Impact of a capacity-building intervention on views and perceptions of healthcare providers towards the provision of adolescent sexual and reproductive health services in southeast Nigeria: a cross-sectional qualitative study

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ABSTRACT

Objectives Negative views of healthcare providers towards adolescent sexual and reproductive health (SRH) services deter adolescents from seeking vital SRH services. This paper assessed the impact of an intervention on the views and perceptions of healthcare providers towards the provision of adolescent SRH services.

Design and setting A descriptive, cross-sectional, qualitative study was conducted between 14 October and 19 November 2021 in six local government areas (LGAs) in Ebonyi state, southeast Nigeria, after the implementation of an intervention comprising of training and supportive supervision.

Participants and data collection Data were collected through: (1) two in-depth interviews (IDIs) with LGA healthcare managers; (2) six IDIs with LGA adolescent health programme managers; (3) two focus group discussions (FGDs) with 15 primary healthcare facility managers; (4) two FGDs with 20 patent medicine vendors and (5) two FGDs with 17 community health volunteers. A total of six FGDs were held with 52 healthcare providers. The interviews were conducted using pretested interview guides. Transcripts were coded in NVivo (V.12) and themes were identified through inductive analysis.

Results As a result of the intervention, most healthcare providers started recognising the rights of adolescents to obtain contraceptive services and no longer deny them access to contraceptive services. The providers also became friendlier and were no longer harsh in their interactions with adolescents. There were some unique findings relative to whether the providers were formal or informal healthcare providers. It was found that the informal healthcare providers were bolder and more comfortable delivering SRH services to adolescents and reported improved patronage by the adolescents. The formal healthcare providers made their facilities more conducive for adolescents by creating safe spaces and introducing extracurricular activities.

INTRODUCTION

Adolescents face multiple barriers when accessing sexual and reproductive health (SRH) services. These barriers include discriminatory and judgemental attitudes from health service providers, lack of privacy and confidentiality, and adverse social norms. Adolescents’ experiences of multiple barriers and inadequacies in the provision of SRH services have a compounding effect on adolescents that results in negative outcomes such as unintended adolescent pregnancies,

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The team of researchers in collaboration with the local stakeholders co-created and implemented the capacity-building intervention over 6 months to enable project acceptance and ownership.

⇒ A limitation of this study is that there could be information bias due to the absence of adolescents’ perspectives about healthcare providers’ views and perceptions toward the delivery of sexual and reproductive health services following the capacity-building intervention.

⇒ Although there could be an overestimation or under-estimation of information by healthcare providers, the project findings were presented to a wide range of stakeholders including adolescents and youths for validation during the project close-out events.

Conclusion These findings highlight the importance of the constant capacity building of both formal and informal healthcare providers, which can address healthcare providers’ biases, views and perceptions of delivering SRH services to adolescents.
complications related to unsafe abortions and increased sexually transmitted infections (STIs). 1-3 About 67% of adolescents living in sub-Saharan Africa have an unmet contraceptive need. 4

Despite the clear need for adolescents to access quality SRH services, 5 the utilisation rate for SRH services, including contraceptives, remains considerably low among this age group. 6-9 Although adolescents have considerable knowledge about contraceptive methods, they do not make use of these contraceptive methods in Nigeria. 10-12 According to the Nigeria Demographic Health Survey, 65.6% of sexually active, unmarried adolescents aged 15–19 years have an unmet need for contraceptives, while 19% of them had begun childbearing. 13 Young girls aged 15–24 years accounted for 41% of maternal deaths. 14 In Ebonyi state, southeast Nigeria, 91.8% of women of reproductive age were not using any method of contraception. 15

In Nigeria, the Ministry of Health is responsible for ensuring the delivery of SRH services. The ministry collaborates with various partners such as the United Nations Population Fund, Marie Stopes International and other non-governmental organisations to provide SRH services. 7, 14 They ensure that adolescents and young people have access to quality health services like modern family planning/contraceptives, cervical cancer screening, vaccination and treatment of genital warts, general outpatient care, miscarriage and post-abortion care, STI screening and treatment, subfertility screening, intending couples testing and screening.

Evidence shows that health service providers, while trying to respect adolescents’ rights to access SRH services, struggle with conflicting values and beliefs when providing services to their adolescent clients. 15 Although healthcare providers are well intentioned when interacting with their adolescent clients, there is an unequal service delivery created by age and status disparity which could be detrimental to the SRH rights and well-being of adolescents. 16 The attitudes, perceptions and behaviours of health service providers towards adolescents are also influenced by situational factors such as their previous experience, level of knowledge, working conditions and the behaviours of adolescents who seek SRH services. 17, 18 Unfavourable working conditions and workplace culture could potentially stimulate provider bias and disrespectful care, whose negative impacts would be felt more by adolescents. 18 Adolescents may exhibit certain risky sexual behaviours and lifestyles (such as unprotected sexual intercourse) with consequences that may affect their demand for services.

In recent years, efforts have shifted from ensuring the availability of SRH health services to making these services adolescent-friendly. 19 There are also policies and programmes to improve the poor SRH status of adolescents in Nigeria. 20-22 The proposed strategies in the policies and programmes include providing youth-friendly comprehensive SRH information, counselling and services. 20-22

Several interventions have been implemented and proposed to improve healthcare providers’ attitudes while delivering SRH services in lower-income and middle-income countries. 23-25 These interventions include advocacy, community-based intervention, capacity building, supervision and provision of basic medicines/supplies in the facility. 23-25 Common capacity-building intervention components that have been reported included: assertiveness training, improving communication skills and problem-solving. 24, 25 These interventions help healthcare providers learn how to express their feelings while respecting the rights of their clients, identify problems and address barriers to delivering SRH services to adolescents.

However, evidence shows that even if healthcare facilities are made adolescent-friendly, they are not likely to attract all adolescents in the community. 26 Hence, SRH services, including contraceptives, should be provided through various channels, necessitating efforts to support informal health providers, such as the patent medicine vendors (PMVs) and the community health workers (CHWs), in delivering comprehensive, youth-friendly SRH services to adolescents. The reason for this is that it would greatly expand adolescents’ access to SRH services thereby benefiting the adolescents, if confidentiality can be assured.

The location of health facilities providing SRH services has been revealed to be significantly associated with adolescents’ utilisation of SRH services. 7 Other factors limiting SRH service utilisation among adolescents were their exposure to SRH information and awareness of SRH service-providing facilities. 7 Therefore, building capacities of informal healthcare providers who are closer to the communities becomes necessary as this has shown improved patronage of SRH service among adolescent clients.

SRH services could be delivered in a way that adolescents may not want to obtain those services even if they can. This is due to the unfriendly attitudes, views and perceptions of healthcare providers towards adolescent clients and the fear of being scolded by these providers, making the SRH services unacceptable. 27 Consequently, there is a need to build the capacities of both formal and informal service providers to deliver adolescent-friendly SRH services. Interventions to make SRH services provided in health facilities more accessible, acceptable, effective, equitable and appropriate would increase the ability and willingness of adolescents to obtain quality service when needed.

This paper assessed the impact of an intervention on the views and perceptions of healthcare providers towards the provision of adolescent SRH services in Ebonyi state, southeast Nigeria. The capacity-building intervention was implemented to strengthen the capacity of formal and informal health service providers to deliver comprehensive and adolescent-friendly SRH services. It was envisaged that the intervention would ultimately positively change the views and perceptions of healthcare
providers, leading to improved access to SRH information and services for adolescents.

METHODS
Study design and setting
This study used descriptive, qualitative, cross-sectional research methods to evaluate the impact of a multicomponent capacity-building intervention on the views and perceptions of healthcare providers. The descriptive research method was employed to understand the experiences and views of health service providers with the provision of SRH services to adolescents following the capacity-building intervention. The intervention focused on improving the skills of formal and informal healthcare providers on how to optimally deliver adolescent-friendly SRH services to their adolescent clients. A team of researchers in collaboration with the Ebonyi state’s Ministry of Health and other agencies co-created and implemented the capacity-building intervention comprising of training and supportive supervision.

Ebonyi state has an estimated population of 6268003 inhabitants, and they are spread across 5935 km² of land.28 29 Ebonyi is divided into three senatorial zones with six federal constituencies, two in each senatorial zone. The state is also divided into 13 local government areas (LGAs) for administrative purposes. The state has a high prevalence of teenage pregnancies and a high unmet need for contraceptives among young people.13 The state also recorded a maternal mortality rate of 30.5% among adolescent girls aged 15–19 years.15

Six LGAs were purposively selected from the three senatorial zones in Ebonyi state. These LGAs were selected based on the prioritisation of the state government for scaling up adolescent SRH interventions.

Description of the capacity-building intervention
Name of the intervention: capacity-building intervention to improve access to comprehensive and youth-friendly SRH services for adolescents.

Rationale: the implementation of the capacity-building intervention was preceded by a baseline assessment and scoping literature review, to determine the views and perceptions of healthcare providers toward adolescent clients seeking SRH services, the capacity needs of these healthcare providers in delivering SRH services to adolescents, and the potential feasible strategies for improving their views and perceptions, and addressing their capacity needs. The baseline assessment highlighted the need for targeted training and supportive supervision of both formal and informal healthcare providers.5 8 11 30–32

Materials: subsequently, training manuals and other intervention materials (such as SRH counselling chart (online supplemental file 1), manuals, registers, referral slips, etc) were co-produced by academic researchers, programme managers, and other content and practice experts in adolescent SRH in the state.32 The training manual (online supplemental file 2) covered the following topics: concept of adolescence and adolescent health; adolescent sexuality and sexual behaviours; prevention of pregnancy and STIs among adolescents; principles and practice of counselling; counselling practices on selected health issues of adolescents (including value clarification); optimal adolescent and youth-friendly services; and record-keeping of adolescent SRH data.

Intervention procedures: two main strategies were implemented to improve access to comprehensive and youth-friendly SRH services for adolescents across the six LGAs where the study was conducted. These strategies include:

► Training of health service providers.
► Supportive supervision of health service providers.

The training of health service providers was delivered through a training-of-trainers approach, which was followed by a supervised stepdown of training to frontline three categories of health workers: primary healthcare (PHC) workers, CHWs and PMVs.

A 3-day residential training workshop was organised in Abakaliki from 12 to 14 February 2020 to build the capacity of senior and mid-level healthcare managers in the provision of comprehensive and adolescent-friendly SRH services. The workshop aimed to raise a critical mass of trainers who are competent and skilled to train other health workers in the provision of adolescent-friendly SRH services, and who would be available in the state, beyond the life of the project, to continue providing this capacity-building intervention. A total of 29 participants were trained by community health physicians who have some expertise in adolescent health. The training was conducted using a training manual that was specifically developed for this project. The manual consists of eight modules, namely: (1) introduction to adolescence and adolescent health; (2) sexuality and sexual behaviours; (3) STIs; (4) principles and practice of counselling; (5) pregnancy and prevention of pregnancy; (6) counselling practices on selected health issues of adolescents (including values clarification); (7) optimal adolescent and youth-friendly services; and (8) record-keeping and health information systems. The training was delivered through lectures, interactive sessions and group discussions/activities.

Following the training of trainers, 81 officers-in-charge (OICs) of PHC were trained in March 2020 on how to deliver adolescent-friendly SRH services to clients. The OICs were trained in two batches using different venues to ensure active learning and full participation of the participants. Two weeks after the training of PHC workers, decentralised training workshops were organised for CHWs and PMVs in the three senatorial zones in Ebonyi state. In each senatorial zone, 30 CHWs and 30 PMVs were purposely selected and invited for the training workshops. Selection of participants was done in collaboration with state and LGA-level health programme managers, health facility managers, and representatives of PMVs’ and CHWs’ professional and regulatory agencies. The training workshops for PMVs and CHWs were conducted separately and each lasted for 2 days. The
CHWs’ workshops were held in March, while the PMVs’ workshops were held in April 2020. A total of 80 PMVs and 82 CHWs attended the workshops.

The training of front-line health workers was facilitated by the trained trainers with the support of the community health physicians. The training manual that was used for the trainers was adopted for the front-line health workers.

Two sessions of quarterly supportive supervision of the formal and informal healthcare providers were carried out by the research team, adolescent and reproductive health programme managers at the state and LGA levels, and adolescent SRH practitioners in the state. The first supportive supervision of PHC workers was carried out from April to May 2020. Among the 81 PHCs that were represented during the training of facility managers, 79 were visited. The two outstanding health facilities could not be accessed due to communal clashes at the time of supervision. The first supportive supervision of PMVs and CHWs took place from June to July 2020. All trained CHWs were visited and supervised. Sixty-four out of the 80 trained PMVs could be reached and supervised. The remaining 16 were either not reachable by phone or refused to participate in the supervision exercise. The second round of supportive supervision of PHC workers was carried out from August to September 2020. All the 81 PHCs that were represented during the training of facility managers were visited. The visit to PMVs and CHWs took place from 2 November to 14 December 2020. Sixty-four of the 79 CHWs were visited and supervised. Seventy-five out of 88 trained PMVs were visited and supervised. The remaining 13 PMVs and 15 CHWs were either not reachable by phone, had relocated from the state or refused to participate in the supervision exercise.

Study population and sampling
The study population comprised of formal and informal healthcare providers who had been trained (in the project) to deliver adolescent-friendly SRH services. They include the local government health managers, adolescent health programme managers, primary healthcare facility managers, PMVs and community health volunteers (CHVs).

Study participants were purposively selected based on their involvement in the adolescent SRH interventions implemented in the state. The criteria for selection of participants are that they (1) must have received the capacity-building training in the delivery of comprehensive SRH services to adolescents, and (2) were supervised during the two sessions of quarterly supportive supervision.

Data collection
Using a pretested interview guide, data were collected for 1 month between 14 October and 19 November 2021. The interview guide (online supplemental file 3) was pretested among health service providers resident in a community that was not sampled for project evaluation. The interview guide was developed by a team of qualitative research experts who participated in the project implementation. The guide was used to collect information basically, on health service providers’ experiences with the provision of SRH services to adolescents and how the capacity-building intervention made an impact on the approach of adolescents’ SRH service delivery. The interviews were continued until saturation was achieved.

A total of six focus group discussions (FGDs) were held with 52 healthcare providers and eight in-depth interviews (IDIs) were conducted with LGA/programme managers. Table 1 shows the demographic characteristics of interview participants. In each LGA, one FGD was conducted for a category of health service providers (PHC facility manager, PMVs or CHVs), ensuring that two interviews were held for each category of health service providers across the six LGAs. The FGD participants ranged from 7 to 10 for each session. Regarding the IDIs, two local government healthcare managers from an urban and a rural LGA were interviewed. All (six) adolescent health programme managers from the six selected LGAs were interviewed.

Table 1 Demographic characteristics of in-depth interview (IDI) and focus group discussion (FGD) participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>IDI</th>
<th>FGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of formal healthcare providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA healthcare managers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Adolescent health programme managers</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>OICs</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Category of informal healthcare providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMVs</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>CHWs</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Age category (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–29 years</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>30–39 years</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>40–49 years</td>
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<td>12</td>
</tr>
<tr>
<td>50 years and above</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Location of residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Rural</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Highest educational qualification</td>
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<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Senior CHEW</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Secondary education</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8 participants</td>
<td>52 participants</td>
</tr>
</tbody>
</table>

CHEWs, community health extension worker; CHWs, community health workers; LGA, local government area; OICs, officers-in-charge; PMVs, patent medicine vendors.
The interviews were conducted by male and female qualitative research experts. Four social scientists were trained for 4 days to familiarise themselves with the study questions. The social scientists worked together with the project qualitative research experts during the data collection exercise. The interviews were held either in English language or the local language, depending on the participants’ preferences. The face-to-face interviews were mostly scheduled in participants’ convenient venues. The interviews were conducted without any record of refusal from participants who were invited to partake in the study. All participants were informed of the study objectives and their rights to participation before the commencement of the interviews. With the permission/consent of the participants, all interviews were audio-recorded, and handwritten notes were also taken, each session lasted between 45 min and 1 hour.

Data analysis
The interview audio-records were transcribed verbatim and translated to English, where necessary. To affirm accuracy, all transcripts were edited, compared with handwritten notes and uniquely labelled. Using a deductive–inductive approach, the thematic analysis of transcripts was performed. Initially, a generic coding framework was developed by four researchers based on the objectives of the research project evaluation. Discrepancies in the coding framework were resolved through a consensus. The codes and their descriptions in the framework are highlighted in figure 1.

The 14 transcripts were then imported into NVivo software (V.12) and each transcript was coded by two independent researchers. Word query output was generated for each code and thoroughly read to identify the themes presented in the Results section. As highlighted in figure 2, a total of five themes emerged across the codes in the generic framework. Findings were shared with the stakeholders (including healthcare providers) during the project close-out events for reflection and endorsement.

Patient and public involvement
Patients and the public were not involved in designing of the project protocol leading to the results presented in this manuscript. However, the study state and LGA-level stakeholders were involved in co-creating and implementing the study intervention. Also, through a validation workshop, the data collection instrument was presented to the stakeholders in Ebonyi state. They reviewed and validated the instrument before entering the field. In this study, the study population were invited and involved (healthcare providers) in the interview. Following the data collection and analysis of findings, the study findings were presented to stakeholders, healthcare providers, adolescents and community influencers during the project close-out event. The public and study participants were not involved in data analysis and writing of the manuscript.

Figure 1 Thematic coding framework for analysing the impact of SRH intervention and their descriptions. CHVs, community health volunteers; PHC, primary health centre; PMVs, patent medicine vendors; SRH, sexual and reproductive health.
## RESULTS

The findings are structured according to the themes (figure 2) that emerged from the coding outputs. First, we present the changes in views and perceptions that cut across the formal and informal healthcare providers, then we highlight the changes that were unique to each category.

### Change in views and perceptions of both formal and informal healthcare providers

- Healthcare providers now recognize the rights of adolescents to obtain contraceptive services
- Healthcare providers no longer deny adolescents contraceptive services
- Change in healthcare providers behaviour and interactions with adolescents
  - Healthcare providers have become more friendly and gentle
  - Healthcare providers have become more respectful of the SRH choices of adolescents

### Change in views and perceptions of informal healthcare providers

- Informal healthcare providers now have more adolescent clients
- Informal healthcare providers are bolder to provide SRH services for adolescents
- Informal healthcare providers are more comfortable and happy providing SRH services for adolescents

### Organizational change in the delivery of adolescent SRH services in primary healthcare facility

- Healthcare providers have made facilities more conducive for adolescents
  - Creation of safe spaces
  - Introduction of extracurricular activities

### Reluctance to provide contraceptives as a result of religious convictions

Apart from condoms, other contraceptives make adolescents promiscuous

Figure 2  Emerging themes across the initial thematic coding framework. SRH, sexual and reproductive health.

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### Change in views and perceptions of both formal and informal healthcare providers

Healthcare providers now recognize the rights of adolescents to obtain contraceptive services

Generally, from the perspectives of both formal and informal healthcare providers, the capacity-building intervention implemented to improve their skills in the provision of adolescent-friendly SRH services altered the views of many healthcare providers about the rights of adolescents to obtain contraceptive services.

Previously, most healthcare providers had the opinion that contraceptives were only appropriate for married people and that adolescents were too young to obtain those services. They also believe that exposing or providing contraception to adolescents encourages promiscuous behaviour. However, following the capacity-building intervention, they recognised that adolescents, irrespective of age or marital status, have the right to access and obtain contraceptives if they need them. This change in views and perceptions of healthcare providers was enforced due to their increased awareness of adolescents’ SRH needs and improved knowledge of adolescents’ SRH services. Health providers became more sensitised and began to look out for the SRH needs of adolescents in the community. See below for supporting quotes:

It helped us very well, like in initially time, on the issue of contraceptives, we thought it is only married women that should access the service but now, we realize and learned that young adolescents can also come for such services, like any adolescent or young person can come and request for any contraceptive they service should be provided. I just learned that from this project. (FGD with OIC in Abakaliki)

Previously, it will be difficult for a child of 12–14 years to get pregnant. I thought that providing contraceptives will be encouraging them to engage in sex but when I started seeing 336 people of 12 years getting pregnant. Then I said okay, I should prevent these children from 337 getting pregnant than for them getting pregnant at this age because you will not know the 338 outcome of these pregnancies. You
will not know whether the mother will be alive or not then, I told myself I needed to provide these services for them. (FGD with CHV in Ohaozara)

Healthcare providers no longer deny adolescents contraceptive services

The formal and informal healthcare providers were of the opinion that in the past, adolescents were denied access to contraceptive services due to age. However, after the SRH training to improve the skills of healthcare providers, they began to provide contraceptives to adolescents of all ages. The observed change in attitude was triggered by their improved knowledge of adolescent SRH services.

because we are mothers although we are health providers, whenever we see someone collecting condoms we will think that the person is too small and tell the person that s/he does not need it, not knowing the person has already gone far in the act. But this was what the training made us understand, that when they want any service, we should provide it for them. (FGD with CHV in Ohaozara)

Change in healthcare providers’ behaviour and interactions with adolescents

Healthcare providers have become more friendly and gentle

Most formal and informal healthcare providers were of the opinion that the SRH capacity-building intervention created an opportunity for a more friendly relationship with adolescents. Healthcare providers were of the opinion that they were less friendly with adolescents in the past and this affected the quality of SRH service delivery to adolescent clients. However, following the SRH training, they have become more friendly and approachable in the delivery of adolescent SRH services. Below are some quotes to support the findings:

I think, for now, it makes me friendlier with them. They feel more comfortable in discussing anything with me, unlike before. (FGD with OIC Abakaliki)

The changes it brings is that it makes me friendly with the adolescent more than before and whenever they have a problem, they will like to come to me willingly with that their problem with confidence. (FGD with PMV in Ezza South)

The program is very interesting, it has brought about a very good relationship between health workers and adolescents because before they (adolescents) use to be shy but since the introduction of this program they now are bold to come to this center. (FGD with CHV in Ohaozara)

So, it has created good rapport between the adolescents including the youths and us the health workers in the community. (FGD with OIC in Abakaliki)

The resonating opinion among most formal and informal health service providers is that they have become more gentle in their interactions with adolescents. Previously, health providers were not gentle in their interactions with adolescents who come to their facilities to obtain SRH services. However, after the capacity-building intervention, health providers believe that they have become calmer, gentler and more relaxed when interacting with adolescents who seek SRH services. In their opinion, this change in attitude has enhanced the quality of SRH services delivered to adolescents. Here are some quotes to support the findings:

We give them a free enabling environment to access any health information, we are gentle...they now use to come to the facility with boldness to ask for anything they want. (FGD with OIC Abakaliki)

It has changed me, the way am talking to them has changed, unlike the way I use to be talking to them before. I have drastically changed in ways I use to talk to them now. It is better now because, before I don’t use to calm down in discussing with them, but now, I do calm down and feel more relaxed. They do receive better services now, unlike before. (FGD with PMV in Abakaliki)

Healthcare providers have become more respectful of the SRH choices of adolescents

The healthcare providers disclosed how the intervention has made them adopt a more flexible approach when communicating to adolescents about available SRH services in their facilities. In their opinion, they also noted that due to their improved knowledge of adolescent SRH services, they could now attend to adolescents without forcing their opinions on them, but present the facts as they are, so they could make informed consent.

With this project, I came to realize that you cannot force everybody to..., and to protect the future of that child, that adolescent, you don’t need to force your belief on that person, I think from this intervention, I learned that, you should present the fact, present everything, just put it on the table and make the adolescent make use of her choice, if she says no, I cannot do it, you don’t need to say, you must do it, allow him or her to see other options, that is the major impact I have, maybe on what I use to hold rigidly and now I know it does not work that way, is not possible. (FGD with PMV in Ezza South)

With the knowledge we have received from the training, we can be able to communicate with them and tell them exactly what services we render in the facility so they can choose what they want. (FGD with OIC in Abakaliki)

Change in views and perceptions of informal healthcare providers

Informal healthcare providers now have more adolescent clients

Specifically, the PMVs and CHVs were of the opinion that they now attend to more adolescent clients following their participation in the capacity-building intervention.
Their delivery of SRH services to adolescents enabled a peer-to-peer referral to their facilities.

I now have customers because when they come, they will like to meet me, discuss with me, tell me their problems because they know that I will listen to them and give them guidelines. (FGD with PMV in Ezza South) These people as they come they are now patronizing our centers they now call their friends to come and tell them this is the kind of services you will obtain, we need at least at the end of the year or after six-months as the case may be to look for something tangible [incentive] and appreciate them for accepting our services and also patronizing our centers. (FGD with CHV in Ohaozara)

Informal healthcare providers have become bolder to provide SRH services for adolescents

Specifically, the CHVs believed that they have become bolder in delivering SRH services for adolescents both in the community and at the facility. They were of the opinion that their participation and involvement in the SRH training improved their knowledge and also enhanced their capacity to deliver quality sexual education/counselling. In their opinion, high community awareness and parental support empowered them to seek consent from parents and boldly discuss SRH matters with adolescents. See the below quotes:

Yes, the training is good, and it helps me before I used to be shy in talking to an adolescent about sexual reproductive services but now I can do it. (FGD with CHV in Ikwo)

No, I wouldn’t have been bold to present such a case [sexual health education and counseling] in the presence of a father, a mother, or even the children but now I am bold . when I wanted to call some adolescents it was in the presence of their father and mother. Even when the girl said no and because people in the community knows about this information it was even the girl’s parents that encouraged her to go that knowledge is power, they gave the daughter some money to come for the counseling section. (FGD with CHV in Ohaozara)

Informal healthcare providers are more comfortable providing SRH services for adolescents

The CHVs were of the opinion that previously, they were not comfortable delivering SRH services to adolescents due to their beliefs. However, succeeding the SRH training and continuous supportive supervision, they have a better understanding of adolescents’ SRH rights. The supportive supervision reinforced the knowledge and skills they gained from the training workshop. So in their own opinion, they have become more comfortable and willing to deliver adolescent SRH services.

As I said before, I will find it difficult because of my beliefs … but now that I have come to the knowledge of it [need for ASRH services] and I am now comfortable and more willing to provide the services for adolescents. (FGD with CHV in Ohaozara)

Before now, I wasn’t comfortable when adolescents come to seek sexual reproductive health services but with your training and the understanding I have now, I know that adolescents have their right to reproductive life, they only need to be guided. I am happy to provide SRH services for them. This is to make sure that they are healthy. (FGD with CHV in Ikwo)

Organisational change in the delivery of adolescent SRH services in primary healthcare facility

Healthcare providers have made facilities more conducive for adolescents

The formal healthcare providers in particular emphasised that a more conducive environment has been created in various primary healthcare facilities as a result of the capacity-building intervention, enabling adolescents’ access to high-quality SRH services.

Creation of safe spaces

Formally, there were no separate spaces for delivering adolescent SRH service in the facility. However, following the capacity-building intervention, the facilities created separate spaces for the delivery of SRH services including counselling services to adolescents who use the health facility.

Yes, you know before now, for those of us that use to handle them, health workers talk to adolescents as if pause, they handle them anyhow, they don’t know they are fragile, they don’t know they need secrecy, they don’t know that they need to be relaxed when counseling them, you know sometimes, their attitude towards them scare them [adolescents] away but with this intervention, there is an improvement, like most of the facilities now, they now have a separate room, they have a separate arrangement where they counsel adolescent. (Adolescent health programme manager in Abakaliki)

Introduction of extracurricular activities

The formal health service providers were of the opinion that the introduction of extracurricular activities and games following the SRH training of healthcare providers improved the use of SRH service utilisation among adolescent clients. The introduction of curricular activities has fostered stronger connection between the healthcare workers and adolescents. According to the participants, the inclusion of these activities which adolescents use provides an opportunity for adolescents to inquire about their broader health concerns.

It has created a synergy between the health worker and the adolescent, initially we use to focus only on treatment for a particular problem they came for at the facility. Like this our facility here, we have games of snooker, table tennis when they come, they do play the games then they will ask some questions on their health needs... (FGD with OIC in Abakaliki)
In spite of the fact that the intervention generally improved the views and perceptions of formal and informal healthcare providers toward the provision of adolescent SRH services, very few of them, especially among the PMVs, still held on to some of their poor perceptions about adolescent SRH issues, particularly as they affect contraceptives.

**Reluctance to provide contraceptives as a result of religious convictions**

One of the participants expressed reluctance to provide various contraceptive methods beyond condoms due to her personal religious beliefs. This perspective demonstrates a conflict between religious or moral values and healthcare providers’ responsibility to provide comprehensive information and services to adolescents. Her views are expressed in the quote below:

> I don’t advise adolescent to use contraceptives except condom; I don’t educate them on other methods of contraceptive, because that very one will be contrary to my own [religious] belief. I don’t educate young girls to take family planning such as implant or IUD [intrauterine device] or whatever. (FGD with PMV in Abakaliki)

**Apart from condoms, other contraceptives make adolescents promiscuous**

Another participant who shared similar sentiments expressed concern that certain contraceptive methods, such as implants and intrauterine contraceptive devices, may have adverse effects. The participants believed that using these methods might make adolescents more promiscuous or ‘wayward’ and could potentially harm their reproductive organs. The quote below reflects her opinion:

> Yes, the reason [I don’t support the use of contraceptives by adolescents] is that using contraceptives like implants may make someone to be wayward more than normal and using IUD, sometimes will affect the reproductive organ of that very person. (FGD with PMV in Ezza South)

**DISCUSSION**

The intervention improved the views and perceptions of healthcare providers toward the provision of adolescent SRH services. However, variations were observed in the improved views and perceptions of formal and informal healthcare providers. Previous studies have shown that healthcare providers have ambivalent views and perceptions toward the delivery of SRH services including contraceptives for adolescents. However, our findings emphasise the need for continuous capacity building of both formal and informal healthcare providers as this was found to be beneficial and for better SRH outcomes among adolescents.

The formal and informal healthcare providers now recognise the rights of adolescents to obtain contraceptive services. Before the intervention, healthcare providers believed that contraceptives were only appropriate for married people and that adolescents were too young to obtain those services. This belief conforms to a Nigerian study that adolescents face barriers to accessing contraceptive services due to their age, gender and marital status. Also, they had the belief that providing contraceptive services for unmarried adolescents promotes sexual promiscuity. Similarly, this belief was expressed by healthcare providers in different studies carried out in Nigeria, Uganda and Swaziland.

The providers now recognise that adolescents, irrespective of their age or marital status, have the right to access contraceptive services and that providing contraceptives to adolescents is necessary to promote safe sex practices and reduce unplanned pregnancies and the incidence of abortion among adolescents. The providers reported that although they previously denied adolescents access to contraceptive services because of their age, they have become more respectful of the SRH choices of adolescents following the SRH training. In order to improve access to contraceptives among adolescents, healthcare providers support adolescents in making contraceptive choices that meet their SRH needs. In a recent qualitative study conducted in India and a Nigerian study, some healthcare providers highlighted that all categories of adolescents should have access to contraceptive services, and that information and services regarding contraceptives should be made readily available for both sexually active and non-sexually active adolescents.

Our finding that the informal healthcare providers have become more relaxed, bolder and more comfortable in delivering SRH services to adolescents corroborates Chandra-Mouli and colleagues’ finding that to improve adolescents’ access and use of SRH services, interventions should target building parent and community support. The capacity-building intervention showed positive parental and community support toward the provision of SRH counselling services to adolescents. The fear of community and parental reaction to the provision of SRH services for unmarried adolescents contributes immensely to the views and perceptions of healthcare providers towards the provision of SRH services such as contraceptive services to adolescents.

Interestingly, the informal healthcare providers believed that their capacity to deliver more adolescent-friendly SRH services following the capacity-building intervention enabled increased patronage by adolescent clients. For the formal providers, an inference was that the introduction of safe spaces, extracurricular activities and games following the SRH training of health providers improved SRH service utilisation among adolescent clients, which was similar to findings from a study in South Africa, where 89.4% of adolescent girls and young women reported that the safe spaces for delivering adolescents’ SRH services offer a safe, quiet and comfortable environment when...
accessing the SRH services. This shows that the creation of safe spaces could reduce the unmet SRH needs of adolescents.

A limitation of this study is that there could be information bias due to the absence of adolescents’ perspectives about healthcare providers’ views and perceptions toward the delivery of SRH services following the capacity-building intervention. Although there could be an overestimation or underestimation of information by healthcare providers, the project findings were presented to a wide range of stakeholders including adolescents and youths for validation during the project close-out events. The use of the qualitative research method enabled a more in-depth assessment of healthcare providers’ views and perceptions toward the delivery of SRH services following the capacity-building intervention.

CONCLUSION

The capacity-building intervention improved the views and perceptions of healthcare providers toward the provision of adolescent SRH services. Both formal and informal healthcare providers now recognise the rights of adolescents to obtain contraceptive services; hence, they no longer deny adolescents contraceptive services irrespective of their age or marital status. They have become more hospitable in their interaction and delivery of SRH services for adolescent clients following the SRH capacity-building intervention. These findings highlight the importance of the constant capacity building of both formal and informal healthcare providers as it addresses healthcare providers’ biases and views and perceptions of delivering SRH services to adolescents.

To sustain and continuously improve adolescents’ access to SRH services, healthcare providers suggested that they should be regularly empowered to create continuous community awareness and education, targeting not just the adolescents but also their parents. The reason is that parents, especially mothers, influence adolescents’ health-seeking behaviours. They also highlighted that there is a need for government organisations and implementing partners to provide incentives/educational souvenirs for adolescents who use the SRH services provided in the youth-friendly centres. Considering the potential negative effects of healthcare providers’ biases on adolescents’ access to SRH services, adolescent health programmes and interventions should be tailored to address the perceived recommendations for sustainability.

Therefore, the findings from this study have several implications for practice. They highlight the importance of capacity-building interventions to enhance healthcare providers’ views and perceptions toward adolescent SRH services. This can lead to better communication, reduced stigma, more patient-centred services and ultimately, improved healthcare quality. Policymakers can also use the results from the study to develop evidence-based policies that support capacity-building programmes for adolescent SRH.

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Acknowledgements The authors wish to acknowledge the ASRH project team and relevant stakeholders in Ebonyi state for their efforts in designing interventions and implementing the 4-year project which seeks to address the SRH needs of adolescents in Ebonyi state. The authors also wish to thank the funder of the project for leading to the results presented in this manuscript. Finally, we thank all the study participants for their active participation and willingness to partake in the study.

Contributors CM and 00 conceptualised and designed the study protocol and data collection instruments. ICA, CA and CM were involved in data collection. All authors participated in data analysis. ICA wrote the first draft of the manuscript. ICA is responsible for the overall content as the guarantor. All authors reviewed the first draft and approved the final version of the manuscript for journal submission.

Funding The research leading to results included in this manuscript received funding from the IDRC MENA+WA implementation research project on maternal and child health (IDRC grant number: 108677).

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Ethics approval This study involves human participants and ethical approval to undertake the study was obtained from the Health Research Ethics Committee of the University of Nigeria Teaching Hospital Enugu (reference number NHREC/05/01/2008B-FWA00002458-IB0000233). Ethical approval was also secured from the Research and Ethics Committee of the Ebonyi State Ministry of Health. Written informed consent was obtained from every participant after informing them of the purpose of the study and their rights to participation. They were informed that participating in the study was voluntary and confidentiality of information was also assured.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

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