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Unmarried Adolescents' Experiences of Using Reproductive and Maternal Health Services in Nigeria and Uganda: A Qualitative Study

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Abstract: Adolescents' access and use of reproductive and maternal health (RMH) services is a critical part of the global strategy for achieving the Sustainable Development Goals (SDGs). However, previous studies have shown that a complex range of factors, including restrictive policies and punitive laws, limit adolescents from accessing a full range of RMH services in Sub-Saharan Africa (SSA). Our study explores the experiences of unmarried adolescents' access and use of RMH services in Nigeria and Uganda to understand the extent to which the diverse policy environment in both countries enables or hinders adolescents' access to and use of RMH services. Our qualitative research design involved eight focus group discussions (FGDs) in Nigeria and in Uganda, 14 in-depth interviews, and eight FGDs among adolescents. The data were analysed thematically and organised according to the WHO's five broad dimensions for assessing youth-friendly health services. Our findings show that RMH services were inequitably delivered in both countries. Adolescents were restricted from accessing services based on age and marital status. Being unmarried and having no partner, especially in Uganda, was a cause for discrimination during antenatal appointments. We also observed that the expectations of adolescents were not adequately met. Service providers tended to be impolite, judgemental, and unwilling to provide services, especially contraceptives, to younger and unmarried adolescents. Our findings suggest that the existence of a youth-friendly health policy does not translate into effective youth-friendly service provision. This underscores the need for further studies to understand the complexities surrounding this by using a realist evaluation method to examine how adolescent and youth-friendly health services can be designed to improve uptake of reproductive and maternal health services among adolescents in Sub-Saharan Africa.

Keywords: sexual and reproductive health; maternal health; youth-friendly services; health policy; Sub-Saharan Africa

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1. Introduction

Globally, more than 1.2 million adolescents (aged 10–19 years) die every year, with two-thirds of these deaths occurring in low-and middle-income countries (LMICs) (WHO 2017). Sub-Saharan Africa (SSA) suffers the worst adolescent health profile in the world (Bearak et al. 2018; Morris and Rushwan 2015; Starrs et al. 2018) and has the highest adolescent birth rate and HIV burden globally (UN Population Fund 2018; Dellar et al. 2015). This is largely due to the low rate of access and use of reproductive and maternal health (RMH) services (Mekonnen et al. 2019; Starrs et al. 2018; WHO 2017). This results in high rates of unsafe abortion, HIV/AIDS, and maternal death among adolescents and is also exacerbated by

early marriage, gender inequality, and early sexual initiation (Starrs et al. 2018; Woog et al. 2015; WHO 2017). This study examines the experiences of unmarried adolescents' use of reproductive and maternal health services in Nigeria and Uganda using the WHO's five broad dimensions of quality for making adolescent-friendly services, which are accessibility, acceptability, appropriateness, equitability, and effectiveness (World Health Organization 2009, 2012).

Many countries in SSA are increasingly enacting policies in line with the International Conference on Population and Development (ICPD) Programme of Action. The ICPD conference in Cairo in 1994 introduced the concepts of sexual and reproductive health and reproductive rights, including making RMH services adolescent and youth-friendly. A new definition of population policy was advanced, giving prominence to reproductive health and the empowerment of women (UNFPA 1995).

Adolescents' access and use of reproductive and maternal health (RMH) services is a critical part of the global strategy for achieving the Sustainable Development Goals (SDGs) (United Nations 2018). Accessing RMH improves and advances human rights and gender equality, saves lives, and reduces poverty by supporting girls in education and supporting an individual in planning their pregnancies (United Nations 2016; WHO and UNDP 2017). However, Mekonnen et al. (2019) and Ninsiima et al. (2021) studies have established that a complex range of barriers, including restrictive policies, limits adolescents from accessing a full range of RMH services. These barriers interact at different levels—individual (lack of knowledge of available services and inaccessible service locations), community (religious and cultural values and social norms), facility (service provider's attitude and lack of confidentiality/privacy) and policy level. These barriers obstruct adolescents' access to services (Starrs et al. 2018; Chandra-Mouli Venkatraman and Wong 2015; Santhya and Jejeebhoy 2015; World Health Organization 2016, 2017; United Nations, Population Division 2019).

Adolescent and youth-friendly service (AYF) is a term used to define health services that are accessible, acceptable, equitable, appropriate, and effective (UNFPA 1995; WHO 2017). In Nigeria and Uganda (the two countries of focus in this study), policies exist to improve adolescent use of services. However, according to the Population Reference Bureau (2020), the policy environment for both countries differs. In Uganda, a policy exists that supports youth access to a full range of family planning methods, regardless of age and marital status. The "National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006" state that all sexually active Ugandans are eligible for family planning services (Ministry of Health Uganda 2006). Uganda's policy environment supports youth access to family planning services without authorisation by a third party (Population Reference Bureau 2020; Ministry of Health Uganda 2006). Uganda implemented a national policy on increasing male involvement in reproductive health as a strategy to improve uptake of antenatal care (ANC), HIV testing, and HIV treatments among young women. However, this policy prioritises couples over unmarried young women (United Nations International Children Emergency Fund (UNICEF) 2016), and the impact on unmarried adolescents, especially the girls, on the use of reproductive and maternal health services has not been well documented.

On the other hand, in Nigeria, the policy environment is restrictive and limits adolescents from accessing the full range of services, including contraceptive methods. For example, the "National Training Manual for the Health and Development of Adolescent and Young People in Nigeria, 2011" (Federal Ministry of Health 2011) discourages providers from providing long-acting reversible contraceptives and recommends certain non-permanent contraceptive method options, even though they have been deemed safe for general use by the World Health Organization (Population Reference Bureau 2020; Federal Ministry of Health 2011).

Although adolescents are seen as a homogenous group and face similar challenges, unmarried adolescents' reproductive and maternal health (RMH) needs and access to services differ from their married counterparts. Evidence from the literature shows that

adolescents are being denied contraceptives on the basis of their marital status (World Health Organization 2010). Unmarried adolescents in developing countries have particular difficulty in obtaining contraceptives, mainly because providers fear that access to family planning will be unsafe to them (World Health Organization 2010). Previous studies (Magadi et al. 2007; Hueston et al. 2008; Ochako Rhoune et al. 2011; Hokororo et al. 2015; Waisel 2013) have shown an observed variation in the use of maternal health care among married and unmarried youth

Also, unmarried adolescents' sources of contraceptives used, reasons for not using contraceptives, and treatment they receive at antenatal appointments differ from their married counterparts (Chandra-Mouli Venkatraman et al. 2017; Agaba et al. 2021), and they have an unrecognised and frequently unmeasured need for contraception (International Federation of Gynecology and Obstetrics 2011; Godia et al. 2013; Chandra-Mouli et al. 2014). The situation reflects the desperate situation for pregnant, unmarried adolescents. Their social, economic, psychological, health, and obstetrical needs; and their experiences during the maternity period differ.

The differences in RMH policies across the two countries necessitated the need to assess the extent to which the diverse policy environment in both countries enables or hinders adolescents' access to and use of RMH services (Population Reference Bureau 2020). Understanding the impact of the policy environment on adolescent access to services is crucial in making health services more responsive to meeting adolescents' health needs, given that the COVID-19 pandemic has disrupted essential services for adolescents and young people (Nanda et al. 2020; WHO 2021). Therefore, our study explores the experiences of unmarried adolescents' access and use of RMH services in Nigeria and Uganda to understand the extent to which the diverse policy environment in both countries enables or hinders adolescents' access to and use of reproductive and maternal health services.

2. Materials and Methods

2.1. Study Site/Settings

This study was conducted in two SSA countries: Nigeria and Uganda. The reason for these two countries is driven by their differences in Sexual and Reproductive Health (SRH) policy environment, as explained above. Three area councils were selected in the Federal Capital Territory (FCT) Nigeria and two districts in Western Uganda. The FCT is highly multi-ethnic, multi-cultural, and multi-faith and has a population of 3,464,123, with 46% of the total population below 19 years of age (World Urbanisation Prospects 2021). FCT Abuja has a high prevalence of HIV within the country, and knowledge of contraceptive methods and use of family planning methods are the lowest for women in this region (National Population Commission 2019). The Bushenyi and Kibale districts in Western Uganda have an observed poor level of the use of maternal health services among unmarried adolescents, especially antenatal care. Kibaale is comprised of one administrative constituency and 11 sub-counties. It has a total population of 140,947; sixty-two percent of them are below 20 years (Uganda Bureau of Statistics (UBOS) and ICF (2018)). Bushenyi has a total population of 234,443 persons, with 57% of the total population below 20 years of age (Uganda Bureau of Statistics (UBOS) and ICF (2018))

2.2. Study Design

This study adopted a qualitative, interpretative phenomenological design to gain an in-depth understanding of the experiences of adolescents on the use of RMH services in Nigeria and Uganda. This approach allows for a rich and complete description of human experiences (Vogt and Johnson 2015). Focus Group Discussions (FGDs) were utilised to gain in-depth insights on the topic (Allen 2017). Face to face, in-depth interviews with unmarried pregnant adolescents were conducted to deductively examine their experiences of services utilisation in further depth (Guest Greg and Mitchell 2013).

2.3. Sampling Strategy and Size

The participants for this study were purposively selected from both urban and rural areas in Nigeria and Uganda. Purposive sampling has been widely used in qualitative research to recruit participants who are knowledgeable, hard to reach, or experienced the phenomenon of interest (Cresswell and Clark 2011). By using this sampling method, we were able to capture diverse characteristics of participants (Patton 1990; Bowling 2009). In Nigeria, our participants were adolescents 10–19 years who were unmarried and had experience in the use of reproductive health services. These adolescents were either in school or out of school. Adolescents who had no experience in the use of reproductive health services were not included in Nigeria to ensure that findings reflect the views of adolescents, both old and young. This was based on the evidence that older adolescents (aged 15–19 years) have more knowledge and are more likely to use SRH services (Ndyanabangi and Diesfeld 2004; Oljira et al. 2013). Altogether, eight Focus Group Discussions were conducted with 8–10 participants in each group in Nigeria to stimulate good and manageable discussion (Ulin et al. 2005).

In Uganda, our participants included adolescents who were unmarried adolescents and were pregnant or had given birth three years before fieldwork. Married adolescents and unmarried adolescents who had never been pregnant were excluded from the study in Uganda. Data collection was performed until data saturation, when new interviews did not generate any new information related to the topic of discussion. In Uganda, In-depth interviews (IDIs) were carried out among fourteen adolescents. A total of eight FGDs among 42 unmarried adolescents were conducted, with 4–8 participants in each group.

2.4. Recruitment Strategy

In Nigeria, participants were recruited through the local NGOs, and Youth Friendly centres in FCT Abuja. The Community Health Officers (CHO) and gatekeepers in the selected local schools helped to identify the study participants and disseminate the information sheet. Furthermore, an information sheet for parents and guardians of adolescents aged 15 years and below was disseminated through the adolescents. FO with the community health officer followed up with phone calls to arrange the FGDs with participants, discuss consent procedure, and agree on potential dates for the FGDs.

In Uganda, community health workers and adolescent social informal networks helped in identifying study participants. PA, together with the Village Health Teams (VHTs), visited households that had an adolescent who was pregnant or had given birth within three years while unmarried. All the potential participants were informed of the study's purpose and advised about informed consent. Adolescents who were selected for in-depth interviews agreed on the day and convenient time when interviews could be conducted. Participant recruitment was by PA, who identified the participants a few days before data collection occurred.

2.5. Data Collection

The data collection was based on the use of FGDs and in-depth interviews (Braun and Clarke 2006). The FGD and interview guides were iteratively developed by FO and PA with input from MH, and BO. The guide was piloted among adolescents and research assistants to ensure the guides were feasible and tested the adequacy of the instruments proposed (Song et al. 2010). All interviews and FGDs followed a semi-structured format, inviting participants to describe their experiences in their own words. The FGDs and interview questions were identified beforehand and followed a broad thematic structure with questions around the health-seeking behaviour, experiences of accessing and use of services in relation to accessibility, equity, and acceptability.

In Nigeria, FGDs were facilitated by FO, while in Uganda, interviews were conducted by trained research assistants with experience in qualitative data collection, who were fluent in Runyoro and Runyankole languages, the native languages in Kibaale and Bushenyi districts, respectively, with the support of PA. In Nigeria, FGDs were conducted in English,

while in Uganda, interviews and FGDs were conducted in Runyoro in Kibaale district and Runyankole in Bushenyi district. The data collection took place in a safe and secured environment. On average, each of the FGDs and interviews lasted for approximately 60 and 40 min, respectively. Data from Uganda were transcribed from Runyankole and Runyoro directly to English.

2.6. Data Analysis

The interviews and FGDs were audio-recorded and transcribed verbatim. The transcripts were deductively analysed, guided by the six steps to thematic analysis described by Braun and Clarke (2006), following the five broad dimensions for assessing youth-friendly services (WHO 2012).

NVIVO software version 12 was used to organise the data, and emerging codes were recorded. Information from the field notes was developed and used to augment the audio-recorded transcripts. The data were analysed in English by FO and PA and cross-checked by MH and BO. Data trustworthiness was ensured through member checking. This was applied during the data analysis to verify the emerging themes and provide participants with the opportunity to offer clarification, add information, and prioritise the initial themes (Prion and Adamson 2014; Creswell and Miller 2000) to ensure all aspects of the studies were well reported (Tong Allison and Craig 2007). The two researchers (FO and PA) were part of the data collection team; they recruited participants and took part in interviews. The researchers (FO and PA) listened to audio recordings and edited the transcripts accordingly to make sure all transcripts were transcribed verbatim. This is because phenomenology requires verbatim transcripts (King and Horrocks 2010). The results were organised according to the five broad dimensions and indicators for assessing youth-friendly services, which are accessible, acceptable, appropriate, equitable, and effective (World Health Organization 2009; WHO 2012; Mazur et al. 2018). See Table 1.

Table 1. Assessment criteria.

Assessment Criteria	Definition
Accessible	Adolescents are able to obtain the services that are provided
Acceptable	Health services are provided in ways that meet the expectations of adolescent clients
Appropriate	The health services that adolescents need are provided
Equitable	All adolescents, not just certain groups, are able to obtain the health services they need
Effective	The right health services are provided in the right way and make a positive contribution to the health of adolescents.

(Source: WHO 2012).

3. Ethical Considerations

Ethical approval for this research project was authorised by the School of Education and Social Sciences ethics review committee, the University of Hull, Mildmay Uganda Research Ethics Committee and Uganda National Council of Science and Technology (SS4465), and the National Health Ethics Research Committee of Nigeria (NHREC/01/01/2007-20/06/2017). Participants gave written consent before the interviews and FGDs were conducted. Participants were assured that participation in the research was entirely voluntary and that they could withdraw at any point. Due to the minors involved in this study (adolescents aged 10–14 years old), parental or guardian consent and assent from participants were obtained. The Beauchamp and Childress Principles of Biomedical Ethics were followed to ensure participants were protected (Beauchamp and Childress 2012).

4. Findings

4.1. Characteristics of Participants

In Nigeria, a total of seventy-five participants took part in the FGDs. The participants were, on average, aged 15.7 years. Thirty-three (34) participants were from the rural part of Abuja, while 41 were from the urban area. Almost half of the participants were out of school (See Table 2).

Table 2. Summary of focus group discussion participants' characteristics-Nigeria.

No of FGDs	No of Participants per Group	Age Range	Used SRH Services	Health Facility Visited	Attending School	Education-Levels	Place of Residence
A	9	10–14	Yes	Public	In-School	2 Primary and 7 secondary	Urban
B	10	10–14	Yes	Private	In-School	1 primary and 9 secondary	Urban
C	10	10–14	Yes	Mixed	Out-of-School	8 primary and 2 secondary	Rural
D	9	10–14	Yes	Private	Out-of-School	6 primary and 3 secondary	Urban
E	8	15–19	Yes	Public	In-school	7 secondary and 1 University	Urban
F	9	15–19	Yes	Mixed	In-school	6 Secondary and 3 university	Rural
G	10	15–19	Yes	Public	Out-of-school	All secondary	Rural
H	10	15–19	Yes	Mixed	Out-of-school	2 primary and 8 secondary	Both

Key: SRH = Sexual and Reproductive Health; PHC = Primary Healthcare centre, Mixed = (Public and Private facility).

On the other hand, in Uganda, all youth IDI participants were adolescent mothers aged 16–19 years, and most had become pregnant at 15 years of age. Only two of the adolescents with IDI had become pregnant while aged below 15 years old, more specifically at 14 years old. More than half (8 of 14) of the IDI participants became pregnant while at school. Almost all participants had some ANC; more than half had delivered in the health facility, while very few had postnatal care. Half of the IDI participants had become pregnant while at school (See Tables 3 and 4).

Table 3. Summary of focus group discussion participants' characteristics- Uganda.

No. of FGDs	No of Participants per Group	Age Range	Pregnant at Time of FGDs	Age at First Birth	ANC Use	Place of Delivery	PNC	Education-Levels	Place of Residence
A	8	16–18	One participant	Missing	Yes	HF	No PNC	2 primary and 5 secondary	Urban
B	5	18–19	One participant	Missing	Yes	HF	No PNC	All secondary	Rural
C	5	18–19	One participant	Missing		HF	No PNC	2 primary and 3 secondary	Rural
D	4	16–18	No	14–16	Yes	HF	2 had PNC	2 primary and 2 secondary	Urban
E	5	17–19	No	16–17	Yes	HF	2 had PNC	3 primary and 3 secondary	Urban
F	4	16–17	No	15–16	One had no ANC	One at home	Missing	Missing	Rural
G	6	16–19	One participant	15–17	Yes	HF	1 had PNC	2 primary and 4 secondary	Rural
H	5	18–19	No	14–19		2 at home	2 had PNC	3 primary, and 2 secondary	Rural

Key: HF = Health Facility; PNC = Postnatal care; TBA = Traditional Birth Attendant.

Table 4. Summary of youth in-depth interview participants' characteristics-Uganda.

Participant	Age	Pregnant at Time of Interview	Age at First Birth	Pregnancy Wanted	ANC Use	No of ANC Visits	HF Delivery	PNC	Education Level	In School at Pregnancy	Place of Residence
1	16	No	16	No	No	0	HF	No	Primary	No	Rural
2	17	Yes	N/a	Yes	Yes	1	N/a	N/a	Primary	Yes	Rural
3	17	No	16	No	yes	3	Home	No	Primary	Yes	Rural
4	17	No	16	No	Yes	Nil	HF	No	primary	Yes	Rural
5	17	Yes	N/a	No	Yes	Nil	N/a	N/a	Primary	No	Rural
6	18	No	17	No	Yes	3	HF	No	Secondary	Yes	Urban
7	18	No	17	No	Yes	2	TBA	No	No Education	No	Rural
8	17	No	17	No	Yes	4	HF	No	Primary	No	Rural
9	19	No	18	Yes	Yes	2	HF	No	Secondary	Yes	Rural
10	16	No	14	No	Yes	3	HF	No	Secondary	Yes	Urban
11	19	Yes	N/a	Yes	Yes	3	N/a	N/a	Missing	No	Rural
12	17	Yes	N/a	No	Yes	1	N/a	N/a	Secondary	Yes	Rural
13	19	No	17	No	Yes	3	HF	No	Primary	No	Rural
14	15	Yes	14	No	Yes	4	HF	N/a	Primary	Yes	Rural

Key: N/A = Not application (If a woman is still pregnant); HF = Health Facility; PNC = Postnatal care; TBA = Traditional Birth Attendant.

4.2. Accessibility of Services

This theme examined the experiences of adolescents in accessing available reproductive and maternal health (RMH) services. Overall, accessibility issues were consistently reported by participants in both Nigeria and Uganda.

In Nigeria, adolescents' experience of access to services varies depending on the sources of services (i.e., private or public clinics). Those who accessed services from private clinic/pharmacy shops or stand-alone youth-friendly clinics found the opening hours to be convenient; no appointment was required, and more dedicated providers and adolescents were well-informed about the range of available services. However, they reported the high cost of the family planning commodities in the private clinics, which they did not mind paying for. This is what one of the participants had to say;

> *"If you go to private clinics, the medical personnel are kind-hearted, dedicated and if you explain things to them, they will understand. They will attend to you but not so in public clinics".* (FGD female 10–14)

However, those that had experience accessing services from public sources (public/government facilities) reported that most services were free, service location was closer, and adolescents knew the services available but were afraid to access them because of lack of privacy, which is an important marker for service accessibility. Quote from one of the participants.

> *Because this place is open and young girls don't like it. For example, if I am coming to the clinic, many people will see me when I am entering. There is no privacy and there is a need to have another entrance that is not too exposed.* (FGD, Female 15–19)

Parental involvement, societal perception, and living in the same community with providers were of great concern. Furthermore, there was no mention of appointment drop-in availability or online booking or if available policies and procedures ensure that health services are either free or affordable to adolescents.

In Uganda, all the adolescents that were interviewed accessed maternal health services from public health facilities. Accessibility challenges centred around service opening times, waiting time, and lack of attention and care at the facility.

Adolescents reported the late opening of the health centres even when they arrived relatively early. Sometimes, the providers are not available, or those who are around are not available to attend to clients. The health providers do not follow the health facility's opening and closing times for antenatal care.

> *"Let me tell you madam nurse what happened to me. On Wednesday, I went to Kibaale hospital and there was no attendant at the facility. Even if you found someone there, they just get your book and write in it the prescription you need, and they will tell you to go to a clinic and buy the medicine. That is what happens. The health workers should at least*

be available in the hospitals, we do not know if these health workers are not enough, or they are always absent at work." (FGD, female 15–19)

The long waiting time is uncomfortable for these adolescents due to the associated stigma of being seen in the maternity wards. In addition, they suffer from hunger due to poverty as they cannot afford to buy food at these health centres. Due to the long distances travelled, youth spend a long time travelling to the health facilities. Therefore, keeping them for a long period at the health centres might often discourage them from coming for the health services on offer.

"I would go without anything to eat, if I couldn't afford transport how could I get what to eat? Sometimes we didn't have what to eat, we would eat supper and there is no breakfast and besides, I would be running late. I would go hungry and then they wait for others who come at 11 and then you go and line up." (IDI participant)

Notwithstanding these challenges, privacy was also ensured as part of the provision of care to unmarried adolescents in Uganda. Although a minority of adolescents reported limited privacy since they would meet with older women in the same waiting area, this somehow affected the use of maternal health services. They reported that some of the service providers tried their best to ensure privacy for the adolescents during the provision of the services. Adolescents reported receiving pregnancy check-ups, palpation, counselling and test results in a private room.

4.3. Acceptability of Services

This theme focused on whether reproductive health services are provided in ways that meet the expectations of adolescents. In almost all the FGDs in Nigeria, services providers rarely meet the expectation of adolescents. The vast majority of adolescents reported receiving poor treatment and services from providers. They noted that service providers embarrassed them, were impolite, and treated them very harshly. Some providers insist on receiving parental consent before administering contraceptives. They noted that some of the providers did not have good inter-personal skills as explained;

"The nurses are very rude, harsh and not polite. They talk to you rudely at the clinics. I will not go to that place because of the way they talk. They will talk and use aggressive words on you". (FGDs, Female aged 15–19)

Also, they highlighted that sometimes, the providers would threaten to call or report them to their parents. This discourages and frightens them from visiting health clinics. Some providers would inform their parents that they visited the clinic to collect condoms. Most of the adolescents reported issues of confidentiality with providers. Many believe that providers do not keep information shared with them confidential. This is more with providers who work at the public/government clinics than those at the private or youth-friendly centres. The following quote supports these points:

"They will ask you, who is your dad? We will call him and tell him what you are doing here. They will tell you that you are too small for this. Go and come with your parents, and because they (girls) don't want to come with their parents, so they would rather go to a private hospital not minding the cost and risk". (FGDs aged 10–14)

In Uganda, adolescents had mixed experiences from providers when accessing RMH services. The results showed that participants were verbally and physically abused by the providers. The words abuse, mistreatment, rude, and poor treatment by providers were common expressions about health providers' behaviour towards the adolescents during the maternity period. Adolescents often felt helpless and found themselves unable to do anything about health provider behaviour, yet they had to use maternity services. This was reflected in the following statements:

"Some midwives are very rude and abusive. Abusing us became a song at the health center. They (health providers) will abuse you; you can even think they are drunk just to abuse you." (IDI Participant)

> *"The health workers treat us harshly. Sometimes you go to the health center dressed in a skirt and a blouse because you don't have a maternity dress, so the midwife insults you for that. Maybe you don't have a cloth to lay on the bed and a birth mat, so they can't treat you. The midwife tells you that if you are poor why did you get pregnant? Or she does not attend to you and tells you to first get the requirements."* (FGD aged 15–19)

While mistreatment by providers was reported, some girls were happy with the care they received and the good relationships they had with health providers. Providers understood the worries of these girls and could attend to them in private when the regular clinics had closed. Some providers even went the extra mile to attend to them in their homes, although this limited the number of services unmarried adolescents received. Interestingly, the participants reported that male providers treated them well than female providers.

> *"I was pleased because the doctor treated me very well and it has even given me the morale to go back all the time for check-ups. Even when am going for my check-ups, I feel eager to go and meet him (health provider)."* (IDI Participant)

> *"Of recent, they brought a male midwife who is better, but when you find the lady!!!"*. (FGD participant)

4.4. Appropriateness of Services Received

This theme centred on whether the health services adolescents' needs are provided. Participants emphasised the idea of service appropriateness as vital to promoting adolescent access to services. In Nigeria, some of the adolescents that visited or had friends that visited the stand-alone youth-friendly centres or private clinics reported that the health services provided were appropriate and largely met their needs at the point of delivery or through referral linkages to specialist clinics. However, those that visited the public hospitals/clinics stated that the required package of services was sparsely met as they had limited choice of treatment and did not receive the services they wanted. In some cases, healthcare providers offer you services based on their own understanding of what you need without seeking your view;

> *"In public hospitals, they do not provide the service you want them to provide for you. They will tell you to go and come back the next day"*. (FGD, Female In-aged 10–14)

Participants who were younger (aged 10–14 years) recounted that the services provided did not meet their expectations as they felt adequate attention was not given to them.

> *The medical personnels are always in a hurry. They don't even give you attention. They will just talk to you in two sentences and that's all.* (FGD female aged 10–14)

In Uganda, during antenatal care, information about postnatal care was lacking, and adolescents knew it for immunisation. Non-use of PNC is a missed opportunity for postpartum family planning counselling and use. Adolescents were given information on childcare for survival and better health of the baby, and there was a hands-on demonstration for some activities such as breastfeeding. However, sometimes information on child and maternal nutrition was lacking. These are illustrated in the following quotes:

> *"There are times when they give me medicine after writing on it, but sometimes, the lady just tells you that she has no time if it is like the iron tablets. Some information was missing, like feeding well and how to breastfeed the baby, the foods to start the baby with, they didn't teach us all that. I got to know them recently when the time had already passed."* (IDI participant)

4.5. Equitability of Services Received

This theme explored whether adolescents can obtain the health services they need regardless of age and marital status. The results showed that there was some level of inequality in the provision of services as the healthcare providers and support staff did not treat all adolescent clients with equal care and respect. While almost all the participants

in Nigeria reported that they were discriminated against and treated unprofessionally by service providers, younger adolescents (aged 10–14 years) seemed to have received worse treatment and less attention compared to the older ones (aged 15–19 years). This was reflected in the following statements;

> *"Imagine! Someone like me going to ask for a condom in the Primary Healthcare centre, the nurses will make jess [ridicule] of you. For example, someone will ask you that what do you need a condom for at your age? Go away from my face. Sometimes they do not pay attention to you as a young person."* (FGD aged 10–14)

Also, the participants in this study reported being treated unfairly compared to their married counterparts in the same community. Furthermore, the participants noted the way the service providers caution and rebuked them in the clinic and added that the advice provided seemed to point the finger that the girls were the problem and should be blamed

> *In your face, they will tell you that they won't do it for you, you are too small for abortion services and you are not yet married. Go and come with your parents*. (FGDs Female aged 15–19)

There was no discrimination reported in terms of sexual orientation, ethnicity, and religion, and there was no mention of restrictive policies in place that limit the provision of health services to adolescents.

In Uganda, adolescents were discriminated against, left alone, and not cared for even when they called for help because of their young age during pregnancy or childbirth. These young women felt isolated and demeaned, as explained in the below quote;

> *"You become so worried, which makes you even deliver an unhealthy baby. They attend to you while giving birth when you are all so worried and sometimes you tell them but they just look at you and ignore you and yet you are in pain, all in the name of not sending you there"*. (FGDs participant)

Being unmarried and having no partner was a cause of discrimination during antenatal care. The unmarried adolescents waited longer or sometimes were denied a service moreover in non-private waiting areas since they are usually the same. This discourages adolescents from coming back for the services, as expressed in the quotes below:

> *"The services are not good because they don't treat you well because you don't have a husband, yet you are pregnant. Those who come with their husbands are given priority and for you who even came early, you end up leaving the facility late."* (FGD participant)

> *"These issues of 'the person who impregnated me is not around', nurses don't want to hear that. So, for a single mother you don't waste time going to the hospital because you don't have a husband."* (FGD participant)

4.6. Effectiveness of Services Received

This theme examined whether the right health services are provided appropriately and make a positive contribution to the health of adolescents. In Nigeria, participants reported that service providers did not give them sufficient time when they consulted with them about sexual health issues. They reported limited supplies and commodities onsite and lack of basic services in the public clinics. In some cases, they did not receive the correct treatment. Some also mentioned that in public hospitals, commodities such as condoms had remained there for a long time, often long after their expiry dates. They noted there had been occasions when possibly defective condoms have been given out or even purchased;

> *In public hospitals, their condom stays longer. It is not good. Some of them keep it for more than six months. The quality is not there, especially in health centres. They will continue to give out the condom even when is no longer good.* (FGD Female aged 15–19)

However, the participants did not report if the care provided followed the approved guidelines from the ministry of health.

In Uganda, adolescents reported poor or inadequate information is provided, for instance, prescriptions for some medicines. They reported the unavailability of commodities in public health facilities. Given that health facilities are located far from communities, girls travel long distances and fail to get medicines. This discouraged them from coming back to the health facilities. Thus, they have to buy them from private health facilities and sometimes, they do not have the money to buy the medicines as quoted below:

> *"For me I was of a view that the government should help us and give us enough medicine. You know there are times when you go to the hospital like for antenatal care, or you go to the hospital when you are pregnant, and you find when the medicine is not enough and so they write for you medicine for you to buy and yet you do not have money, so you end up missing the dose."* (FGD five participant)

The lack of health supplies in public health facilities discourages girls from visiting private clinics in the communities, as illustrated in the quote below:

> *"You left home, you're in pain, you are tired, you have put in your own transport only to reach the health centre and you are told there's no medicine, at times you have no money with you. You came running to hospital for help, you are in pain but that's what you get. Now what someone decides is not to go there completely but rather go to the clinic and buy her tablets."* (FGD participant)

5. Discussion

This study explored unmarried adolescents' experiences of using reproductive and maternal health (RMH) services in Nigeria and Uganda. We presented the findings using the WHO's five broad dimensions and indicators for assessing and improving youth-friendly health service provision and utilisation (World Health Organization 2009, 2012). Overall, our findings show that adolescents face challenges across the five domains used to assess their experiences of utilising reproductive and maternal health services. However, these challenges were less common in Uganda than in Nigeria. Our findings reveal that RMH services were not equitably delivered to adolescents in both countries. There was persistent inequity in the delivery of reproductive and maternal health services, such that younger adolescents were discriminated against on the assumption that they were too young to access services and feared that access to family planning would encourage promiscuity. Some providers insist on receiving parental consent before administering contraceptives as they fear this may result in backlash from parents and the community (Madsen et al. 2019). Furthermore, young girls were punished for their naivety in accessing antennal services.

Interestingly, being unmarried and having no partner, especially in Uganda, was a cause of discrimination during antenatal appointments. This is not surprising since a policy on increasing male involvement in reproductive health prioritises couples during ANC visits in Uganda (United Nations International Children Emergency Fund (UNICEF) 2016). Unmarried adolescents come mostly for ANC without partners because most partners have denied any involvement in the pregnancies or are not willing to accompany them (Agaba et al. 2021). Still, male involvement in Reproductive, Maternal, Newborn and Child Health (RMNCH) has been widely encouraged due to its positive effect on enhancing maternal access to antenatal and postnatal care (Tokhi et al. 2018). However, the potential impact of this policy on unmarried adolescents' access to RMH services should not be overlooked. This policy could disadvantage unmarried adolescents. Astoundingly, no discrimination was reported in terms of sexual orientation, ethnicity, and religion.

Several key policies both in Nigeria and Uganda acknowledge adolescents' rights to access RMH services regardless of age and marital status. For example, the Nigerian National Reproductive Health Policy (2017) (Federal Ministry of Health 2016) and the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights in Uganda 2006 (Ministry of Health Uganda 2006) explicitly state that all adolescents, irrespective of their age and marital status should receive family planning services. However, our findings show that this recommendation is not adopted in practice.

Further studies are needed to understand whether this was because this policy has not been well operationalised in these settings due to lack of political will, inadequate resource allocation and commitment to the realisation of Sexual and Reproductive Health (Oronje et al. 2011), or due to socio-cultural norms and belief held by service providers which hinders them from following the guidelines (Onukwugha et al. 2019).

Lack of privacy and confidentiality was a key hindrance to service accessibility among adolescents in Nigeria. In a systematic review that assesses how youth-friendly sexual and reproductive health services are measured worldwide, privacy and confidentiality was the most common feature in assessing youth-friendly sexual and reproductive health services (Mazur et al. 2018). However, this was not reported as a major issue in Uganda, as some participants recounted positive experiences about privacy and confidentiality. In Uganda, the challenges of access to RHM services focus on service opening/waiting times and lack of attention and care at the facility.

Some adolescents reported having a good experience with providers in Uganda. Across the two countries, the expectations of adolescents were not adequately met as service providers were impolite, judgemental, and treated harshly, and these were major barriers to accessing services. The major causes of these abuses were sometimes beyond the control of adolescents. For example, in Uganda, it was sometimes due to factors such as the age of the girls, the late start of ANC, and failure to meet hospital requirements. This finding is consistent with the results of other studies, which have shown that providers' attitudes influence the use of health services (Onukwugha et al. 2019; Tilahun et al. 2012; Chilinda et al. 2014).

The WHO guidelines on ensuring human rights in the provision of SRH information and services recommend the need to ensure all healthcare facilities and services are delivered in a respectful way (WHO 2014, 2018). This indicates that the RMH services provided in Nigeria and Uganda fall short of this recommendation and person-centred care model where people are placed at the centre of healthcare services through shared decision-making as adolescents were disenfranchised, disrespected, and abused in some cases (WHO 2015). This was more commonly reported in Nigeria than in Uganda, where healthcare providers take a paternalistic approach to care. This is not surprising as previous evidence has shown that the concept of shared decision-making in healthcare delivery is relatively new in developing countries (Tong Allison and Craig 2007).

6. Strengths and Limitations of the Study

Notwithstanding the methodological rigour and robustness of the study design, some limitations were acknowledged. Overall, the focus of our study was to explore the experiences of adolescents' access to reproductive and maternal health services. However, most participants in Uganda reported more experiences in accessing health services during pregnancy, childbirth and the postnatal period compared to adolescents in Nigeria that reported issues accessing reproductive health services. Therefore, experiences of adolescent access to SRH may differ from their experiences accessing maternal healthcare services, making it difficult to make a fair comparison in access to services. Although the sample was diverse and captured different demographics, however, participants were recruited from only one state in Nigeria and two districts in Uganda. Further research is needed to extend this study to more states in Nigeria and districts in Uganda.

7. Conclusions

Our study shows that despite the existence of national policies that support adolescents' access to reproductive and maternal health (RMH) services, the majority of adolescent girls were discriminated against on the basis of age and marital status, and service providers were impolite, rude and judgemental. This suggests that the existence of a youth-friendly health policy does not necessarily translate into effective youth-friendly service provision and is adopted in practice. Further studies are needed to understand the complexities surrounding this by using a realist evaluation method to examine how adolescent and

youth-friendly health services can be designed to improve uptake of reproductive and maternal health services among adolescents. This is necessary to ensure that the UN programme of action for gender equality on universal access to sexual and reproductive health becomes a reality by 2030.

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