts to provide quality adolescent sexual and reproductive health (ASRH) services for pregnancy prevention still require understanding from the perspective of healthcare providers. **Objective**: This review aims to explore the perceptions, barriers, and challenges faced by healthcare providers in delivering ASRH services using a Theory of Planned Behavior framework approach. **Methods**: The initial step involved exploring scholarly works from 2020 to 2025 within the Scopus, ScienceDirect, and EBSCOhost databases. This process adhered to the methodological framework of Arksey and O'Malley, alongside the PRISMA-ScR reporting guidelines. From this comprehensive screening, 11 peer-reviewed articles were identified that strictly matched the inclusion criteria, focusing specifically on the viewpoints of healthcare professionals. **Results**: This review analyzed 11 articles selected from an initial pool of 337 articles. The articles originate from the United States of America, Uganda, South Africa, Tanzania, Lebanon, Haiti, Zambia, and Kenya. Nine articles employed a qualitative design, and two employed a cross-sectional design. The review identified three key themes in adolescent sexual and reproductive health (ASRH) services: varying provider perceptions, systemic and cultural barriers, and challenges faced in adolescent-friendly service delivery. **Conclusion**: Healthcare providers play a key role in the success of ASRH services. The Theory of Planned Behavior (TPB) suggests that healthcare providers' attitudes, social pressures, and perceived behavioral control may hinder the delivery of adolescent-friendly ASRH services. The findings emphasize the need for training, support systems, and supportive policies to promote more private, friendly, and effective services for adolescents.*

***Keywords**: Healthcare provider, perceptions, barriers, challenges, adolescent pregnancy*

INTRODUCTION

According to 2022 data from the World Health Organization (WHO), approximately 21 million girls between the ages of 15 and 19 become pregnant annually in developing nations, with around 12 million continuing to deliver their babies (WHO, 2024). The proportion of adolescent pregnancies in developing countries tends to be higher than in developed countries, as 90% of the world's adolescent pregnancies occur among adolescents in developing countries (Purnami, Wicaksono and Permani, 2023). This indicates that teenage pregnancy continues to pose a major public health challenge, especially in low- and middle-income nations.

Adolescent pregnancy is associated with increased maternal and child health risks, including high rates of morbidity, mortality, premature birth, low birth weight, neonatal complications, and other adverse outcomes. Additionally, adolescent pregnancy can increase the risk of abortion, school dropout, social marginalization, socio-economic consequences for the young mother and her child, and gender inequality (Maheshwari *et al.*, 2022).

Therefore, preventing adolescent pregnancy is not only about improving maternal health but also a strategy to promote gender equality and reduce the cycle of poverty. Prevention of adolescent pregnancy is a priority strategy in low- and middle-income countries (LMICs), including through improved access to quality adolescent sexual and reproductive health (ASRH) services to achieve global health and development goals. The United

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Nations Population Fund (UNFPA) emphasizes that providing comprehensive sexuality education (CSE), ensuring access to contraception, and offering adolescent-friendly services are key strategies in preventing early and unwanted pregnancies. (Loaiza and Liang, 2013). These strategies require support from the health system, including healthcare providers who are trained and sensitive to adolescents' conditions.

Although there have been worldwide efforts to promote youth-friendly sexual and reproductive healthcare, actual usage of these services remains limited. The effectiveness of such programs depends not only on supportive infrastructure and regulations but also heavily on how well healthcare professionals communicate reliable reproductive health information, including access to contraception and counseling. The role of healthcare providers influences the care and services that adolescents receive, shaped by their perceptions and comfort levels. Studies suggest that the personal beliefs of healthcare providers and the culture of the institution can influence whether services are adolescent-friendly, non-judgmental, respectful, and confidential (Corley *et al.*, 2022).

Health professionals are central to the delivery of adolescent sexual and reproductive health (ASRH) services. The way they approach young people—including their skills, mindset, and the atmosphere they create—can greatly affect adolescents' ability to seek and receive care. While international frameworks like WHO's Global Accelerated Action for the Health of Adolescents promote respectful and confidential service delivery, many providers remain unfamiliar with these recommendations or lack the confidence and resources to implement them. Adolescents still report experiencing stigma, misinformation, and denial of services when interacting with healthcare providers. According to a report from the (Riley *et al.*, 2020), adolescents are often denied access to contraception and counseling unless they are married or accompanied by parents, causing discomfort (Riley *et al.*, 2020). Several healthcare providers view adolescents seeking sexual health services as problematic, creating an unsupportive environment and leading to decreased adolescent engagement in contraceptive access (Janighorban *et al.*, 2022).

The barriers and challenges faced by healthcare providers are not solely individual; many operate within systems lacking clear protocols for adolescent care, adequate training on counseling, and facing socio-cultural pressures that consider adolescent sexuality taboo. These issues create a challenging environment for healthcare providers, impacting the quality of services delivered (Chandra-Mouli *et al.*, 2019).

Understanding the perceptions, experiences, barriers, and challenges faced by healthcare providers is essential to identify issues that hinder access and compromise the quality of care received by adolescents. Within this framework, the Theory of Planned Behavior (TPB) posits that an individual's intention to act is shaped by three key factors: personal attitudes (such as internal beliefs and value systems), perceived social expectations (including peer pressure and lived experiences), and perceived behavioral control (including obstacles and enabling conditions) (Ajzen, 1985); (Ajzen, 2002). As an extensively applied theoretical model, TPB offers valuable insights into how healthcare providers can influence health-related behaviors, particularly those driven by strong intentionality (Chernick *et al.*, 2021). Personal attitudes and prevailing social and institutional norms may influence whether healthcare providers feel able and willing to offer adolescent-friendly and non-discriminatory services.

This review aims to explore the perceptions, barriers, and challenges faced by healthcare providers in delivering ASRH services using the Theory of Planned Behavior framework. The findings are expected to provide a strong empirical foundation for policy development and effective interventions to reduce adolescent pregnancy rates globally.

METHODS

This scoping review was conducted using the five-step framework developed by Arksey and O'Malley, which includes formulating the research question, locating relevant literature, selecting eligible studies, organizing the data, and finally synthesizing and presenting the findings. To ensure methodological rigor

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and transparency, the process also adhered to the PRISMA-ScR guidelines, aligning with established standards for conducting systematic reviews.

Research question and eligibility criteria

This study aimed to investigate how healthcare providers perceive, experience, and navigate the obstacles in enhancing both the quality and accessibility of adolescent sexual and reproductive health (ASRH) services. The inclusion criteria were defined as follows: (1) articles published between 2020 and 2025, (2) original research studies, (3) written in English, (4) available as free full texts, and (5) involving healthcare providers. Exclusion criteria included review articles, editorials, conference abstracts, newspaper articles, non-full-text publications, and studies not focused on adolescent pregnancy or healthcare providers.

Search strategy

Relevant studies were identified through searches in the Scopus, ScienceDirect, and EBSCOhost databases using the following keywords: ("perceptions") AND ("barriers") AND ("challenges") AND ("healthcare providers" OR "health workers") AND ("prevention" OR "services") AND ("adolescent pregnancy" OR "teenage pregnancy"). The articles included in this review were sourced from various journals and publishers.

These articles, published in journals such as *Reproductive Health*, *BMC Women's Health*, and *BMC Public Health* (Springer Nature), explore health workers' perceptions and challenges in providing contraceptive and ASRH services. Other studies from *International Journal of Africa Nursing Sciences*, *Journal of Adolescent Health*, and *Sexual & Reproductive Healthcare* (Elsevier) focus on providers' views and practices regarding adolescent pregnancy. Additionally, a study published in the *Journal of Multidisciplinary Healthcare* (Taylor & Francis) examines health workers' perceptions of adolescent pregnancy and its impact on the healthcare system.

Furthermore, contributions from various reputable journals, such as *The Pan African Medical Journal*, the *African Journal of Primary Health Care and Family Medicine* (published by AOSIS), and a study featured in *PLOS ONE*, provide valuable perspectives on the barriers, challenges, and facilitating factors affecting adolescents' access to ASRH services from the viewpoint of healthcare professionals. The inclusion of a broad range of scholarly sources reflects a comprehensive and well-rounded analytical approach. Initially, 337 articles were retrieved and organized using Mendeley Reference Manager, with duplicate entries carefully removed.

Study selection

After the database search, 337 article titles and abstracts were imported into Mendeley. The lead author screened and coded these, with team discussions to resolve uncertainties. Four duplicates were removed. A two-stage screening process then excluded 313 irrelevant studies, leaving 20 articles. Of these, 6 lacked necessary information, and 3 had restricted full-text access. Ultimately, 11 studies were included for synthesis. The detailed reasons for inclusion and exclusion are presented in the PRISMA flow diagram (Figure 1).

Data Extraction and Synthesis

Data extraction was performed using Microsoft Excel®, capturing key information such as the study title, authors, publication year, location, population, research design, and study objectives. The collected data were then organized into a matrix format using Microsoft Word (see Table 1).

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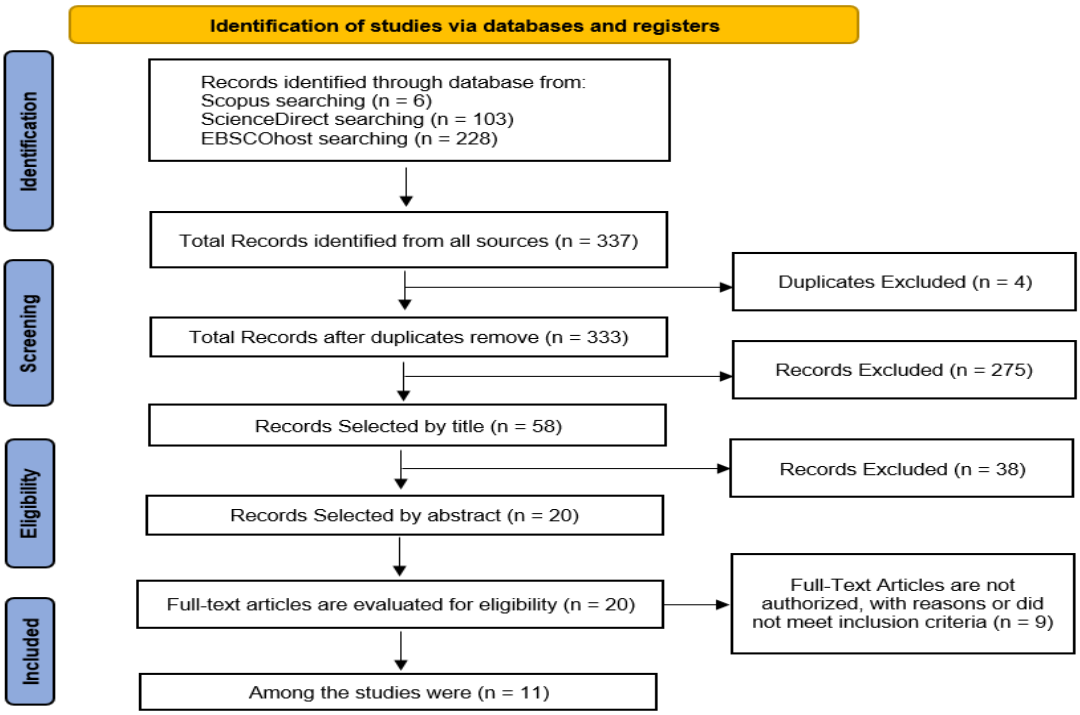

Figure 1. Prisma flowchart, article selection process

Table 1. Data Extraction Matrix

No	Title, Author, Year	Country	Study Population	Aim The Study	Study Design
1.	"Healthcare Providers' Perspectives on Pregnancy Experiences among Sexual and Gender Minority Youth (Tabaac *et al.*, 2022)	United States of America	10 healthcare providers (physicians, nurse practitioners, social workers)	To explore healthcare providers' views on the factors affecting pregnancy experiences among sexual and gender minority (SGM) youth.	Qualitative study using semi-structured interviews and thematic analysis
2.	Promoting Sustainable Health and Wellbeing for Pregnant Adolescents in Uganda - A Qualitative Case Study among Health Workers (Manhica *et al.*, 2021)	Uganda	4 healthcare workers (female, aged 20-40 years, working with pregnant adolescents)	To examine health workers' experiences in promoting sustainable health and well-being for pregnant adolescent girls in Uganda.	Qualitative case study using semi-structured interviews and content analysis
3.	Adolescent Pregnancy and Parenting: Perceptions of Healthcare Providers (Govender, Taylor and Naidoo, 2020)	South Africa	33 healthcare providers from various disciplines (nurses, doctors, psychologists, dietitians)	To investigate healthcare providers' perspectives on adolescent pregnancy and parenting at a district hospital in KwaZulu-Natal, South Africa.	Qualitative, exploratory study using semi-structured interviews

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4.	Healthcare providers' knowledge and perceptions regarding the use of modern contraceptives among adolescent girls in Umlazi Township, KwaZulu-Natal province, South Africa (Hlongwa, Tlou and Hlongwana, 2021)	South Africa	35 healthcare providers from 10 primary healthcare clinics in Umlazi township	To evaluate healthcare providers' understanding and attitudes toward the use of modern contraceptives by adolescent girls in Umlazi Township, South Africa.	Descriptive cross-sectional study using structured questionnaires
5.	Perceptions of Community Health Workers on Teenage Pregnancy in Rural Limpopo (Malapela, Mboweni and Risenga, 2024)	South Africa	81 Community Health Workers (CHWs) from rural Limpopo districts	To obtain a comprehensive insight into how Community Health Workers perceive teenage pregnancy in rural Limpopo, South Africa.	Qualitative, exploratory study using focus group discussions (FGDs)
6.	Would you offer contraception to a 14-year-old girl? Perspectives of health students and professionals in Dar es Salaam, Tanzania (Mwakawanga *et al.*, 2021)	Tanzania	121 participants (61 health professionals and 60 students from Muhimbili University of Health and Allied Sciences)	To outline the views of healthcare professionals and students regarding the delivery of contraceptive services to adolescents.	Qualitative formative assessment with 18 focus groups stratified
7.	Sexual and reproductive health of adolescent Syrian refugee girls in Lebanon: a qualitative study of healthcare provider and educator perspectives (Fahme, Sieverding and Abdulrahim, 2021)	Lebanon	18 participants (8 educators and 9 healthcare providers, including midwives, nurses, and obstetricians)	To investigate the perceptions of healthcare providers and educators concerning the factors influencing sexual and reproductive health and the care-seeking behaviors of adolescent Syrian refugee girls.	Qualitative study with in-depth interviews and focus group discussions
8.	Barriers to pregnancy prevention for adolescents in rural Haiti : perceptions of healthcare providers (Wooten *et al.*, 2024)	Haiti	58 healthcare providers (nurses, doctors, midwives)	To investigate healthcare providers' views on the obstacles and enablers affecting adolescent contraceptive care in rural Haiti.	Mixed-methods (cross-sectional survey and qualitative interviews)

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9.	Understanding Primary Care Providers' Perceptions and Practices in Implementing Confidential Adolescent Sexual and Reproductive Health Services (Sieving *et al.*, 2020)	United States of America	25 primary care providers (pediatricians, family physicians, nurse practitioners)	To examine how primary care providers handle confidential sexual and reproductive health services for adolescents.	Qualitative study with in-depth individual interviews
10.	Experiences of teachers and community-based health workers in addressing adolescents' sexual reproductive health and rights problems in rural health systems: a case of the RISE project in (Chilambe *et al.*, 2023)	Zambia	21 participants (16 women, 5 men): teachers and community-based health workers (CBHWs)	To investigate the roles, difficulties, and approaches of teachers and community health workers in tackling adolescent sexual and reproductive health and rights issues in rural Zambia.	Qualitative narrative inquiry study design
11.	Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya (Mutea *et al.*, 2020)	Kenya	13 participants in 61 sessions; includes 70 adolescents, 12 community representatives, 14 teachers, 10 healthcare workers, and 7 county leaders	To identify the obstacles and enabling factors affecting access to and utilization of adolescent sexual and reproductive health (ASRH) services in Kisumu and Kakamega, two counties in Kenya with high service demand.	Qualitative study Methods used: FGDs, IDIs, KIIs

RESULTS AND DISCUSSION

Characteristics of Included Studies

The initial database search yielded 337 articles from Scopus (6), ScienceDirect (103), and EBSCOhost (228). Following abstract screening and full-text assessment, 11 articles met the inclusion criteria. These studies were conducted in various countries, including the United States (2), Uganda (1), South Africa (3), Tanzania (1), Lebanon (1), Haiti (1), Zambia (1), and Kenya (1). Of these, nine employed qualitative methods, while two used cross-sectional designs.

All studies included healthcare providers as participants and represented various fields. The healthcare providers involved comprised primary health workers, healthcare workers (HCWs), community-based health workers (CBHWs), and community health workers (CHWs). The reviewed studies highlight different factors that influence the effectiveness of ASRH services, as perceived by healthcare providers across different countries. These factors include personal beliefs and moral values, sociocultural and religious norms, and institutional limitations such as lack of training, insufficient privacy, and inadequate adolescent-friendly infrastructure. Biases and discomfort in addressing adolescent sexuality are often

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associated with judgmental attitudes and limited contraceptive counseling.

Perceived barriers such as the absence of clear protocols, inadequate policy support, and limited access to contraceptives hinder service provision. Conversely, facilitators such as comprehensive training, a non-judgmental communication approach, and active engagement of community stakeholders have been identified as important strategies for improving service quality and acceptability.

Attitude Toward the Behavior of Healthcare Providers

The attitudes of healthcare providers toward ASRH (Adolescent Sexual and Reproductive Health) services, as reported in this review, are strongly influenced by personal values, culture, and moral understanding. Negative attitudes often stem from the belief that adolescents should not be sexually active and should not receive contraceptive services if unmarried, as well as from social pressures exerted by families and communities. Several studies describe healthcare providers as skeptical and judgmental toward adolescents seeking these services.

For example, a study in Tanzania revealed that some healthcare professionals hesitated to provide contraception to adolescents, believing that they should be advised to abstain and that parental consent should be obtained before offering contraceptives (Mwakawanga *et al.*, 2021). Similarly, in South Africa, 57% of healthcare providers expressed negative attitudes toward adolescents trying to access contraception, with 82.9% of adolescent respondents reporting judgmental behavior from providers when accessing services (Hlongwa, Tlou and Hlongwana, 2021). In Kenya, most adolescents reported experiencing negative attitudes from healthcare workers, such as rudeness and a lack of respect for privacy and confidentiality (Mutea *et al.*, 2020).

Conversely, some studies noted positive attitudes among healthcare providers toward adolescents accessing ASRH services, often due to policy support and adolescent-centered training. For instance, in Zambia, community health workers supported contraceptive education for all adolescents and perceived themselves as key educators in sexual and reproductive health (Chilambe *et al.*, 2023). In Haiti, healthcare providers felt a significant responsibility to educate adolescents about pregnancy prevention and held positive views of long-acting reversible contraception (LARC) for adolescents (Wooten *et al.*, 2024). Additionally, in the United States, primary healthcare providers emphasized the importance of providing private time and maintaining confidentiality for the success of ASRH services (Sieving *et al.*, 2020).

Cross-country comparisons indicate that healthcare providers' attitudes are shaped by the social context and healthcare system within each country. Countries with inclusive training systems and rights-based approaches to adolescent health tend to foster more supportive attitudes among providers. Conversely, countries with strong religious and social norms often experience more resistance from healthcare providers. This is consistent with findings from Malawi, where health workers often internalize social norms that restrict adolescents' access to contraceptive services (Solo and Festin, 2019).

Within the framework of the Theory of Planned Behavior (TPB), these findings suggest that healthcare providers' personal and moral beliefs significantly influence their attitudes toward providing ASRH services. Negative attitudes rooted in social and moral norms may reduce providers' intentions to offer these services, even when resources and opportunities are available. Judgmental behaviors and lack of empathy can serve as barriers, discouraging adolescents from seeking sexual and reproductive health services. Therefore, training programs should not only focus on technical skills but also prioritize developing non-judgmental, supportive approaches when working with adolescents (Chandra-Mouli *et al.*, 2019).

Subjective Norms of Healthcare Providers

Subjective norms refer to an individual's perception of social pressure or expectations from others regarding a particular behavior. In the context of ASRH (Adolescent Sexual and Reproductive Health) services, healthcare providers often face pressures from adolescents' families, communities, religious leaders, and society at large, which can implicitly

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influence their decision-making. Studies from various countries reveal that healthcare providers, although personally willing to provide contraceptive services, may restrain themselves due to fear of disapproval from adolescents' families, community pressure, or lack of supportive policies.

In South Africa and Haiti, healthcare providers often report feeling caught between their professional responsibilities and the dominant social norms within their communities concerning contraception and ASRH services (Malapela, Mboweni and Risenga, 2024); (Wooten *et al.*, 2024). In Lebanon and Tanzania, it has been shown that when adolescents voluntarily sought contraceptive services, healthcare providers were reluctant to provide them without parental consent, citing strong community moral and cultural views that prevented them from freely offering contraceptive services to adolescents (Fahme, Sieverding and Abdulrahim, 2021); (Mwakawanga *et al.*, 2021).

In Kenya, healthcare providers often avoid direct discussions about sexuality with adolescents due to societal taboos surrounding the topic (Mutea *et al.*, 2020). In KwaZulu-Natal, South Africa, providers reported experiencing peer pressure in the workplace to adhere to conservative norms. They feared violating cultural values by being too open with adolescents regarding contraception or sexual relationships (Govender, Taylor and Naidoo, 2020). Additionally, a lack of parental support for contraceptive use among adolescents can make young people fearful of accessing services, as they often require permission from guardians. This leaves providers feeling burdened and sometimes prompts them to limit services to avoid social conflict (Wooten *et al.*, 2024).

In contrast, in the United States of America, ASRH services are supported by a more progressive and inclusive social environment. This encourages the provision of youth-friendly, non-discriminatory services. Healthcare providers in such contexts often feel supported and are ethically obligated to uphold adolescents' rights to reproductive health information and services (Sieving *et al.*, 2020).

Cross-country analyses suggest that subjective norms are shaped not only by the broader community but also by internal dynamics within the healthcare system. In progressive environments, social norms can reinforce positive behaviors, supporting providers in delivering adolescent-sensitive services. Conversely, in conservative systems, norms often act as significant barriers to providing services aligned with adolescent health and rights principles.

Within the framework of the Theory of Planned Behavior (TPB), these findings illustrate that social norms influence service delivery decisions. When social norms discourage adolescent access to services, even providers with positive attitudes and sufficient resources may withdraw from service provision. Conversely, when social and institutional environments are supportive, providers are more likely to deliver high-quality, adolescent-sensitive services confidently. To improve the sustainability and quality of ASRH services, supportive and responsive policies are essential, including clear regulations regarding age of consent and parental permission (Ooms *et al.*, 2022).

Perceived Behavioral Control of Healthcare Providers

Perceived behavioral control refers to an individual's belief in the extent to which they can influence or perform a particular behavior. In the context of ASRH (Adolescent Sexual and Reproductive Health) services, this pertains to healthcare providers' perceptions of their ability to deliver services, which are influenced by the availability of resources, training, policy support, and the work environment. Multiple studies across countries have found that many healthcare providers in low- and middle-income countries often face significant limitations, including inadequate infrastructure, regulatory constraints, and systemic healthcare challenges.

Limited resources and facilities remain prevalent in developing countries, with issues such as inappropriate service hours, insufficient contraceptive supplies, hidden service costs, long travel distances and transportation expenses, and high workloads. These factors frequently inhibit the optimal provision of care (Mutea *et al.*, 2020); (Fahme, Sieverding and Abdulrahim, 2021); (Hlongwa, Tlou and Hlongwana, 2021); (Malapela, Mboweni and Risenga, 2024). In South Africa and

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Haiti, the lack of specialized training for ASRH services and inadequate knowledge of contraception and adolescent reproductive health rights led to a lack of confidence among providers, negatively impacting service delivery. Additionally, many facilities lacked clear adolescent-specific service standards, resulting in confusion and inconsistency in service provision (Mutea *et al.*, 2020); (Wooten *et al.*, 2024).

Another factor reducing perceived control is the presence of institutional policies that do not support services for unmarried adolescents. In Tanzania and Kenya, healthcare providers faced ambiguity regarding the implementation of ASRH policies and were often unaware of or confused about legal restrictions affecting adolescent service delivery (Mutea *et al.*, 2020); (Mwakawanga *et al.*, 2021). Meanwhile, in the United States, research focusing on Sexual and Gender Minority Adolescents highlighted challenges related to clinical procedures that do not account for sexual and gender diversity, thereby limiting access for these populations (Tabaac *et al.*, 2022). This finding suggests that behavioral control is influenced not only by technical resources but also by policies and rules within the work environment.

Furthermore, countries with less supportive health systems—such as South Africa, Uganda, and Kenya—face shortages of trained health workers, adolescent-friendly spaces, and facilities for health education, which hinder the provision of private and youth-friendly services (Govender, Taylor and Naidoo, 2020); (Mutea *et al.*, 2020); (Manhica *et al.*, 2021). In Uganda and Kenya, lack of funding and institutional support limit the scope for service delivery and innovation (Mutea *et al.*, 2020); (Manhica *et al.*, 2021). In contrast, in the United States, healthcare providers often receive training in adolescent-centered care and work within systems that uphold adolescent reproductive rights. This supportive environment enhances their confidence and autonomy in service delivery (Sieving *et al.*, 2020).

Cross-country comparisons reveal that most low- and middle-income countries face multiple barriers—including infrastructural, regulatory, and systemic challenges—that reinforce healthcare providers' perceptions of their inability to deliver effective services. However, in countries where adequate resources, managerial support, and clear referral structures are in place, providers are better equipped to fulfill their roles effectively. Negative emotional responses, lack of knowledge, stigmatization, judgmental attitudes, and negative perceptions among providers also contribute to decreased care-seeking behaviors among adolescents, particularly those who are pregnant (Hamza, 2021).

Within the framework of the Theory of Planned Behavior (TPB), healthcare providers with low perceived behavioral control tend to have reduced intentions and a lower likelihood of performing desired behaviors, ultimately impacting their motivation and ability to deliver services. This underscores the importance of creating a supportive work environment. Adolescent-centered training, health system strengthening, and clear policies can enhance providers' perceived behavioral control, leading to more adolescent-friendly and high-quality ASRH services. Effective interventions should consider the cultural context and health system realities, emphasizing capacity building, policy reform, and socio-cultural change to improve services for adolescents (Erasmus, Knight and Dutton, 2020).

Behavioral Intention and Actual Behavior of Healthcare Providers

Within the TPB framework, behavioral intention is the most immediate determinant of actual behavior and is shaped by attitude, subjective norms, and perceived behavioral control. In the context of ASRH services, healthcare providers' intentions to deliver services are influenced by these three constructs. Often, even when providers hold positive attitudes, their intention to act remains inhibited due to social norm pressures or low perceived control.

In many countries with weaker health systems or restrictive social norms, a gap exists between providers' intentions and their actual behaviors. Healthcare providers who wish to assist adolescents may feel unable to do so because of a lack of regulatory support—such as requirements for parental consent—or fear of social sanctions. As a result, service delivery becomes inconsistent, and adolescents continue to face significant barriers in accessing safe and reliable care.

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These findings underscore the need for a comprehensive intervention strategy that includes technical capacity building, attitude change, social norm modification, and policy reforms that offer protection and clarity for health service providers. Such measures can help bridge the gap between intention and practice, leading to more private, adolescent-friendly, and effective ASRH services.

CONCLUSION

This review highlights the critical role of healthcare providers in delivering adolescent sexual and reproductive health (ASRH) services. By examining their perceptions, barriers, and challenges through the lens of the Theory of Planned Behavior (TPB) framework, it was found that negative attitudes toward adolescent sexuality, social pressures, and low perceived behavioral control can hinder healthcare providers' intentions and actions in delivering inclusive and adolescent-friendly services. The implications of these findings underscore the need to improve the quality of ASRH services through targeted provider training, system support, and enabling policies. Such efforts can enhance provider confidence and readiness to effectively meet adolescents' reproductive health needs.

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