Title

Types, processes, and constraints to provision of youth-friendly sexual and reproductive health services in Nigeria: a qualitative exploration of young people and health providers' perspectives

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Abstract

Background: Young people suffer disproportionately because their sexual and reproductive health (SRH) needs are underserved. This study explored young people's and health providers' perspectives on what, who, and how SRH services are delivered to young people and factors constraining access to youth-friendly SRH services in Ebonyi State, southeast Nigeria.

Methods: Employing qualitative study design, data was collected using twenty in-depth interviews with SRH service providers and ten focus group discussions with young people (male and female aged 15–24 years) in six communities of Ebonyi State, southeast Nigeria. Interview guides were used to collect information on the types of SRH services, processes of SRH service delivery, and the factors influencing young people's access. Data were analyzed in NVivo using thematic analysis.

Results: The findings revealed that many SRH services are provided to young people, including contraception services, sexuality education, counselling, maternal and childcare, treatment of sexually transmitted infections, and gender-based violence services. Trained health workers provide the SRH services with support from relevant agencies of the Ministry of Health and development partners. The process of SRH service delivery takes a systematic yet swift procedure of reception, registration, consultation, and delivery of required services (that is usually courteous, empathic, friendly, and friendly ensuring confidentiality and privacy). However, access to comprehensive SRH services is noted constrained by health system factors like inadequate workforce, infrastructure/equipment, as well as personal and relational factors- fear, anxiety, shame, and service acceptability due to sociocultural influences and facilitated by free or subsidized costs for donor-supported services.

Conclusions: Many youth-friendly SRH services are provided to young people. However, inadequate human, material, and financial resources limit comprehensive access. Governments should create supportive environments, such as providing adequate health personnel, infrastructures, affordable fees for non-donor supported services, and inclusion of SRH services for young people in basic healthcare provision schemes, to maximize access.

Introduction

Young people are at high risk of sexual and reproductive health (SRH) problems like teenage pregnancies, unsafe abortion, sexually transmitted infections (STIs), and other life-threatening SRH problems.[1] Despite the demonstrated SRH need of young people and the recognition of youth-friendly reproductive health services as pivotal to improving access to SRH services (SRHS), the SRH needs of young people remain underserved.[2] Evidence from low and middle-income countries (LMICs) revealed that only about 10% of adolescent women who visited health facilities were informed about family planning, 20 to 25% reported an unmet need for contraception,[2] and the prevalence of new STI cases remains staggeringly high, with the highest rates among those aged 15 to 24,[3] and only 10% of young

men and 15% of young women are aware of their HIV status.[3] Thus, young people consequently suffer a disproportionate burden of poor SRH indices, often with significant socio-economic consequences.[2]

Delivering quality SRH services tailored to young people's needs increases the likelihood of obtaining healthcare.[4] However, young people are inadequately provided with the needed SRHS; attributable to disparities in access to services and lack of priority to young people's SRH.[5] Many young people face significant barriers to accessing quality and youth-friendly SRH services.[2] Even when young people access SRH services, they may feel embarrassed, face stigma, or have concerns about the attitudes of judgmental and unfriendly providers.[6] According to the World Health Organization's (WHO) Global Consultation on Adolescent-Friendly Health Services, SRHS should aim to achieve at least one of three goals: (a) provide a supportive environment, (b) improve reproductive health knowledge, attitudes, skills, and behaviours, and (c) increase utilization of health and related services.[7]

Youth-friendly health services (YFHS) are a promising approach to delivering health services to meet the SRH needs of young people.[7] However, there is a paucity of information on youth-friendly SRH service provision regarding how accessible, acceptable, equitable, appropriate, and effective they are for young people who may have specific needs associated with accessing such services.[8] An in-depth understanding of the users' and providers' perspectives of what aspects of YFHS are most relevant and essential to meet the health needs of young, especially in developing countries, where culture and tradition still affect young peoples' SRH[9] will help to guide policy, programs, and practice. This paper provides in-depth evidence on health providers' and young people's perspectives of what, who, and how SRH services essential to improving SRH outcomes of young people are delivered and factors that potentially influence access to YFHS; this will enhance universal SRH coverage for young people.

Methods

Study design, setting, and population: Employing a qualitative study design, focus group discussions (FGD) and in-depth interviews (IDI) were conducted to explore young people's and health providers' perspectives regarding access to SRH services (SRHS) in Ebonyi State, southeast Nigeria. The study population comprised 68 young people (males and females aged 15-24 years) and 20 healthcare workers who provided SRHS at the primary health centres. A modified cluster sampling (three-stage) was used. Stage one entailed selecting the LGAs by stratifying the state into three senatorial zones and purposively selecting two from each zone based on poor sexual indices of high teenage pregnancy. In the second stage, two communities (serving as clusters) were selected from each LGA using simple random sampling by balloting. In the third stage, there was a purposive selection of young people based on a report of having accessed SRHS at the PHC and service providers based on involvement with SRH service provision at the study sites, thus, could share their experiences.

Data collection method: Ten FGDs and twenty IDIs were conducted using pre-tested question guides developed by the researchers to obtain information on the types and processes of SRH services, and facilitators and barriers to young people's access to SRH service provision. The FGDs were conducted with young people stratified by gender (males and females) and age categories (older and younger). Each FGD had six to twelve young persons. The FGDs were conducted in English and local dialects in secluded chosen sites and lasted 45-60 minutes. The IDIs with SRH service providers were conducted in English in the respondent's offices and lasted 30-40 minutes. The discussions/interviews were conducted by four experienced researchers trained for three days on qualitative data collection methods and ethical principles. Two persons, a moderator and a notetaker, conducted each interview, which was also audio-recorded for completeness after getting informed consent from the participants.

Ethical consideration: Ethical approval for the study was obtained from the Research and Ethics Committee of Ebonyi State Ministry of Health Abakaliki, Nigeria. (EBSHREC/07/03/2022-06/02/2026). Permission and buy-in for the study were secured through advocacy to the council of traditional rulers, the community development union's leadership, and the management of Ebonyi State Primary Health Care Development Agency (EBSPHCDA), and the purpose of the study were communicated to them.

Written informed consent to participate in the study and publication of the findings was obtained from respondents 18 years and above and assent from those below 18 years, while written informed consent was obtained from their parents/legal guardians. Participation was voluntary, and confidentiality was assured participants.

Data management and analysis: The audio recordings were transcribed verbatim and then translated to English by two persons with good command of both languages. The scripts were compared with the field notes and against the audiotape for completeness and quality assurance by an independent reviewer. The software NVivo 1.7.7 (1534) was used to analyze the data. Two reviewers coded the transcripts (double coding) for similarity; where differences existed, they were reconciled by an independent, experienced reviewer. The coding process involved familiarisation with the transcripts, coding two scripts to generate initial ideas, and building more codes (coding tree) and themes as they emerged. The co-investigator (an experienced social scientist) reviewed and grouped the emerging themes under broader themes. Four themes and fourteen subthemes emerged, comprising a) description of types of SRHS provided to young people, b) SRHS providers and users attributes, c) processes of SRHS delivery, and d) barriers and facilitators of young people's access to SRHS. The findings are presented as narratives.

Results

Types of SRH services provided to young people: Various types of SRH services are provided to young people including management of sexually transmitted infections **(**STIs), sexuality education contraception services, and maternal and childcare services, at variance with a previous study that reported a lack of SRHS attributed to the absence of youth-friendly clinic in health facilities.[10] A respondent stated "...*I had sexual intercourse and contracted gonorrhea, so I went there and was informed about the dangers of unprotected sex and how to avoid the complications. They encouraged me to avoid sex or use a condom while having sex. They sent me for tests and gave me drugs"* (FGD, OM, 10-R02). "…*For gender-based violence, like harassment, assault, or rape, we explain to them to come and report; we run a test to know if she has contracted maybe HIV, give antibiotics, and refer the person to a place where she will get the appropriate services* (IDI, URB-06)

Processes of SRH service provision: Respondents stated that healthcare providers are usually receptive, courteous, friendly, and fair and attend to them promptly in a conducive environment; a finding that contradicts an earlier study which reported that services were not youth-friendly.[11]

"*…at the health centre, workers are on standby. First, they welcome you, give you a seat, ask you what brought you to the health centre, and make arrangements on how to get your treatments. There is no preferential treatment; they attend people on a first-come, first-served basis"* (FGD, YF06, R07). "*The summary is that when they come, you welcome them, exchange pleasantries, create a rapport with the person, and place her in a comfortable and private place so she isn't scared to open up. I don't merge older and younger ones, married and unmarried. I separate them so that they can feel free. We usually attend to them* [young people] *immediately without wasting any time"* (IDI, RUR-5)

Barriers to SRH service provision and utilization.

Health systems factors, including inadequate human, material, and financial resources, and individual and relational factors were reported as constraints to SRHS provision and utilization. Respondents stated that insufficient healthcare workers and a lack of equipment limit SRH service provision and negatively impact service costs. "*…we don't provide treatment for STIs…we have not gotten what we will use to do the tests"* (IDI, RUR-19). A similar challenge of commodity supply was reported in a previous study[12] highlighting the importance of commodity availability in ensuring quality care and a priority in young people's access to SRHS. On the cost of service, a respondent stated "…*You know they shouldn't pay for some of the services, but sometimes you know the Government doesn't provide*

certain things that we use; that is why we collect some amount from them. They also buy if we don't have donor-non-supported drugs or ANC routine drugs we buy with our money (IDI, URB-06)

Respondents noted that lack of living accommodation for staff limits operation schedules and their ability to provide 24-hour service; thus, young people cannot access SRH services at their preferred time. "*We don't open for 24 hours because we have no accommodation for sleeping over; you know young people like coming late when nobody will see them* (IDI, URB-10). They further added that the citing/location of some health facilities in places that are not central, easily accessible, or appropriate for young people (e.g. close to the market) discourages young people from accessing services from them as they can be easily seen or identified by relatives or passers-by, and their motives for coming to the health facilities may be misconstrued. "*You know, there is a way this structure* (health facility*) is built; it is not all that encouraging. This place is a market, and some people may know them. If you walk in, somebody may be looking at you somehow- that kind of scenario.* (IDI, URB-04)

On provider and client characteristics, respondents stated that although SRH services are provided primarily by trained government-employed health workers corroborating a study in Vanuatu where SRH services are provided at government health facilities,[13] our study found that most health facilities have few workforces, who are predominantly females, hence, limits opportunity to make preferred gender choices of health provider. They added that different categories of young people come for services, however, the client load is very low. *"Sincerely speaking, it is rare for young people to come for family planning commodities. Most of our clients are married people, both boys and girls come here, but females come more. Some of them are students, like undergraduates, and some of the boys are working apprentices; they are not in school"* (IDI, URB-07)

Respondents expressed that personal values about SRHS among some healthcare workers influence their disposition toward service provision. For instance, some health providers are reluctant to provide contraceptive services to young people, even when the sexually active young people who genuinely need these services seek them. *"Sincerely speaking, I will not allow them to access it* [contraception] *because I will not give them if they are my children. I will counsel them on the implications of those things and advise them to keep on their own* [abstain]" (IDI, URB-08). *The* young people expressed that their utilization of SRH is also constrained by personal attributes such as fear and anxiety about their revealed health outcome and cultural acceptability of some of the services; hence, desist from accessing the services**. "***I am afraid to go because I may have positive results. Also, our parents because of ignorance, think that they were teaching us bad things that will make us go astray because they show us how to use condoms and other prevention drugs and so, they don't support us"* (FGD, OM 10-R02). The influence of community support of sexual matters in improving SRH has been described by other authors[14] as an essential predictor of young people's care-seeking behaviour.

Facilitators to SRH service provision and utilization

Regarding funding, the respondents stated access to SRHS is facilitated by the free or subsidized costs for some services like sexuality education, counselling, contraception, gender-based violence, and maternal and childcare services with support from some line agencies, state health insurance agencies, and some development partners. *"…Many NGOs collaborate with the state government to support these* [SRH] *services like UNFPA, USAID-IHP to provide free commodities for family planning and other drugs." (*IDI, URB-08). *The young people don't pay for some of the services. Services like immunization, family planning, ANC, HIV counselling, and testing are free. Also, those who registered with the state health insurance scheme don't pay.* (IDI, RUR-18). The financial accessibility through free service provision by government and partners' support is noteworthy and corroborates another study in Nigeria.[11]

To address the problem of inadequate workforce, health providers stated that volunteer health workers are usually recruited, trained, and mentored by the officers in charge of the facilities, while other facility health workers not formally trained to provide SRH services are co-opted and guided to assist in service provision. *"We are only three staff. I, a nurse, a CHEW, and an environmental health worker. I have volunteers. I step down training to them because they are helping me".* (IDI, URB-07)

Limitation: While we aimed to sample a broad cross-section of the study area, the purposive sampling of the communities that have poor SRH indices and youth-friendly centres may have resulted in sampling bias of respondents who were more likely to be acquainted with youth-friendly services. Also, the study focused in southeast Nigeria and may not be used to generalize in a setting like Nigeria with multi-ethnic and multi-religious influences. Thus, we recommend the inclusion of parents and community members in future studies as more holistic findings may emerge.

Conclusions: The findings study show that varied SRH services tailored to meet the needs of young people are provided systematically by trained health workers. However, inadequate manpower, equipment/infrastructure, and service costs for non-supported SRH services constrain adequate provision of youth-friendly SRH services, while free or subsidized costs for supported services facilitate access. Governments should strengthen strategies that aim to create a more supportive environment, such as the provision of adequate health personnel, affordable fees for services, and the inclusion of SRH services for young people in basic healthcare provision schemes to maximize access.

References

1. Dida N, Darega B, Takele A. Reproductive health services utilization and its associated factors among Madawalabu University students, Southeast Ethiopia: cross-sectional study. BMC research notes. 2015;8(1):1-8.
2. Woog V, Susheela S, Alyssa B, Jesse P. Adolescent women's need for and use of sexual and reproductive health services in developing countries. New York: Guttmacher Institute; 2015.
3. Newton-Levinson A, Leichliter JS, Chandra-Mouli V. Sexually Transmitted Infection Services for Adolescents and Youth in Low- and Middle-Income Countries: Perceived and Experienced Barriers to Accessing Care. J Adolesc Health. 2016;59(1):7-16.
4. Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Meeting the contraceptive needs of teens and young adults: youth-friendly and long-acting reversible contraceptive Services in U.S. Family planning facilities. J Adolesc Health. 2013;52(3):284–92.
5. Enwereji EE, Enwereji KO. Increasing use of reproductive health services through community-based and health care financing programmes: impact and sustainability in Abia state Nigeria. Global Advanced Research Journal of Peace, Gender and Development. 2013;2(4):81–5.
6. Santhya KG, Jejeebhoy SJ. Sexual and reproductive health and rights of adolescent girls: evidence from low- and middle-income countries. Glob Public Health. 2015;10(2):189–221.
7. WHO: Making health services adolescent friendly: developing national quality standards for adolescent friendly health services. Geneva: Department of Maternal, Newborn, Child and Adolescent Health, World Health Organisation; 2012
8. Brittain AW, Williams JR, Zapata LB, Pazol K, Romero LM, Weik TS. Youth-friendly family planning services for young people: a systematic review. Am J Prev Med. 2015;49(2):S73–84.
9. Odo AN, Samuel ES, Nwagu EN, Nnamani PO, Atama CS. Sexual and reproductive health services (SRHS) for adolescents in Enugu state, Nigeria: a mixed methods approach. BMC health services research. 2018;18:1-12.
10. Wilunda C, Oyerinde K, Putoto G, Lochoro P, Dall'Oglio G, Manenti F, Segafredo G, Atzori A, Criel B, Panza A, Quaglio G. Availability, utilisation and quality of maternal and neonatal health care services in Karamoja region, Uganda: a health facility-based survey. Reproductive health. 2015;12(1):1-11.
11. Alli F, Maharaj P, Vawda MY: Interpersonal relations between health care workers and young clients: barriers to accessing sexual and reproductive health care. J Community Health 2013, 38(1):150–155.
12. Ebonyi State Ministry of Health; Government strategic health Development plan (2017 – 2022). SMOH Abakaliki. 2017.
13. Kennedy E, Bulu S, Harris J, Humphreys D, Malverus J, Gray N. Increasing adolescents' access to sexual and reproductive health services in Vanuatu. Policy brief. 2010.
14. Ezenwaka U, Mbachu C, Ezumah N, Eze I, Agu C, Agu I, Onwujekwe O. Exploring factors constraining utilization of contraceptive services among adolescents in Southeast Nigeria: an application of the socio-ecological model. BMC Public Health. 2020;20:1-11.