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Original Research Article

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AT THE FEDERAL MEDICAL CENTRE, GUSAU: A QUALITATIVE ASSESSMENT OF SERVICE AVAILABILITY AND PROVIDER ATTITUDES

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ABSTRACT
Adolescents in Nigeria face significant sexual and reproductive health (SRH) challenges, including early pregnancy, sexually transmitted infections (STIs), and limited access to youth-friendly services. Despite national policies promoting adolescent SRH, service readiness and provider attitudes at tertiary facilities remain poorly understood. This study assessed the availability, appropriateness, and quality of adolescent SRH services at a tertiary hospital in Northwestern Nigeria. A Qualitative assessment, conducted at the Federal Medical Centre, Gusau, using key informant interviews and facility observations guided by WHO adolescent-friendly service standards. Twenty-two healthcare providers from obstetrics/gynaecology and family medicine units were purposively selected. Data were analyzed thematically to explore service readiness, provider perspectives, and delivery barriers. The facility provides a wide range of SRH services family planning, antenatal/postnatal care, and HIV/STI testing, but lacks integration and adolescent-specific pathways. Youth-focused materials, guidelines, and dedicated spaces are absent, and services operate only on weekdays. None of the providers had formal training in adolescent communication or SRH, leading to inconsistent practices and moral reservations toward contraception for unmarried adolescents. Identified barriers included sociocultural norms, judgmental attitudes, limited youth-rights awareness, and weak policy implementation. Overall, services were available but not adolescent-friendly. The findings in this study have the potential to inform necessary interventions for improving Adolescent sexual and Reproductive health services in our study centre and in the country as a whole.

Keywords: Adolescents; sexual and reproductive health; youth-friendly services; Nigeria; healthcare providers; qualitative study

INTRODUCTION
Adolescents, defined as individuals aged 10–19 years, represent a critical developmental stage that bridges childhood and adulthood, embodying a nation's future social and economic potential (Morris & Rushwan, 2015). When

adequately supported, adolescents can transition into healthy, productive adults; however, insufficient support exposes them to heightened health and social risks (Lancet Commission, 2016). Adolescence is characterized by rapid physical, cognitive, emotional, and social changes that significantly influence lifelong health outcomes (Lancet Commission, 2016).

Globally, adolescents constitute approximately 1.3 billion people, representing about 16% of the world's population, with nearly 85% living in low- and middle-income countries where health systems often struggle to meet their needs (Morris & Rushwan, 2015). In Nigeria, adolescents and young people comprise over 40% of the population, underscoring the need for targeted interventions to address their health and developmental needs (National Bureau of Statistics & UNICEF, 2021). Adolescents in Nigeria face considerable sexual and reproductive health challenges, including early sexual debut, low contraceptive use, unmet family planning needs, unsafe abortion, and increased vulnerability to STIs, including HIV (Envuladu *et al.,* 2021; Morris & Rushwan, 2015). Structural, cultural, and legal barriers further restrict adolescents' access to SRH information and services, leading to adverse outcomes that compromise educational attainment, economic productivity, and national development (Lancet Commission, 2016).
Sexual violence remains a major concern, particularly in security-challenged and humanitarian settings. Studies indicate that a significant proportion of Nigerian girls experience physical or sexual violence before the age of 15, increasing their vulnerability to poor SRH outcomes (Odutola *et al.,* 2016). Adolescents also bear a disproportionate burden of maternal morbidity and mortality, with early pregnancies associated with complications such as obstructed labour, preterm birth, and unsafe abortion (Schweitzer & Guzzo, 2020).

Policy and Global Context for Adolescent SRH

Despite the high burden of adolescent health challenges, adolescent sexual and reproductive health (ASRH) has historically received limited attention. In recent decades, however, global initiatives such as the Millennium Development Goals and Sustainable Development Goals have emphasized adolescent health as central to sustainable development (Lancet Commission, 2016).

In Nigeria, several policies support ASRH, including the National Policy on the Health and Development of Adolescents and Young People and the Nigeria Family Planning Blueprint (Federal Ministry of Health [FMOH], 2007, 2020). While these policies promote access to SRH services regardless of age or marital status, gaps remain in implementation, particularly regarding confidentiality, cost-free services, and adolescent-friendly care (Envuladu *et al.,* 2021). In 2021, the Federal Government launched updated adolescent health and development strategies (2021–2025), emphasizing inclusivity, multisectoral collaboration, youth participation, and gender sensitivity (FMOH, 2020). However, translating these commitments into practice at the facility level remains a challenge.

Challenges with Available ASRH Services

ASRH service delivery in Nigeria is hindered by inadequate infrastructure, limited trained personnel, poor funding, and sociocultural resistance. Many youth-friendly services are supported by donor-funded civil society organizations concentrated in urban areas, leaving rural and peri-urban adolescents underserved (Olujide *et al.,* 2022).
Barriers to effective ASRH service utilization include lack of privacy, judgmental provider attitudes, limited adolescent involvement in service design, and fragmented service delivery (Arije *et al.,* 2022). The absence of integrated SRH services further undermines adolescents' trust in the health system and reduces service uptake.

Study Design

This Qualitative assessment employed a qualitative approach, utilizing key informant interviews (KIIs) and non-participant observations to gather data.

Study Setting

The study was conducted in the obstetrics and gynecology department and the family medicine department at the Federal Medical Centre, Gusau, Nigeria.

Sampling Technique

Participants were purposively selected, including unit heads and an additional staff member from key units: antenatal

care (ANC), family planning (FP), postnatal clinic, general outpatient department (GOPD), and maternity. These units were selected based on the fact that they serve as the main service points where adolescents access sexual and reproductive health services. All units were evaluated for readiness to deliver adolescent-friendly SRH services. In total, 22 participants were interviewed.

Ethical Considerations

Ethical approval was obtained from the centre's ethics committee, with permissions from department and unit heads. Participating health providers gave informed consent following briefings on the study's nature, purpose, and procedures. Interviews were held privately, pre-scheduled to uphold anonymity, confidentiality, and privacy.

Data Collection

Data collection tools—an observation checklist and a KII guide—were developed based on study objectives, literature review, and expert input. The checklist assessed facility readiness (services available, costs, adolescent data recording, privacy measures, and youth-friendly infrastructure). The interview guide covered providers' demographics, prior training, SRH service availability, and perspectives on adolescent care and barriers. Interviews were conducted face-to-face and lasted between 45 minutes to one hour; all were audio-recorded and transcribed. Field notes supplemented the audio data to ensure completeness of information.

Data Analysis

Interview transcripts were manually coded inductively by two researchers. Through thematic analysis, codes were organized into categories reflecting SRH service availability, accessibility, appropriateness, and provider attitudes. Discrepancies were resolved by consensus. Facility observation data were integrated to triangulate findings.

RESULTS

A total of 22 respondents participated in the study: 10 doctors (consultants, senior registrars, registrars) and 12 nurses/midwives. Table 1 shows the distribution by cadre.

Table 1: Distribution and composition of responders

Health Worker Category	Number
Doctors – Consultant	4
Doctors – Senior Registrar	4
Doctors – Registrar	2
Nurses – Matrons/In-Charge	6
Nurses – Second-in-Charge	4
Nurses – Other cadres	2

Facility Readiness

Availability of services: The hospital provides a broad range of SRH services, including family planning (e.g., condoms), antenatal care, delivery services, postnatal care, STI treatment, and HIV counselling/testing. However, these services were not integrated for youth; adolescents seeking care were seen in the general population. No emergency contraception, psychosocial counselling, or peer support programs for adolescents were available.

Appropriateness of services: Adolescents had no involvement in service planning or delivery (no peer educators or youth committees). No SRH guidelines or educational materials targeted specifically at adolescents were found in any unit. Clinic schedules ran Monday–Friday (no evenings/weekends) with no designated adolescent clinic times. Service delivery was group-based (adults and youths mixed), and adolescents did not receive priority in waiting areas.

Privacy and confidentiality: Private consultation rooms existed, but these served all patients; there were no separate waiting or consultation areas for youth. No code of conduct or staff training on adolescent confidentiality was documented.

Grievance mechanisms: Suggestion boxes and a SERVICOM (patient feedback) process existed, but adolescents were not specifically encouraged to use them.
Equipment and spaces: Equipment (vaginal specula, fetal monitors, BP cuffs) was appropriate for adult patients only; smaller sizes for adolescents were unavailable. No dedicated adolescent waiting area, counselling room, or examination space existed.

Accessibility: Clinic hours (8:00 am–4:00 pm weekdays) were inconvenient for school-going adolescents; no weekend or after-school services were offered. Fees were charged uniformly, with no discounts or waivers for young people.

Provider Perspectives

Training and capacity: None of the providers had formal training in adolescent SRH or communication. They relied on general OB/GYN training. As one stated, "I did not have specific training to talk to adolescents about SRH, I just use my general knowledge." Another noted that ASRH topics were not covered in continuing medical education locally.

Guidelines and materials: No adolescent-specific SRH protocols or IEC materials were available. Providers reported using generic guidelines (adult-focused) when available.

Attitudes and practices: While acknowledging adolescents' right to SRH care, many providers admitted personal discomfort in serving unmarried youths. For example, one respondent said "I would prefer to counsel a 17-year-old to abstain rather than give her pills." Nonetheless, nearly all agreed that, ideally, contraceptive services and counseling should be offered to all sexually active adolescents.

Barriers to care: All participants identified sociocultural norms and stigma as major barriers. They cited poverty, illiteracy, and lack of parental support as factors pushing adolescents toward early sex or poor SRH outcomes. Judgmental attitudes among some staff were noted as deterring youth from attending services.

Vulnerability factors: Providers unanimously agreed adolescents were vulnerable to sexual violence. Table 2 summarizes the factors identified as contributing to this vulnerability.

Table 2: Factors responsible for adolescents' vulnerability to sexual violence

Common causes	Number (%)
Poverty, illiteracy, ignorance 20(90%)	20 (100%)
Effects of social media	20 (90%)
Child hawking/street hawking	20 (90%)
Indecent dressing(perception by providers)	14 (63.6%)

Peer influence/pressure	12 (54.5%)
Insecurity	16 (72.7%)

Contraception access: Providers were split on giving contraceptives to unmarried adolescents. About half felt it encouraged promiscuity, while the other half supported youth access. However, nearly all agreed adolescents should not be denied services due to age. No providers had consistent procedures; some would covertly provide condoms, others insisted on parental involvement.

Perceived quality issues: Many noted the absence of privacy and comfort for adolescents. One nurse observed, "Adolescents have to wait in the same crowded room as grandmothers for family planning. That is embarrassing for a 16-year-old." Complaint mechanisms and confidentiality protections were reported as weak.

DISCUSSION

This study demonstrates that while essential SRH services are available at FMC Gusau, they do not meet WHO standards for adolescent-friendly care (WHO, 2012). Similar findings have been reported in other Nigerian and sub-Saharan African settings, where adolescents are served within adult clinics without tailored support (Envuladu *et al.,* 2021; Olujide *et al.,* 2022). The absence of adolescent-specific training and guidelines contributed to provider discomfort and moral judgment, particularly regarding contraceptive provision to unmarried adolescents. Such attitudes have been shown to discourage adolescents from seeking care (Hallum-Montes *et al.,* 2016). Structural and policy implementation gaps were also evident. Although national policies support free and confidential services, adolescents continued to face cost and access barriers, echoing findings from studies in Tanzania and Kenya (Busse *et al.,* 2022).

CONCLUSION

This study reveals significant gaps in ASRH services at the Federal Medical Centre, Gusau. Despite providers' awareness of adolescents' needs, service delivery fell short of global standards for youth-friendly care. Provider attitudes, rooted in cultural norms, and a lack of adolescent-specific training and resources contributed to these shortcomings. Key barriers identified include inadequate facility infrastructure (no dedicated youth spaces or equipment), absence of clear guidelines or training for staff, and pervasive stigma. To achieve equitable SRH outcomes for Nigerian youth, these gaps must be addressed urgently.

RECOMMENDATIONS

A multi-faceted approach is needed to address the gaps identified:

Short-term: Conduct comprehensive training for all health workers on adolescent-friendly SRH standards and counselling. Develop and disseminate clear ASRH guidelines and IEC materials. Establish a dedicated youth-friendly service point (e.g., a youth corner) and designate specific clinic hours for adolescents.

Medium-term: Form an interdepartmental ASRH working group to coordinate services. Implement peer education and school outreach programs to increase youth awareness and service uptake. Engage community leaders, parents, and adolescents in advocacy to reduce stigma around adolescent SRH.

Long-term: Integrate ASRH into the hospital's strategic plan and routine monitoring, including adolescent-specific indicators. Expand the youth-friendly model to other departments and referral networks. Collaborate with national ASRH initiatives and other hospitals to scale best practices. These efforts, consistent with Nigeria's Adolescent Health Policy and FP Blueprint, will help ensure sustained, nonjudgmental SRH care for young people.

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