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Exploring the perceptions of health service providers and adolescents on the utilization of adolescent sexual and reproductive health services in Tikur, 2023: A qualitative study

Befkad Derese Tilahun[1], Gizachew Yilak[1], Shewangizaw Amena[1], Gebremeskel Kibret Abebe[2] and Mulat Ayele[3]

Abstract

Objectives: Globally, twenty-three million adolescents aged 15–19 years have an unmet need for sexual and reproductive health services and are at risk of unintended pregnancy. In Sub-Saharan Africa, including Ethiopia, it might be difficult for adolescents to get access to sexual and reproductive health services that are acceptable to use. Privacy, a fear of sharing health concerns, a sociocultural environment, the unfriendliness of current services, and traditional taboos are some of the key reasons. This study aimed to explore the perspectives of service providers and adolescents on the use of sexual and reproductive health services.
Methodology: A qualitative phenomenological study was conducted from January to February 2023 in the Tikur Anbessa specialized hospital. Purposive sampling was applied to select the study participants. A total of 17 in-depth interviews (with 7 adolescents and 10 health providers) were held. Instead of relying on the number of participants, data saturation was used. Thematic analysis was employed in analyzing the data.
Result: The findings indicate that obstacles to the use of sexual and reproductive health services include challenges related to the availability of resources and accessibility; resistance from religious beliefs, cultural beliefs, and customs; quality and institutional-related challenges; and stigma and discrimination in sexual and reproductive health services, which pose the biggest barrier to health professionals providing standardized sexual and reproductive health services.
Conclusion: A multi-pronged approach should be created to overcome these challenges, including community outreach for sexual and reproductive health and increasing awareness of the importance of early access to sexual and reproductive health through appropriate community forums. Existing sexual and reproductive health services are not promoted to adolescents and youth, and a lack of and difficulty getting resources for sexual and reproductive health services should be resolved.

Keywords
Adolescents, Tikur Anbessa, sexual and reproductive health services, Ethiopia

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Introduction

The goals of sexual health go beyond procreation- or sexually transmitted disease-related counseling and care to include improving life and relationships. Reproductive health denotes a person's capacity for a responsible, fulfilling, and safe sexual life as well as their ability to choose whether, when, and how often to have children.[1] Both men and women should have access to the fertility control methods of their choice that are acceptable, safe, affordable, and effective, as well as to the necessary health services that will allow women to safely experience pregnancy and childbirth and give couples the best chance possible of having healthy offspring.[2]

[1]Department of Nursing, College of Health Science, Woldia University, Woldia, Ethiopia
[2]Department of Emergency and Critical Nursing, School of Nursing, College of Medicine and Health Sciences, Woldia University, Woldia, Ethiopia
[3]School of Midwifery, College of Health Science, Woldia University, Woldia, Ethiopia

Corresponding author:
Befkad Derese Tilahun, Department of Nursing College of Health Science, Woldia University, PO Box. 400, Woldia, Ethiopia.
Email: befkadderese6@gmail.com

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Depending on their phases of personal development and environmental factors, adolescents are a varied group with a variety of requirements that change over time and they require assistance in making their own decisions and acting on them, as well as safety from harm. They also require medical care and counseling services that can assist in keeping them healthy and helping them regain their health.[1,3,4] "Adolescence (10–19 years of age) is one of life's most fascinating and complex life stages."[5]

There are more young people than ever before in the world: 1.8 billion of them are between the ages of 10 and 25 and 90% of them live in developing nations. Half of the world's population is under the age of 25.[6] Twenty-three million adolescents aged 15–19 years have an unmet need for modern contraception and are at risk of unintended pregnancy.[7] Adolscents who understand the advantages of contraception and want to use it face many obstacles, including laws and policies that restrict access to contraception based on factors like age or marital status, bias on the part of healthcare providers or a refusal to recognize adolescents' needs in this area, and adolescents' own inability to use contraception due to lack of information, lack of transportation, or financial limitations. Even when adolescents are able to obtain and use contraceptives, they encounter obstacles that prevent their consistent and appropriate use. These obstacles include pressure to have children, the stigma associated with non-marital sexual activity or contraceptive use, fear of side effects, ignorance of how to use contraceptives correctly, and reasons for discontinuation (such as refusal to seek contraception again).[8] As a result, unmet sexual and reproductive health services needs among adolescents are greater than in any other age group.[7]

In Sub-Saharan Africa, it might be difficult for youth to get access to sexual and reproductive health (SRH) services that are acceptable. Lack of political will and a sociocultural climate that thinks they should not have access to SRH services are the reasons for the difficulties.[7] While there are SRH services available in Nigeria, for instance, many young people do not consider them to be youth-friendly since they encounter stigma and discrimination while using the SRH programs.[8]

In Ethiopia, 16% of adolescents and 41% of women aged 20–24 were married by age 18, respectively. Due to early marriage ages and high adolescent pregnancy rates (71% of women aged 15–24 had a live birth or were pregnant, according to the 2011 Ethiopia demographic and health survey), young Ethiopians are particularly susceptible to maternal mortality and morbidity. The highest unmet demand in Ethiopia in 2011 was among those between the ages of 15 and 19, at 32%, despite the fact that utilization of modern contraceptive techniques among those aged 15–24 climbed from 5% in 2000 to 27% in 2011. Furthermore, 25% of pregnant women between ages of 15 and 24 think their pregnancy was not planned or came at the wrong time.[9]

According to a study done in Ethiopia, young people think that using contraception while single is a sign of promiscuity[10] and the subjects of privacy, a fear of disclosing health concerns, low approachability to services, unfriendliness of existing services, and traditional taboos were among the main reasons stated by adolescents for low utilization of SRHs in the country. Furthermore, usage is very low, especially in the country's urban centers, where it ranges from 21% to 38%. Additionally, just 2% of the population in rural areas of the country at any given time used SRH services. Age, communication styles, knowledge, parent and peer discussion of SRH topics, poor educational levels, and other factors have all been related to the use of SRH services. Understanding the obstacles to adolescent SRH service use is essential to developing efficient policies and programs to combat poor health as a result of the services' low usage in Ethiopia.[11] It is possible that there are not enough hospitals that offer SRH for adolescents that will provide high-quality sexual and reproductive health services. Additionally, access to services, quality, and utilization of quality services are directly impacted by how healthcare professionals and adolescents view sexual and reproductive health services. However, there is insufficient data in Ethiopia regarding how healthcare professionals and adolescents perceive the provision of SRH services for adolescents. Therefore, the purpose of this study was to investigate and fully understand how healthcare professionals and adolescents perceived the provision of SRH services in the context of the Black Lion Hospital in Addis Ababa, Ethiopia.

General objectives

- To explore the perspectives of service providers and adolescents on the use of sexual and reproductive health services in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia, in 2023.

Specific objectives

- To probe the perspectives of health professionals on the use of sexual and reproductive health services in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia, in 2023.
- To understand the perspective of adolescents on the use of sexual and reproductive health services in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia, in 2023

Study setting and period

This qualitative study explored the perspectives of health professionals and adolescents regarding sexual and reproductive health services in the maternity and child health unit (MCHU) in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia, in 2023. Tikur Anbessa is found in Addis Ababa, the capital city of Ethiopia. It is one of the largest

referral public hospitals in Ethiopia and the only tertiary referral hospital in the country. In 1998, Tikur Anbessa Hospital was given to Addis Ababa University (AAU) by the Ministry of Health (MOH) for the faculty as the main teaching hospital. The faculty is the oldest among the health training institutions in the country, staffed with the most senior specialists. The hospital provides tertiary-level referral treatment and is open 24 h a day for emergency services. It is administered by AAU and provides teaching for about 300 medical students and 350 residents every year.

The hospital offers diagnosis and treatment for approximately 370,000–400,000 patients a year. It has 800 beds, 130 specialists, and 50 non-teaching doctors. The emergency department serves around 80,000 patients a year. The MCHU clinic is one unit of the hospital, and it has one gynecologist, four residents, six midwives, and five nurses. This hospital was selected due to its high client flow and the fact that it serves a large number of populations. The study was conducted from January to February 2023.

Study design

We employed a qualitative phenomenological study design to achieve the objectives of the study. We approached the research question from the providers' perspective and that of adolescents regarding sexual and reproductive health services.

Patient and public involvement statement. None (not applicable).

Sampling methods

Sampling size

The data was collected from 17 individuals (10 health professionals and 7 adolescents) for the study. The number of participants was determined by information redundancy or saturation, which occurred when no new information, theme, or coding emerged from the data. To ensure saturation, the data was reviewed at the end of each interview day for the presence of codes or categories, as well as the necessity for further interviews in a preliminary manner. Furthermore, the researcher ensured that interviews were no longer generating new information since newly conducted interviews tend to be redundant with previously collected data. After a number of similar responses or ideas, the recorded data no longer generates fresh code. Data saturation was assured after 17 interviews, and we have added two interviews to ascertain that saturation has been reached.

Sampling technique

Purposive sampling was the method used to identify participants (adolescents and health care professionals) who satisfied the inclusion criteria and could provide detailed information.[12] The primary author explained the study's goal and methods and offered to participate. Once the participants agreed to participate, the researcher approached them and accompanied them to the interview. Variations in age, educational level, and relationship status were considered for adolescent and educational status, year of experience in SRH services, and age of health professionals during participant selection.

Eligibility criteria

Inclusion criteria for adolescents. Adolescents who fulfilled the following criteria were included in the study:

- Adolescents who receive SRH services in the Tikur Anbessa specialized hospital within the data collection period
- Adolescents with written consent to participate in the study
- Adolescents between the ages of 15 and 19

Inclusion criteria for health professionals. Health professionals who fulfilled the following criteria were included in the study:

- Age 18 years and above
- Responsible for any sexual and reproductive health service for adolescents in Tikur Anbessa specialized hospital
- Working as SRH service provider in Tikur Anbessa specialized hospital for at least 1 year
- Provided written consent to participate in the study

Operational definition. *Health services providers*: are those individuals who are working in adolescent and youth sexual and reproductive health centers.

MCHU: in this study this applies to the unit in which, physical examination, treatment and counseling of sexual and reproductive health issues take place.

Data collection technique and tools

An in-depth interview using a semi-structured interview guide was used to collect the data. In-depth interview guides were pretested to check for accuracy and consistency and improve validity before the official data collection process. The in-depth interview (IDI) guide and consent form were translated from English to Amharic for IDI participants who could not comprehend the English language.

The interview guide was prepared in English, translated into Amharic by team members, and translated back to English by a third person to check for consistency. Matching was made based on the exact fitness of the two versions. Throughout the interviews, a probe was used to offer clarification and encourage elaboration from the participants on

specific issues or topics that were of interest to the researcher. Using in-depth interviews enabled us to explore issues for a better understanding of adolescents and health professionals' perspectives on the SRH services of the study site. Individual face-to-face interviews were performed to get the data. The primary author and one qualified research assistant conducted the interviews. Both the research assistant and primary author had a strong foundation in qualitative research and had received training in qualitative data collection and interpretation. The researchers pretested the interview guide on 2 (20%) health service providers and 2 (14%) adolescents who met the criteria for eligibility. However, the findings were not included in the main study. The interview guide was enriched by the researchers following the pilot study. The interviews were held in the designated officer room at the hospital to protect the study participants' privacy and confidentiality. The research assistant audio recorded the interviews and made notes with the participants' explicit consent to preserve the subjects' original reports of their responses. The primary author also asked the participants follow-up questions on issues presented during the interviews to gain a better grasp and clarification of their ideas. The interview began with warm-up and general questions and was regularly changed during data collection to cover developing issues and increase interview question clarity. "Please, tell me about yourself?" was raised as the central beginning sentence for each participant. Furthermore, in the course of the interview, several minor aiding questions were utilized, such as "Can you tell me more?" and "Don't you have other options?" and "What do you mean when you say this?" The interviews were audio recorded and field note was taken with assistance from one note taker for all of the participants. The audio-taped interview ranged from 9 to 30 min.

Data analysis and interpretation

A descriptive statistic was used to summarize the sociodemographic characteristics of the respondents. Data collection and analysis were carried out concurrently. After the first interview, analysis commenced, and ideas and new questions were incorporated into the following interviews throughout the data collection process. The audio recordings were transcribed verbatim in Amharic, the language of the interview. The data was coded line by line after being verbatim transcribed in English and input imported to the ATLAS.ti 9 software.[13] Deductive qualitative thematic analysis was used for the analysis. To ensure coding uniformity, the coding framework was constantly updated by building a code book. The investigator coded the majority of the translated data, although another researcher also coded some of it. Differences in the identified codes among the coders were handled by conversation, and coding with the investigator was changed and discussed to clarify the research findings. The identified 24 codes were assigned to subthemes based on similarities and differences. Themes were formed by grouping similar sub-themes. Finally, the sub-themes and code were identified as expressions of the text's latent meaning. Quotations from participants' expressions were used throughout the presentation of study findings. Lastly, quotes from the statements of the participants were used to illustrate the study's main themes.

Trustworthiness

The trustworthiness of a qualitative study is determined by the extent to which it is dependable, confirmable, credible, and transferable.

Credibility

To ensure credibility the team discussed on data coding, data analysis and interpretation continuously throughout the research process with peers who are also conducting qualitative research and with a researcher who is experienced in doing qualitative research. Member checking with participants was also carried out throughout data collection by probing questions, within this; member checking was done by reiterating statements made by participants during the interview and also participants received their data back so they could verify and validate their responses, ensuring the accuracy of the results.

Dependability

It refers to a criterion for evaluating integrity in qualitative studies namely the stability of data over time and conditions, analogous to reliability in quantitative research. To establish dependability, the findings of this study was audited and verified by advisors and others who have experience in qualitative research so that an outside individual can examine the data. Each process was documented, and audio records were used for cross-checking.

Conformability

This criterion refers to the extent to which the research findings could be confirmed or corroborated by other researchers in the field. It is concerned with establishing that data and interpretations are not figments of the inquirer's imagination, but clearly derived from the data. To establish conformability, when the interview was conducted, field notes were taken; furthermore, the interviews were tape-recorded, hence the raw data is available. By refining the data collection instrument in the course, by using codes and categorization and by developing themes from the coded data, the data were analyzed without personal biases.

Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other

Table 1. Socio demographic profiles of study participating adolescents.

Age	Gender	Educational level	Relationship status
15	F	9th grade	Single
15	F	8th grade	Single
18	F	10th grade	Single
17	M	11th grade	Has a girlfriend
15	F	7th grade	Single
18	F	Year one university	Has a boy friend
19	M	Year two university	Has a girlfriend

F: female; M: male.

similar contexts or settings or groups. To this end, we are willing to provide description that could be rich enough for other researcher to be able to make judgment about the transferability of our research findings to another similar context.

Results

Finally, 7 adolescents and 10 health providers were included in the study. Among the adolescents, three had no experience with SRH services before the current position, and four had experiences with general SRH services from a public hospital. The mean age of adolescent participants was 16.42 years (range 15–19). Approximately three of them were in secondary school at the time; the other two were in elementary school, and the remaining continued their studies at university. The most common services delivered to adolescents were safe abortion, sexual assault, postnatal care, and mostly seeking sexual assault and family planning (Table 1).

Of the health professionals, nine were female and one was male; their ages ranged from 26 to 54 years. Five of the professionals were BSc graduates, four had MScs in related fields, and one had a doctoral degree in medicine. Their work experience in the discipline ranged from 1 to 30 years (Table 2).

This study sought to explore health service providers' (HSP) and adolescents' perspectives about their experiences of SRH services to young people in Ethiopia. Three main thematic areas emerged: Potential challenges in sexual and reproductive services, stigma and discrimination in SRH services, and adolescent and health professionals' thoughts on the importance of SRH services.

Theme I: Potential challenges in sexual and reproductive service

Adolescent feedback revealed that SRH programs face various difficulties. In order to access SRH services, respondents cited resistance from religious organizations, culture and custom, and parents as major obstacles. Despite this, health service providers thought that a broad dialogue would be necessary to achieve wider acceptability. It was noted that some cultural norms and practices posed a significant obstacle to providing SRH services, primarily because it is "taboo" for sector employees to offer either family planning services or abortion treatment. SRH is a subject that is not freely discussed, particularly between men and women. Under the potential challenges in the sexual and reproductive service theme, five subthemes developed, including challenges related to availability of resources, accessibility, challenges related to resistance from religious beliefs, cultural beliefs, and practices, quality and institutional or physical environment-related challenges, challenges related to misconceptions and perceived side-effects of family planning, and challenges related to accessing information on SRH services and care. The quotes that follow demonstrate these various viewpoints:

Challenges related to availability of resource and accessibility. Service delivery-related barriers such as the lack of essential equipment and supplies (medication, contraceptives), the inability to remain anonymous and private, and a high workload were barriers that the majority of health service providers encountered when providing reproductive health services.

> . . . There are many of difficulties here. Each day, we serve more than 110 clients. As a result, we do not have enough time for counseling." (Midwife MSc in RH)

> . . .The case flow is more than our capacity. So sometimes there is a big gap in providing family planning. (Nurse)

The health services provider explained that some supplies are not fully available or fully equipped, and they feel that a lack of these resources challenges their work or prevents them from giving the full package.

> . . .There is no female condom available, so this is one of the reasons that prevent us from providing complete family planning service. (Midwife)

> SRH services supposed to be free, but there is scarcity of medications like misoprostol and digoxin, you know if the fetus is near the age of viability, it is better to give digoxin to avoid dilemma. SRH is free service but we ask them to buy such medications, so they might think the service is not free and may decide not to come again. In my opinion MCHU clinic should fulfill the required materials (Obstetrics, and gynecology resident)

Challenges related to resistance from religious belief, cultural beliefs and customs. The respondent's or health professional's efforts to provide adolescents with SRH services are frequently hindered, according to the in-depth interview, by either religious members (view), community members, and family members who restrict access or by adolescents' seeking behavior.

Table 2. Socio demographic profiles of study participating health professionals.

Profession	Age	Working experience	Experience in SRH services	Educational level
Midwife	27	4 years	One and half years	BSc midwife
Midwife	27	3 and half years	2 years	MSc in RH
Nurse	52	22 years	2 years	MSc in RH
Midwife	34	10 years	3 years	BSc midwife
General practitioner	26	1 year	6 months	R1 gynecology student
Nurse	54	30 years	3 years	MSc
Midwife	30	4 years	1 years	BSc midwife
Midwife	32	8 years	2 years	BSc midwife
Nurse	41	15 years	3 years	MSc in nutrition

> . . . the important reproductive health issues I don't talk about because I am not allowed to talk about condoms. I don't feel good. We have many problems but we don't talk about them. . . some communities and churches you can't. (Nurse)

> . . .When we counsel about family planning, one client's husband has said that you are committing genocide, why would we counsel such option for his wife. Because it causes infertility and sin for his religion. (Nurse)

Challenge related to misconceptions and perceived side-effects of family planning. Parents expressed negative attitudes about adolescents who used family planning (FP), and parents could discourage young children from seeking FP support, according to health service providers. According to health service providers, adolescent and parent misconceptions about how contraceptives work and their negative effects were pervasive. The most frequent myth was that using contraception caused irreversible sterility and illness.

> . . . It is another challenge, people sometimes have the wrong ideas about family planning, and they tell you intrauterine contraceptive device (IUCD) can go through your head and decline the service. It is one of the reasons not to pursue our services. (Midwife MSc in RH)

> . . . Due to dalliance of some family planning like DEPO-Provera (DEPO), the client perceives as family planning agent cause infertility so health professional should give adequate information regarding the importance of family planning and their side effects. (Nurse)

> . . .Think of a woman who is bleeding. She believes it has something to do with the birth control she is on. That deters a lot of women from using family planning. . . Some even believe that using birth control will make it impossible for them to have sex or will make them less driven. . . (Nurse)

> . . . even our community doesn't have the right attitude towards family planning, so adolescents from these community have a challenge to overcome this barrier and receive the services. . . (Midwife)

Quality and institutional related challenges. The different SRH services were accessed for different purposes. First, public FP units were mainly used for pregnancy care and contraception services for married couples. Adolescents perceived these services as the least comfortable for them to use for other SRH issues, mainly because of a lack of privacy and their perception that the services are for married women with children. Health providers in these facilities reported that they rarely have adolescents as clients.

> . . . They don't come here because of privacy, confidentiality problem and also, they do not think we provide SRH services. There is a big information gap. Generally, there is a problem with providing them with adequate information. (Nurse)

> . . .When adolescents come with their family, sometimes it is challenging because they do not disclose the right information and express their feeling and even don't tell you what kind of service they needed. (Midwife)

> . . . This hospital is a territory hospital, so most adolescents do not come here due to the hospital being very crowded and busy. (Midwife)

Furthermore, the health professionals felt that the health care system does not prioritize the SRH needs of adolescents. SRH provision was designed for the general population without considering adolescents as a priority.

> . . . In this hospital the main focus is antenatal care (ANC). Family planning has been forgotten. I think we should give attention for family planning. It is better if we start post-abortion care and other SRH services (Midwife MSc in RH)

> . . .The lack of privacy is due to how our facility were designed. The hospital has no space provided for that. (Nurse)

> . . .There is a problem with the rooms. They are not sufficient to provide the service. The rooms are not comfortable for counseling and in these rooms, we provide different types of services (Midwife)

> . . .Here in these compounds, people always have a problem finding a place they want, so if we provide every SRH service together, we might reduce this problem. (Midwife)

Adolescents claimed a lack of privacy because they were easily seen, lacked enough time to get adequate information, or were distracted by others in the facility; someone was present throughout the session. Evidence suggests that adolescent mistrust of healthcare practitioners is exacerbated by a lack of adequate time for counseling and a lack of privacy and confidentiality. It is one of the most important factors influencing an adolescent's desire to seek care from healthcare providers.

> . . . The nurses are very busy to clear of the crowed. If you start a long story, they tell you to make it short. How can you make it short when you do not even know how to start? (Adolescent)

> When our parent witness we are seeking sexual and reproductive health services, it becomes a major concern, which is why many young people are afraid to use contraception. When someone is seen using such facilities, it causes a problem at home. . . As a result, children and adolescents are scared (Adolescent).

Challenge to accessing information on SRH services and care. Most adolescents received SRH care information from formal sources such as radio, TV, health service providers, and schools. The challenges are that family members are unwilling to support services and share information about SRH services.

> . . .mostly I don't share sexual related thing with my mother because I feel shy. So, I have to ask health care professionals who have experienced those things and follow different social media. I can consult them about how you do abortion, prevent HIV and ways through which one can acquire HIV and prevention as well. (Adolescent).

> Occasionally, I tune in to radio and television programs that talk about family planning and other care program to my mother, of course, but mostly I don't share with my mother because I feel shy. So, I have to ask friends who have experienced those things. I can consult them about how you do abortion, prevent HIV and ways through which one can acquire HIV. That's what I ask them." (17 years old)

It is important to know the sources of information for adolescents on the subject of sexuality. It is noted that the information is a necessary resource for the prevention and promotion of adolescent sexual and reproductive health.

> "Nowadays adolescents are using the internet as a source of information on sexual and reproductive health." In addition to the media, there are other ways of providing information on the sexual and reproductive health to adolescent though leaflet, giving adequate counseling in spite of shortage of time and, we recommend them to share information with their peer. (Midwife)

> . . . Adolescents' expressed beliefs and their actions in accessing SRH services were at contrast with one another. Despite saying they didn't know enough about SRH, they didn't ask SRH services for advice. When directly questioned, the majority of young people appeared to be aware of SRH services and the dangers of pregnancy and STIs. However, they lacked proper information, which occasionally resulted in health problems and unintended pregnancies. (Midwife)

Theme II: Stigma and discrimination in SRH services

Healthcare professionals attribute adolescents' non-use of facilities (health services) to stigma from the community as well as service providers' attitudes. They also suggested that certain adolescents were shy. Some also acknowledged that they are not well-oriented, which makes them hesitant to offer these services. Fear and shame related to socio-cultural norms and attitudes regarding adolescent sexual behavior were the most significant reasons why adolescents found it difficult to access SRH services. This contributed to a perception among adolescents that they were "underage" or "too young" to be sexually active or seek SRH services and a fear of disclosing sexual activity to judgmental providers.

> . . . [Unmarried adolescent girl] come in with her mothers, who will list their [the mothers'] who will either list their names at the front desk or a different name entirely. They won't acknowledge they are there for their daughter until after they enter to see me. They feel humiliated. In our society, that is not acceptable. (Midwife)

> . . .The biggest challenge for adolescents to seek service is stigma. the stigma starts from health service providers. For example, if a teenage comes here for family planning services, the health provider might say with your age why would you involve in this kind of situations and the teenage might not come again and this is from my personal experience. (Nurse)

> . . . The first one is family. In our community families are not frank to each other. Children are not growing up in a frank family. If you don't tell or teach your child frankly about reproductive health, they will not seek our service. Because they are very shy. (Midwife)

Practitioners reported minimal increases in sexually transmitted infection (STI) service usage despite needs. Providers described patients as "shy" about discussing sensitive health issues, potentially contributing to STI treatment-seeking delays.

> . . .Most of the patients that come here have some form of STIs. Health professionals and the aid community have not really paid any attention to SRH, rather giving medication for STI. . . (Nurse)

Adolescents identify problems related to deep-seated sociocultural norms and attitudes around adolescent sexuality that may prevent them from seeking SRH services for fear of social stigma and labeling as a consequence of their sexual activity. Even health care providers treat adolescents like

children when they ask them a question and promise to answer it when they are older.

> ". . . It worries me a lot to see such small children getting involved in sexual activities at an early age exposing themselves to diseases, it touches me a lot." Furthermore, adolescents reported that nurses often asked them "funny questions" such as: "did you tell your mother? . . .why are you wearing a mini-skirt?" (Adolescent)

> . . . A lot of people go to clinic asking for contraception for other women in their communities because their husbands don't allow them to use contraception. (Adolescent)

Theme III: Adolescent and health professionals' thoughts on the importance of SRH services

Adolescents definitely have a significant need for a variety of sexual and reproductive knowledge and services. To satisfy these demands, information from adolescents on actual service utilization as well as preferences and perceptions regarding sources is crucial for determining the types of interventions that could be done to improve adolescent sexual and reproductive health. One method of increasing adolescent utilization of sexual and reproductive health care has been to make services more youth-friendly, which has been accomplished in part through the training of existing practitioners and facility-based improvements.

> . . .Nowadays there is advancement of technology, the adolescent may have mobile phone, pc and the like before reaching 16 years old that enforce them to participate in early initiation of sexual activities. They do not have any information about pregnancy and HIV. . . so health education package should be given in outreach areas before the age of 14 (Nurse).

> . . . In general, I believe that every service offered here is essential and required, but since giving abortion treatment to teenagers under the age of 18 is extremely traumatic, we should put more of an emphasis on raising awareness, offering counseling, and offering family planning services. We must use numerous family planning measures to ensure that teenagers do not become pregnant unnecessarily. (Nurse)

> . . . SRH services needs so much focus and work. In addition to addressing SRH services in health centers and hospitals, we need to work on community level and draw solution. If we do that, I think it would be better (Midwife MSc in RH)

> . . . I do not believe that any service is unnecessary, but maintaining privacy is certainly difficult. This hospital is dealing with a serious issue. since each room is quite small. It's challenging to speak openly here. However, I do not think that any service is optional. (Nurse)

Interviews with adolescents revealed that information on SRH for adolescents in the communities was scarce and, therefore, adolescents were uninformed about potential reasons for seeking SRH services. Adolescents spoke of the difficulty of knowing fully about SRH and about sex and sexual relations openly, and health service providers play a little role in giving SRH-related education and counseling in this situation, which affords adolescents very little opportunity to learn about SRH either at home or in school. This statement is supported by the following quotation:

> Reproductive health services are the service that teach us how to protect ourselves from getting pregnant by using condoms while having sex. . .even if it can be challenging for us to utilize contraception at times. (Adolescent).

> Yes, the risk is there because one can get pregnant by having sex but we still do it. You can also get other sicknesses by having sex but what can we do? We have to do it to get what we want, so early sexual and reproductive health services packages are very important (Adolescent).

Discussion

To our knowledge, this is the first qualitative study to explore the perspective of health professionals and adolescents regarding sexual and reproductive health services in Ethiopia. This study provides insights into some of the challenges faced by adolescents and health service providers in SRH services at the Maternal and Child Health Clinic in Ethiopia. The findings from this study suggest that challenges related to misconceptions and perceived side-effects of family planning, quality, and institutional health care barriers, challenges related to availability of resources and accessibility, challenges related to resistance from religious beliefs, cultural beliefs and customs, stigma, and discrimination in SRH services were key factors that affected the utilization of SRH services by adolescents.

This study explored the perspectives of health service providers and adolescents on the utilization of sexual and reproductive health services by adolescents. Our main finding was that SRH provision was designed for the general population without being specialized for adolescents. Furthermore, health service providers felt that the healthcare system does not prioritize the SRH needs of adolescents. Our result agrees with previous studies conducted in Nigeria and Kenya,[14] which hinders the provision of integrated sexual and reproductive health services for adolescents, and the challenge for health professionals in managing the various messages they receive about their ability to provide sexual and reproductive health care to adolescents.

The study data reveals that some of the medications are not available in the hospital due to being underfunded, such as the female condom and misoprostol. These findings differ from those in Nigeria, where it was reported that female condoms and other SRH services were available,[14] although FP services are supposed to be free in Ethiopia, adolescents stated that they had to purchase supplies from private pharmacies because some family planning materials and drugs

for abortion were unavailable at the time of their visit. However, this study, supported by further studies in Nepal, has found that adolescents are unable to get SRH services from health facilities (i.e., obtain misoprostol and other medical supplies) due to a financial inability to purchase the prescribed medicines.[15] In an Ethiopian study, adolescents who received medicines while visiting a health institution were 2.7 times more satisfied and likely to seek treatment than those who did not.[16] As a result, to address the cost barrier on the supply side, the MOH needs to ensure that all public providers follow government protocol when offering free FP services and continue working together with non-governmental organizations to provide reasonable or no-cost FP services.

A study among health workers in Ethiopia found that 30% of health care providers had negative attitudes toward providing SRH services to unmarried adolescents.[17] These are congruent with the findings reported in the current study; although HSPs are well aware that they should not refuse adolescents access to SRH services in general, their own values and views occasionally take precedence. This hesitation derives from HSP's cultural, religious, and perceived medical eligibility concerns that discourage young people from attending clinics and keeping follow-up appointments. This also undermines adolescents' rights to adequate quality SRH services, as stipulated by the WHO and the United Nations Population Fund Agency. The rights of young people to SRH services and the cultural and traditional values of HSPs appear to be in conflict, so providing the health services provider with training programs that emphasize value clarification may help them to separate their personal beliefs and norms from the working practice. This may help them to focus on the needs of the adolescent in a way that is beneficial to them.

Adolescents in developing countries are hindered from accessing SRHs due to stigma and discrimination by health care providers, the social-cultural norm of the community, and a lack of youth-friendly reproductive health services. It was evident from the studies that adolescents were "labeled" and perceived as "children" whenever they wanted to access SRHs.[8] In this study, cultural norms, customs, and provider biases in SRH provision to adolescents have been discovered, such as restricting access to certain contraceptive methods based on age or marital status. Importantly, prior studies have shown that fear and experience of such bias and mistreatment in SRH affect SRH care-seeking behaviors.[18] To effectively address such biases, research has demonstrated that more than simply providing evidence-based guidance, judgment-free social and behavioral adjustments are required. The findings of these studies also revealed that SRH services still need to be youth-friendly. As to the present study in Nigeria, for example, while youth admit the availability of SRH services, many do not find them to be youth-friendly, as they face stigma and discrimination when trying to access the SRH services;[19] healthcare providers have historically been accused of having judgmental and stigmatizing attitudes when providing sexual and reproductive health care. Stigma and unfavorable attitudes toward adolescents are well established in the literature. Therefore, the stigma and unwelcoming attitudes experienced by healthcare providers of sexual and reproductive health care as described in this study are probably a result of the difficulties they encounter in navigating social norms, an unclear legal framework and policies, and statements from political leaders.

Health service providers' perception of the reasons for adolescents' non-utilization of reproductive health services is that they indicate shyness on the part of some adolescents. Additionally, some admitted that they are not well-oriented, so they hesitate to provide these services.[20] Unlike this study, our respondents feel that adolescents do not utilize the service due to a lack of privacy and confidentiality and due to the high case flow. Protecting adolescents' confidentiality and increasing the number of working staff members are crucial to ensuring their access to sexual and reproductive health care and are also key components of that care. Assured confidentiality is associated with improved delivery of sexual and reproductive health services.

In this study, in a variety of ways, health service providers claimed that their working environment made it harder for them to provide SRH services. They reported an increase in patient load that made it impossible for them to devote adequate time to counseling and teaching adolescents about SRH. Similar findings were found in other studies done in Soweto, South Africa, and Uganda[21,22] providers also complain that it is difficult to provide personalized, specialized services to clients because of the large client load. At some health facilities, the situation was so serious that clients may be turned away without receiving services.[17] The respondent from this research also agrees and believes that in order to provide a satisfactory service, the number of staff should increase or the number of cases seen by health providers should be minimized. This can be explained by the fact that a shortage of staff providing SRH services might be affecting the time spent providing the services.

The evidence in many countries has shown that most young people do not routinely seek sexual and reproductive health services. The role of health professionals as a source of information is found to be low.[23] But in the case of these studies, adolescents responded that health professionals are the primary source of information. The SRH service providers' views on the quality of the services for adolescents include facing several barriers, mostly posed by community members, family members, and religious leaders. These barriers play a role in affecting the general quality of services. The findings are consistent with those from other low- and middle-income countries (LMICs) regarding the numerous barriers adolescents face while accessing SRH services.[24] This calls for policymakers, activists, and the community to formulate methodologies to ensure that the accessibility,

availability, and quality of SRH services are considered while designing health service provision to ensure that the "no one left behind" principle is applied to achieve sustainable development.

Strengths and limitations

Strengths

- As this is the first study conducted in the study area, it provided a baseline finding from the perspective of health care providers and adolescents about sexual and reproductive health services
- This is also the first qualitative study conducted to explore the deep experiences of both health care providers and adolescents regarding SRH services

Limitations

- Language and interpretation constraints for three interviewers may have limited the quality of the data since no professional interpreter could be used
- The time that passed may be the reason that some aspects of their experiences could have been difficult to recall accurately
- Findings from a single hospital may not be representative of other hospitals or healthcare settings. Each hospital has unique characteristics, such as patient demographics, organizational culture, and healthcare practices. Therefore, the findings from this study may not be applicable to different contexts, limiting the generalizability of the study

Conclusion

Sexual and reproductive health is an urgent public health matter in Ethiopia. Failure to address the delivery of healthcare to this population group is likely to result in poor health outcomes, including high rates of STIs, unwanted and early pregnancies, and difficulties in accessing contraceptives and safe abortion services. This study aimed to explore the understanding of health professionals' and adolescents' perceptions to deliver sexual and reproductive health services in Ethiopia. The results show that challenges related to availability of resource and accessibility, challenges related to resistance from religious belief, cultural beliefs and customs, quality and institutional related challenges, stigma and discrimination in sexual and reproductive health services, adolescent and health professionals' thoughts on the importance of SRH services and, inadequacies of the built environment and infrastructure of the health facility impact the privacy of adolescents, are important factors that need to be addressed to improve the effective and sensitive delivery of sexual and reproductive health services for adolescents. This paper urges policymakers, donors and implementers of adolescent sexual and reproductive health programs in Black Lion specialized hospital and in general for Ethiopian adolescents to address this uncertainty at the political, legal and practical level to help support health professionals in serving the healthcare needs of adolescents.

Recommendation

Health services providers, and adolescents face multiple barriers to accessing sexual and reproductive health services. Barriers exist at the levels of providers, health facilities, adolescents, community, and broader health system. These insights would be useful to policy makers to improve access to SRH services for youth in Black Lion specialized hospital. Recommendations to improve SRH services by adolescent include:

- A multi-component strategy should be developed including: promotion of SRH in the community; a formal referral system between the community and the SRH; and community support interventions
- It is critical to involve whole communities and governments in raising awareness about underpinning the moral framework around adolescent sexual behavior
- It is necessary to address not only the structural components of the facilities, but also to increase the capability of health care providers. Because cultural, religious, and traditional norms continue to affect SRH service providers to young people, providing evidence-based advice and health services to adolescents and the community is critical
- The government and its partners could consider a SRH mobile clinic in cooperation with school health services, to be taken to schools on specific days as an interim measure to developing sexual and reproductive health services
- Existing FP and SRH services are not promoted at all to adolescents and youth, so links between information and services should be strengthened. The youth friendly health services should be integrated into existing reproductive health services at provincial, district and health center levels
- In the communities, it is essential to promote awareness on the importance of early access to SRHs through appropriate community forums
- Further research is needed on the applicability of SRH services.

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Authors' contributions

BD: Designed the study, involved in data collection, analysis, writing of the result and data of the manuscript. GK and MA: Involved

in proposal development, data analysis and all stages of the thesis. GY and SA: Involved in proposal development, data analysis and all stages of the thesis.

Availability of the data

The data is available on responsible request from the corresponding author by the following address. Email: befkadderese6@.gmail.com

Declaration of conflicting interests

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Ethical approval

The study received ethical approval from the research ethics committee of AAU, specifically from the College of Health Sciences and the School of Nursing and Midwifery, under the assigned protocol number. SMW/MID/016/15. The study objectives, as well as the potential risks and benefits of participation, were clearly communicated to the study participants before seeking their willingness to take part in the research. The participants were not forced, and they could refuse at any time during the study when they felt uncomfortable. Withdrawal to participate did not affect their services; they should seek them at any of the health facilities at any time. To ensure adolescent rights, privacy and confidentiality were protected, the investigator took the following measures: The adolescent was guaranteed that all of the data given during the interview was treated with strict confidence and was used only for the purpose of the research. The investigator was confident that the data was kept private and protected in a safe place, that the files were keyword- and name-based, that the names of the adolescent were not recorded in audio records, and that the information was reported in a way that did not identify the women.

Informed consent

Informed verbal and written consent were obtained from each respondent prior to data collection and for those age less than 18 years their parent or legal guardian gave the consent. After getting informed consent from the respondents, the right of the respondents to refuse to answer for few or all of the questions was also valued.

Trial registration

Not applicable.

ORCID iDs

Befkad Derese Tilahun https://orcid.org/0009-0006-6205-1139
Gizachew Yilak https://orcid.org/0000-0001-5650-9699

Supplemental material

Supplemental material for this article is available online.

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