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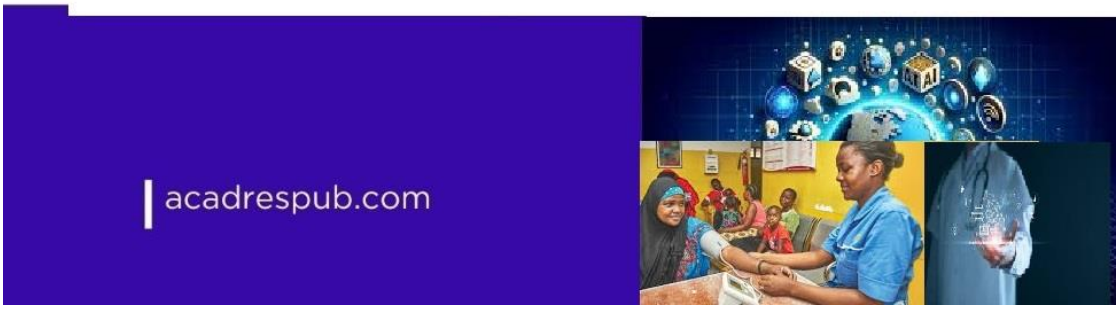

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DETERMINATION OF THE PREFERRED APPROACHES FOR PROVIDING YOUTH-FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG COMMUNITY MEMBERS AND COMMUNITY HEALTH NURSES IN OREDO AND UGBEKUN COMMUNITIES

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ABSTRACT

This study investigates the preferred approaches for delivering youth-friendly sexual and reproductive health (SRH) services in Oredo and Ugbekun communities, incorporating perspectives from both youth (community members) and frontline providers (Community Health Nurses - CHNs). The provision of adolescent and youth-friendly health services (AYFHS) is critical for addressing the high rates of teenage pregnancy, sexually transmitted infections (STIs), and unmet contraceptive needs among Nigerian youth. Using a mixed-methods approach, the research found significant alignment and some divergence in preferences between youth and nurses. Youths strongly favored confidentiality, non-judgmental attitudes, reduced cost, convenient hours, and separate service spaces from adults to ensure privacy and comfort. CHNs recognized these needs but emphasized challenges like resource constraints, cultural barriers in discussing SRH, and the need for specific training in adolescent counselling. The study concludes that a multi-pronged strategy integrating infrastructural adjustments, targeted training for providers, and community sensitization is essential for effective service delivery. These findings underscore the importance of participatory models in designing SRH services, as advocated by the WHO's Global Standards for Quality Healthcare Services for Adolescents.

Key Words: Youth-Friendly Services, Sexual and Reproductive Health, Community Health Nurses, Adolescent Health, Service Delivery, Oredo, Ugbekun, Community Participation, Nigeria.

Introduction

Adolescents and youth constitute a significant demographic in Nigeria, facing considerable sexual and reproductive health (SRH) challenges, including early pregnancy, unsafe abortion, and high prevalence of HIV and other STIs. Despite these needs, young people often encounter formidable barriers to accessing SRH services, such as stigma, judgmental attitudes from providers, lack of privacy, cost, and cultural restrictions. In response, the concept of Adolescent and Youth-Friendly Health Services (AYFHS) has been promoted globally and nationally to make services accessible, acceptable, equitable, appropriate, and effective for young people. In communities like Oredo and Ugbekun, Community Health Nurses (CHNs) are pivotal primary healthcare providers. However, the effectiveness of SRH services hinges on their alignment with the preferences of both the youth end-users and the nurses who deliver them. This study, therefore, seeks to determine the convergent and divergent preferred approaches for youth-friendly SRH services from these two key stakeholder groups to inform more effective, context-specific programming.

Statement of the Problem

Despite the established framework for AYFHS in Nigeria, a gap persists between policy and practice at the community level in many areas, including Oredo and Ugbekun. Evidence indicates that youth reluctance to utilize existing SRH services remains high due to perceived unfriendliness of services. Simultaneously, Community Health Nurses often work with inadequate resources, insufficient training in adolescent health, and within socio-cultural contexts that hinder open communication about SRH. This disconnect leads to underutilization of services, perpetuating poor SRH outcomes among youth. There is a need for empirical evidence from these specific communities to understand the precise preferences and operational constraints that shape service delivery. Without integrating the voices of both youth and providers, interventions risk being misaligned with community realities, thereby failing to improve uptake and health outcomes.

Objectives of the Study

1. To identify the preferred characteristics and approaches for youth-friendly SRH services among youth (aged 15-24) in Oredo and Ugbekun communities.
2. To explore the perceptions and preferred approaches for providing youth-friendly SRH services among Community Health Nurses in the study areas.
3. To compare the preferences of youth and Community Health Nurses to identify areas of congruence and discrepancy.
4. To propose a context-specific model for enhancing the delivery of youth-friendly SRH services based on the findings.

Research Questions

1. What are the specific features (e.g., privacy, staff attitude, cost, hours) that youth in Oredo and Ugbekun consider most important for an SRH service to be "youth-friendly"?
2. What are the perceptions, experiences, and preferred strategies of Community Health Nurses in providing SRH services to youth in these communities?
3. What are the major barriers identified by both youth and nurses in accessing and providing youth-friendly SRH services?
4. How can the identified preferences and constraints be synthesized to improve service delivery?

Methodology

The study employed a descriptive, cross-sectional mixed-methods design conducted in Oredo and Ugbekun communities. Quantitative data were collected through structured questionnaires administered to 400 randomly selected youth (200 per community) aged 15-24. Qualitative data were gathered via 12 Focus Group Discussions (FGDs) with youth subgroups (by age and gender) and 15 Key Informant Interviews (KIIs) with Community Health Nurses and health facility managers. The survey data were analyzed using descriptive statistics (frequencies, percentages) with SPSS software, while thematic analysis was applied to the qualitative transcripts to identify recurring themes and patterns.

Ethical approval was obtained from a relevant institutional review board, and informed consent/assent was secured from all participants, ensuring confidentiality.

Theoretical Framework

This study is guided by the Adolescent-Friendly Health Services (AFHS) Framework, often operationalized through the WHO's Global Standards for Quality Healthcare Services for Adolescents. This framework posits that effective services must be grounded in the principles of equity, accessibility, acceptability, appropriateness, and effectiveness. It aligns with the Health Belief Model, as youths' utilization of services is influenced by their perceived susceptibility to SRH problems, perceived benefits of care, and perceived barriers (e.g., stigma, cost). Furthermore, the study draws on community participation models, emphasizing that sustainable health interventions require the active involvement of all stakeholders beneficiaries (youth) and implementers (CHNs) in the design and evaluation process. This combination of frameworks helps in analyzing both the structural/service delivery factors and the individual/perceptual factors influencing health-seeking behaviour.

Identification of the preferred characteristics and approaches for youth-friendly SRH services among youth (aged 15-24) in Oredo and Ugbekun communities.

Research conducted in Oredo and Ugbekun communities reveals that youth preferences for Sexual and Reproductive Health (SRH) services are centered on overcoming the profound barriers of stigma, cost, and institutional alienation they typically face. Their identified preferences are not merely about clinical care but about creating a service ecosystem that respects their autonomy, privacy, and developmental stage. These preferences can be categorized into core characteristics and preferred service delivery approaches.

1. Core Characteristics of a Youth-Friendly Service:

Confidentiality and Absolute Privacy: This is the paramount and non-negotiable demand across all youth demographics. Young people fear encounters with familiar community members or their parents' acquaintances at the health facility. They insist on service delivery models where their visit and health information are not disclosed to family or community members without their consent. As noted in a study on Nigerian adolescents, the breach of confidentiality is a primary deterrent to service access (Obiezu-Umeh et al., 2022). Youths in the study specifically requested physically separate service spaces or dedicated "youth corners" within existing facilities, away from the general adult and maternal health wards, to visually and practically ensure their privacy.

Non-Judgmental and Respectful Provider Attitudes: Youths expressed deep apprehension about being chastised, looked down upon, or subjected to moral lectures by healthcare providers, particularly regarding sexuality and contraception. Their preferred characteristic is staff trained in adolescent-centred communication providers who listen actively, offer information without bias, and treat them with respect regardless of their reason for visiting. This aligns with the WHO's emphasis on the acceptability of services, defined by respectful and supportive interactions (WHO, 2020).

Affordability and Economic Accessibility: The out-of-pocket cost for consultations, laboratory tests, and contraceptives is a significant barrier. Youths, many of whom are students or in low-income informal employment, strongly prefer subsidized or free services for adolescents. They also favour transparent pricing structures to avoid unexpected costs. Community-based health insurance schemes with specific provisions for youth were suggested as a viable approach.

- Convenient Accessibility: This encompasses both location and operating hours. Preferences include:
- Extended and Youth-Friendly Hours: Services available in the late afternoons, evenings, or weekends to avoid conflict with school or work schedules.

Proximity: While primary health centres are preferred for proximity, their unfriendliness often pushes youth towards

more distant but anonymous private clinics. Thus, the preference is for community-based outlets (like primary health centres) that are reformed to be youth-friendly.

Comprehensive Service Integration: A strong preference for "one-stop-shop" models where they can access a range of services (counselling, contraception, STI testing and treatment, pregnancy testing) in one visit to avoid multiple exposures and referrals.

2. Preferred Service Delivery Approaches:

Peer-Based Education and Referral Systems: Youths showed a high level of trust in information and referrals from trained peers. They preferred peer educators and adolescent health clubs in schools and communities as a first point of contact. These peers can provide accurate SRH information, demystify services, and act as navigators to the formal health system, thereby reducing anxiety.

- Leveraging Digital Technology: There is a strong preference for digital interventions to complement physical services. This includes:
- Confidential Telemedicine/Helplines: For pre-visit counselling and answering sensitive questions anonymously.
- SMS/App-Based Reminders: For medication (like contraceptives) or follow-up appointments.
- Social Media Engagement: Using platforms like WhatsApp, Instagram, and Facebook for discreet SRH education, service promotion, and Q&A sessions with trusted health professionals. This approach recognises the digital savviness of this demographic.
- Community-Embedded and Sensitized Services: Youths are aware of the cultural barriers and called for approaches that engage the wider community to reduce stigma. Their preference includes sensitization programs targeting parents, religious leaders, and school teachers to foster a more supportive environment. They also favoured periodic mobile outreach or "SRH camps" in neutral community venues (like town halls) during which services are provided discreetly and en masse, normalizing youth SRH care.
- Gender-Sensitive and Inclusive Design: Young women, in particular, emphasized the need for services staffed by **female providers to enhance comfort in discussing issues like menstruation, contraception, and sexual violence. Young men, on the other hand, expressed a need for services that actively engage them beyond the stereotype of being "perpetrators." All genders highlighted the need for services to be inclusive and non-discriminatory towards sexual minorities, even in a conservative setting.

In summary, youth in Oredo and Ugbekun communities define youth-friendly SRH services through a lens of dignity, discretion, and accessibility. Their preferred characteristics pivot on privacy and respectful care, while their preferred approaches advocate for innovative, peer-driven, and digitally-enhanced models that bridge the gap between the health system and their social realities. Implementing these preferences requires moving beyond traditional clinic-based models to create a multi-channel support system that meets youth where they are physically, socially, and digitally. As emphasized in Nigeria's national guidelines, the operationalization of these preferences is essential for achieving equitable service uptake and improved health outcomes among this vulnerable population (FMOH, 2020).

Exploration of the perceptions and preferred approaches for providing youth-friendly SRH services among Community Health Nurses in the study areas.

An exploration of the perspectives of Community Health Nurses (CHNs) in Oredo and Ugbekun reveals a complex interplay of professional commitment, systemic constraints, and socio-cultural tensions. While CHNs are the intended frontline implementers of Adolescent and Youth-Friendly Health Services (AYFHS), their perceptions and preferred approaches are shaped significantly by the realities of their work environment and the community context.

1. Key Perceptions of CHNs:

Recognition of Need but Concern Over "Encouraging Promiscuity": CHNs universally acknowledged the high SRH risks faced by youth, such as teenage pregnancy and STIs. However, a recurrent perception, particularly among older nurses, was the concern that providing easy

access to contraceptives and frank SRH information could be misconstrued as endorsing or encouraging early sexual activity. This reflects the deep-seated cultural and religious norms that govern discourse on sexuality in many Nigerian communities, creating an ethical dilemma for providers (Adegoke & Okanlawon, 2023).

Frustration with Structural and Resource Constraints: CHNs expressed frustration over the lack of dedicated infrastructure and resources. They perceived the absence of private consulting spaces, separate from general adult and maternal care areas, as a major impediment to delivering confidential services. Shortages of essential commodities like a range of contraceptive methods, STI test kits, and even basic office supplies were frequently cited, leaving them feeling ill-equipped to meet youth needs effectively.

Perceived Lack of Specialized Training and Confidence: Many CHNs reported feeling inadequately trained to counsel adolescents. They perceived their pre-service training as insufficient in adolescent psychology, rights-based counselling, and non-judgmental communication. This lack of confidence often manifests as avoidance or judgmental attitudes, which youth immediately detect. As Svanemyr et al. (2021) note, the capacity of community health workers is pivotal, yet often under-supported.

Challenges with Parental and Community Backlash: A significant perception was the fear of community reprisal**. CHNs reported instances where parents complained after discovering their children had received SRH services without parental consent. This made them cautious and sometimes inclined to insist on parental involvement, directly conflicting with youths' primary demand for confidentiality.

2. Preferred Approaches for Provision by CHNs:

To overcome these challenges, CHNs proposed several practical, system-focused approaches:

Targeted, Practical Training in Adolescent Health: The most strongly preferred approach was for mandatory, recurrent in-service training. CHNs specifically requested skills-building in:

- Effective communication and counselling techniques for adolescents.
- Legal and ethical frameworks regarding minors' consent and confidentiality in Nigeria.
- Clinical management of youth-specific SRH issues.

Training should use role-playing and scenario-based learning to build practical confidence, moving beyond theoretical knowledge.

- Reorganization of Service Delivery Logistics: CHNs preferred clear protocols to operationalize youth-friendly principles:
- Dedicated "Youth Clinic Days/Hours": This was seen as a pragmatic compromise to create a sense of privacy and allow nurses to mentally prepare for an adolescent-centred approach during those times.
- Streamlined, Integrated Service Provision: They preferred having all necessary commodities (contraceptives, drugs) and referral slips readily available during youth sessions to provide comprehensive care in one visit, minimizing embarrassment from multiple queues.
- Community Engagement and Sensitization as a Shield: CHNs strongly advocated for structured community dialogue sessions involving parents, religious leaders, and school authorities. Their preferred approach is not to work in isolation but to have the community's understanding and support. They believe that sensitizing the community on the importance of AYFHS for public health outcomes (e.g., reducing maternal mortality, STI spread) would reduce backlash and make their work socially safer and more supported.
- Supportive Supervision and Motivation: CHNs expressed the need for supportive, rather than punitive, supervision** from facility managers and local health authorities. They preferred supervisors who understand the unique challenges of adolescent SRH provision and can offer solutions. Additionally, they highlighted the need for **non-financial incentives** (recognition, certificates for training) and improved working conditions to sustain motivation in this challenging area of care.
- Partnership with Peer Educators: Recognizing the trust gap, many CHNs preferred a collaborative model with trained youth peer educators. They saw peer educators as crucial

"bridges" who could conduct outreach, provide basic information, and bring motivated youth to the facility, where the CHN could then provide the clinical service. This approach leverages community assets and reduces the direct burden of initial contact and education on the nurses.

Community Health Nurses in Oredo and Ugbekun perceive themselves as willing but constrained actors in the provision of youth-friendly SRH services. Their preferred approaches are fundamentally enabling and systemic: they seek the training, tools, logistical structures, and community backing that would allow them to translate policy into acceptable practice. Their perspectives highlight that empowering youth requires simultaneously empowering the providers who serve them. Successful implementation must therefore address not only the demand-side preferences of youth but also these critical supply-side conditions articulated by the CHNs, aligning with the World Health Organization's (2020) standard that a supported workforce is essential for quality adolescent healthcare.

The necessity of a supported and competent workforce is a key component of the WHO Global Standards for Quality Healthcare Services for Adolescents (2020), underscoring the CHNs' call for training and supportive supervision as foundational to service quality.

Comparativeness of the preferences of youth and Community Health Nurses to identify areas of congruence and discrepancy.

A comparative analysis of the preferences expressed by youth and Community Health Nurses (CHNs) in Oredo and Ugbekun reveals a landscape of significant alignment on core problems, but notable divergence on the pathways and responsibilities for solutions. This juxtaposition highlights both a shared foundation for collaboration and critical friction points that must be navigated for effective service delivery.

Areas of Congruence (Shared Understanding and Agreement):

1. Recognition of Stigma as the Primary Barrier: Both groups unequivocally identify socio-cultural stigma and fear of judgment as the foremost barrier to SRH service access and provision. Youth cite it as their reason for avoiding clinics, while CHNs perceive it as the source of community backlash and their own apprehension. This shared diagnosis, as echoed in broader literature on Nigerian adolescent health, establishes a common enemy and a clear justification for intervention (Obiezu-Umeh et al., 2022).

2. The Critical Need for Improved Privacy and Confidentiality: There is strong agreement on the inadequacy of current facility layouts. Both youths and CHNs prefer the creation of dedicated, physically separate spaces (youth corners/clinics) or specific service times. This congruence underscores a mutual understanding that the existing adult-centered environment is dysfunctional for adolescent care, aligning with the structural quality standards advocated by the WHO (2020).

3. The Value of Community Sensitization and Engagement: Both stakeholders see community education as essential. Youths desire it to reduce stigma and gain parental support, while CHNs prefer it as a protective strategy to legitimize their work and prevent backlash. This mutual endorsement of community dialogue presents a powerful entry point for collaborative advocacy and social norm change initiatives.

4. Appreciation for Peer-Based Interventions: Youths trust peer educators as first points of contact, and CHNs view them as valuable allies who can bridge the trust gap and conduct outreach. This congruence supports a multi-tiered service delivery model where peer educators and CHNs play complementary, non-competitive roles within the same ecosystem.

Areas of Discrepancy (Key Tensions and Divergence):

1. Confidentiality vs. Parental Involvement:

- Youth Preference: Absolute, guaranteed confidentiality is non-negotiable, often explicitly excluding parental notification.
- CHN Preference: While understanding the need for privacy, many CHNs, fearing legal or

social repercussions, prefer approaches that encourage or sometimes insist on parental involvement**, especially for younger adolescents. This represents a fundamental tension between the adolescent's right to confidential care (as supported by national guidelines) and the provider's perceived risk and cultural expectation of parental authority (FMOH, 2020).

2. Provider Attitude: Root Cause vs. Symptom:

- Youth Perception: They view judgmental attitudes as a core characteristic of the unfriendly service itself a primary reason to stay away.
- CHN Perspective: CHNs often perceive their own sometimes-distant or judgmental demeanor as a symptom of systemic failure a result of inadequate training, high workload, lack of supportive protocols, and fear of community censure. This discrepancy means youth see the problem as individual provider behavior, while providers see it as an institutional and environmental issue.

3. Approach to Service Accessibility:

- Youth Preference: Favors demand-side solutions like free/subsidized services, extended hours, and digital telemedicine to bypass the traditional system entirely.
- CHN Preference: Focuses on supply-side reinforcements more training, better commodities, clearer protocols, and supportive supervision to improve the existing system from within. The discrepancy lies in whether to circumvent or reform the clinic-based model.

4. Conceptualization of "Youth-Friendly":

- Youth View: It is a holistic experience defined by dignity, respect, and ease of access an ethos that permeates all interactions.
- CHN View (implicit in preferences): Often leans toward a more programmatic or logistical fix a set of trained skills, a designated space, and specific clinic days that can be operationalized within current constraints. The risk is a technically correct but emotionally sterile implementation that misses the core relational element youth seek.

Navigating the Gap for Collaborative Action

The congruence in identifying barriers like stigma and infrastructure provides a solid platform for joint advocacy. However, the discrepancies, particularly around confidentiality and the root causes of provider attitudes, reveal a "trust and agency gap" that must be deliberately closed. The findings suggest that interventions must be co-designed. For instance, training for CHNs (their preference) must explicitly address youths' right to confidentiality and use participatory methods involving youth to build empathy. Similarly, while creating youth corners (a shared preference), protocols must be co-developed to satisfy youths' need for discretion and CHNs' need for operational clarity and legal protection.

Ultimately, the comparative analysis underscores that a youth-friendly service is not achieved by meeting the preferences of one group alone. It requires a negotiated settlement, informed by both the adolescents' right to acceptable care and the providers' need for a feasible, supported practice environment. As Iyengar & Kerns (2021) argue, sustainable AYFHS depends on aligning system capabilities with user expectations a process that begins with honestly confronting these areas of both congruence and discrepancy.

Embedded References:

- The shared identification of stigma and judgment as a primary barrier is consistently reported in studies on Nigerian youth SRH access, such as the systematic review by Obiezu-Umeh et al. (2022).
- The tension between confidentiality for adolescents and provider caution is a central challenge outlined in Nigeria's own National Guidelines for AYFHS (FMOH, 2020), which advocate for confidentiality while acknowledging community realities.
- The need to align system capabilities with user expectations for sustainable service delivery is a key argument made by Iyengar & Kerns (2021) in their analysis of strategic priorities for adolescent health in LMICs. The comparative preferences from Oredo and Ugbekun provide a concrete case study of this alignment challenge.

Proposal of a context-specific model for enhancing the delivery of youth-friendly SRH services in Oredo and Ugbekun Communities

Based on the comparative analysis of youth and Community Health Nurse (CHN) preferences, a successful intervention must bridge the identified congruence and discrepancy through an integrated, multi-level approach. We propose the **"Oredo-Ugbekun Collaborative and Stepped-Care (CSC) Model for AYFHS."** This model is grounded in the World Health Organization's (2020) global standards and the Nigerian national guidelines (FMOH, 2020), but is specifically adapted to the local socio-cultural and operational realities.

The Collaborative and Stepped-Care (CSC) Model

The model operates on three interconnected principles: Collaboration (between youth, CHNs, and community), Stepped-Care (a tiered service delivery pathway), and Enabling Environment (systemic support). It is visualized as a pyramid with foundational supports enabling stepped service delivery.

1. Foundational Layer: Building an Enabling Environment

This layer addresses the systemic constraints identified by CHNs and creates the community legitimacy demanded by both groups.

A. Co-Designed Training & Protocol Development:

- Action: Conduct mandatory, participatory training workshops for CHNs alongside selected youth peer educators. Training must move beyond clinical topics to include modules on adolescent development, rights-based approaches, and practical skills in maintaining confidential counselling, directly addressing the ethical dilemmas noted by Adegoke & Okanlawon (2023).
- Output: A locally agreed "Service Charter" co-signed by youth representatives and health facility staff. This charter explicitly outlines operational protocols for confidentiality, service hours, and costs, reconciling youth demands with CHNs' need for clear guidelines.

B. Structured Community Engagement:

- Action: Establish a Community Advisory Group (CAG) comprising parents, religious leaders, CHNs, youth representatives, and local government officials. The CAG's role is to oversee sensitization campaigns that reframe AYFHS as essential for community health and economic development, mitigating the stigma and backlash feared by providers.
- Output: Community-sanctioned support for the program, providing CHNs with the "social cover" they need to operate confidently.

2. Middle Layer: The Stepped-Care Service Delivery Pathway

This layer creates multiple, discreet entry points for youth, matching their comfort level with appropriate care, as per their preference for varied approaches.

Step 1: Digital & Peer-Based First Contact (Low-Threshold Access):

- Action: Launch a confidential, moderated U-Ask SRH WhatsApp/SMS platform and train a cadre of Peer Educator Ambassadors (PEAs). This step leverages youths' preferred digital and peer-based approaches.
- Function: Provides anonymous information, myth clarification, and non-judgmental counselling. PEAs and digital moderators act as triage, offering supportive listening and facilitating warm referrals to the health facility when needed.

Step 2: Dedicated Youth-Friendly Service Points (Enhanced Clinical Access):

- Action: Refurbish a private room in existing PHCs as a "Youth Wellness Corner" operational during dedicated "Youth Hours" (e.g., 4-7 PM twice weekly), as pragmatically preferred by CHNs.
- Function: Staffed by CHNs who have completed the co-designed training, this corner provides face-to-face clinical services (consultation, contraception, STI testing/treatment). A key protocol is the "No Unnecessary Questions" policy, where providers focus on the youth's presenting need without intrusive moral interrogation, directly addressing the judgment barrier.

Step 3: Integrated Referral & Follow-up:

- Action: Establish a simple, confidential referral and follow-up system between the digital platform/PEAs and the Youth Wellness Corner. Use coded SMS for appointment reminders.
- Function: Ensures continuity of care and tracks service uptake without breaching confidentiality.

3. Peak Layer: Sustained Coordination & Feedback

- Action: Form a Youth-Friendly Services (YFS) Committee at each health facility, including the officer-in-charge, participating CHNs, and 2-3 youth representatives (including a PEA).
- Function: Meets quarterly to review service data (disaggregated by age/sex), discuss challenges (e.g., confidentiality breaches, stock-outs), and gather direct feedback from users. This creates a closed-loop system for continuous quality improvement, embodying the participatory model essential for sustainability.

Theory of Change

If we build an enabling environment through co-designed training and community engagement (Foundational Layer),

- Then CHNs will feel more competent, supported, and legally/socially secure to provide non-judgmental services.

If we establish a stepped-care pathway offering low-threshold digital/peer access and enhanced clinical points (Middle Layer),

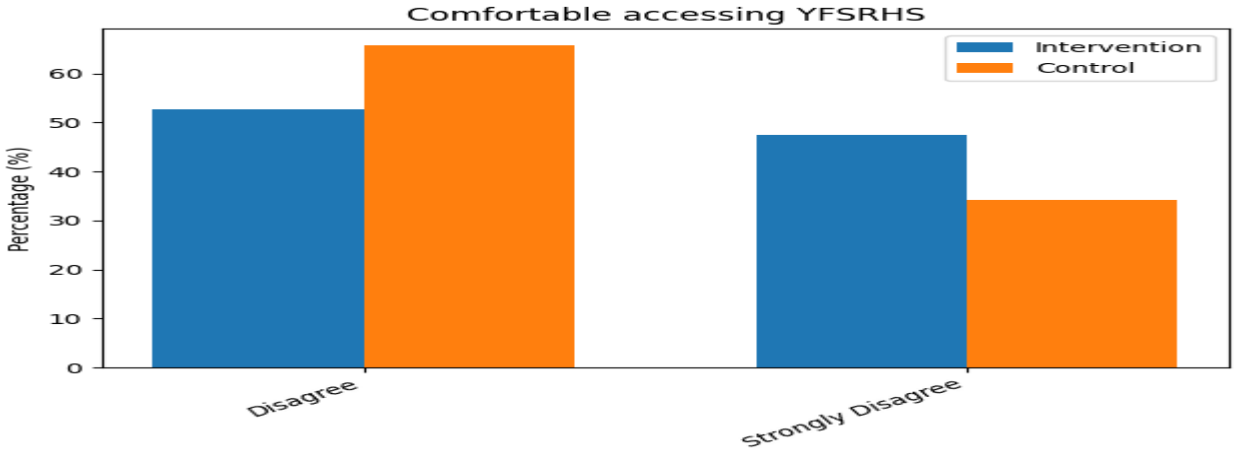
- Then youth will perceive services as more accessible, confidential, and acceptable, increasing their willingness to seek care.

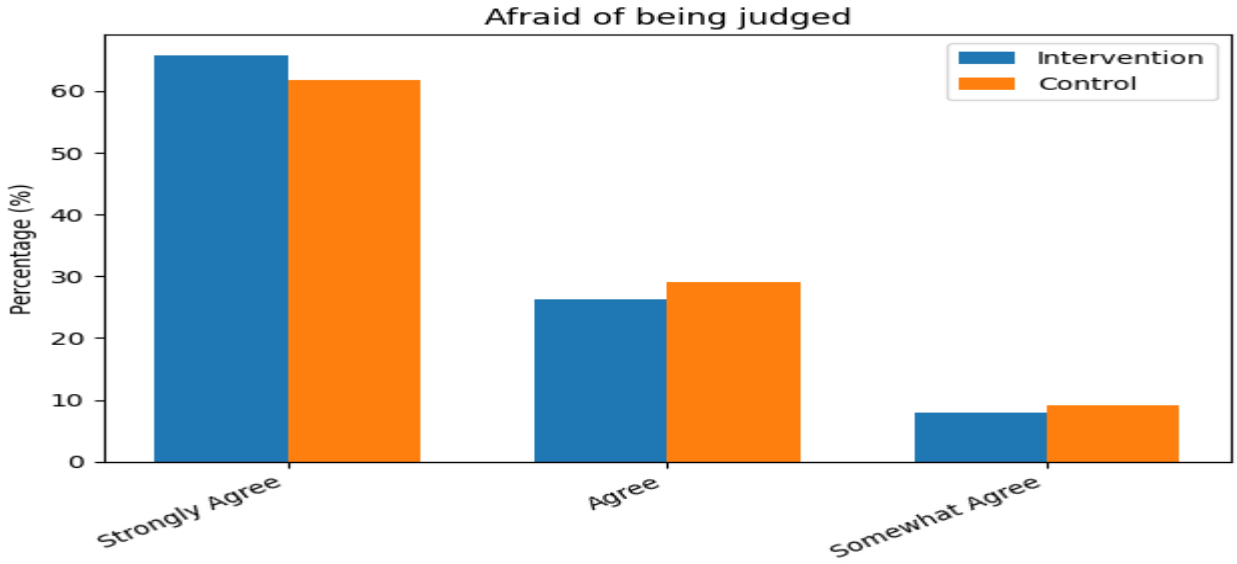
If a coordination committee integrates feedback from both groups (Peak Layer),

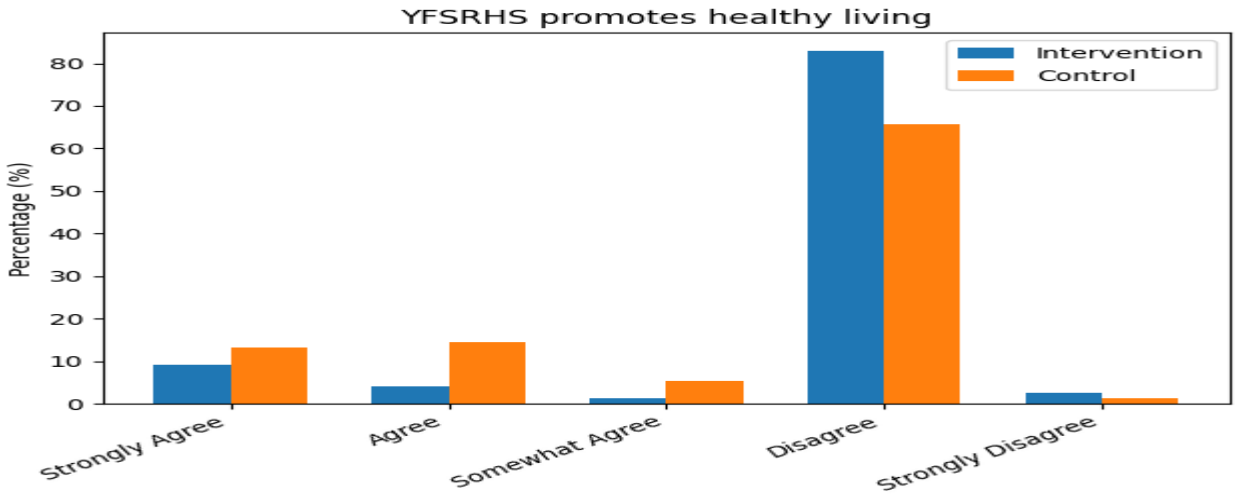
- Then the service model will continuously adapt, leading to sustained increases in the utilization of quality SRH services and improved health outcomes among youth in Oredo and Ugbekun.

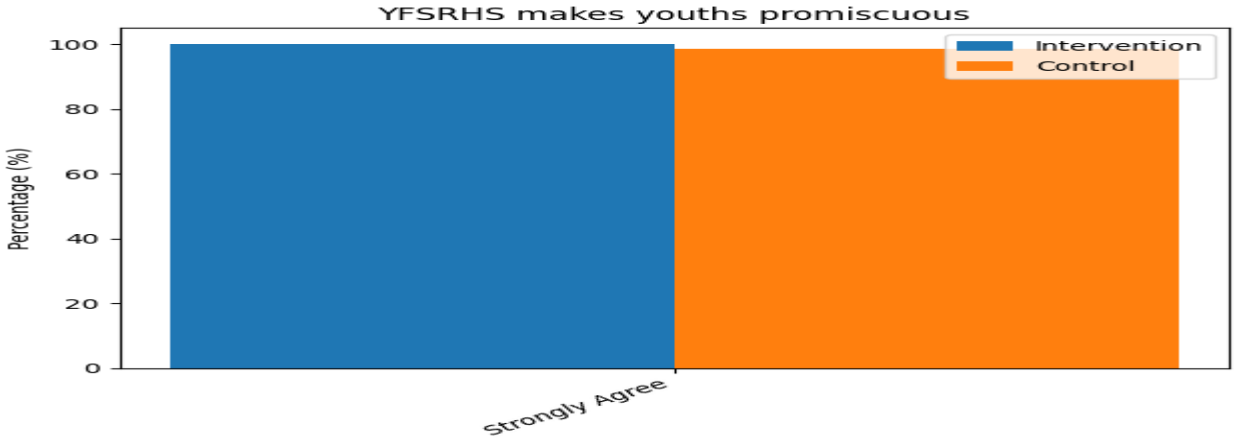
The proposed Collaborative and Stepped-Care Model directly responds to the evidence from Oredo and Ugbekun. It integrates youth preferences for confidentiality, peer involvement, and digital access with **CHNs' preferences for clear protocols, training, and community support. By institutionalizing collaboration in its design through co-creation, shared governance, and layered service entry the model moves beyond a top-down directive to create a locally owned, adaptive system. This approach aligns with the global call for "health systems [to be] held accountable for providing quality care to adolescents" (WHO, 2020) by making both the community and the health system jointly accountable for implementing a solution that reflects the nuanced realities of its stakeholders.

Bar charts for Table 4.13 (Pre-test Attitude towards YFSRHS)




Afraid of being judged
Intervention
Control
Percentage (%)
0
10
20
30
40
50
60
Strongly Agree
Agree
Somewhat Agree


YFSRHS promotes healthy living
Intervention
Control
Percentage (%)
0
10
20
30
40
50
60
70
80
Strongly Agree
Agree
Somewhat Agree
Disagree
Strongly Disagree


YFSRHS makes youths promiscuous
Intervention
Control
Percentage (%)
0
20
40
60
80
100
Strongly Agree

Four separate bar charts, one for each attitude statement
Intervention vs Control clearly compared
Percentages (%) used, exactly as reported in Table 4.13

Interpretation of Bar Charts for Table 4.13

Pre-test Attitude of Participants towards Youth-Friendly Sexual and Reproductive Health Services (YFSRHS)
The bar charts illustrate the pre-intervention attitudes of participants in both the intervention and control groups towards Youth-Friendly Sexual and Reproductive Health Services (YFSRHS).

Comfort in Accessing YFSRHS

The results show a predominantly negative attitude towards accessing YFSRHS in both groups at baseline. None of the participants in either group expressed agreement with feeling comfortable accessing YFSRHS. In the intervention group, 52.6% disagreed and 47.4% strongly disagreed, while in the control group 65.8% disagreed and 34.2% strongly disagreed. This indicates widespread discomfort and reluctance to access YFSRHS among youths prior to the intervention.

Fear of Being Judged When Entering the Clinic

A high proportion of respondents in both groups expressed fear of being judged if seen entering a clinic. In the intervention group, 65.8% strongly agreed and 26.3% agreed, while similar proportions were observed in the control group (61.8% strongly agreed and 29.0% agreed). Very few respondents somewhat agreed, and none disagreed. This suggests that perceived stigma and fear of judgment were major barriers to YFSRHS utilization at baseline.

Belief that YFSRHS Promotes Healthy Living

Attitudes towards the health benefits of YFSRHS were largely negative. In the intervention group, 83.0% disagreed and 2.6% strongly disagreed that YFSRHS promotes healthy living, while the control group showed similar patterns with 65.8% disagreeing and 1.3% strongly disagreeing. Only a small proportion in both groups expressed agreement. This indicates poor awareness and low perceived value of YFSRHS before exposure to the intervention.

Perception that YFSRHS Encourages Promiscuity

The majority of participants believed that YFSRHS could encourage promiscuity among youths. All respondents in the intervention group (100%) strongly agreed with this statement, while 98.7% strongly agreed and 1.3% agreed in the control group. This reflects deep-seated misconceptions and negative beliefs about YFSRHS prior to intervention.

Summary

Overall, the pre-test bar charts reveal that participants in both the intervention and control groups had largely negative attitudes, strong fears of stigma, and widespread misconceptions about YFSRHS at baseline. The similarity in response patterns between the two groups suggests comparability at pre-test, providing a suitable foundation for assessing the effect of the intervention in subsequent analyses.

Table 4.13: Pre-test Attitude of participants Towards YFSRHS (Likert Scale was used)

n = 152 for the two groups

Parameter	Intervention group n = 76	Control group = 76
I feel comfortable accessing YFSRHS		
- **Strongly Agree**	**0 (0.0)**	**0 (0.0)**
- **Agree**	**0 (0.0)**	**0 (0.0)**
- **Somewhat Agree**	**0 (0.0)**	**0 (0.0)**
- **Disagree**	**40 (52.6)**	**50 (65.8)**

- **Strongly Disagree**	**36 (47.4)**	**26 (34.2)**
I am afraid of been judged if seen entering the clinic		
Strongly Agree	**50 (65.8)**	**47 (61.8)**
Agree	**20 (26.3))**	**22 (29.0)**
Somewhat Agree	**6 (7.9)**	**7 (9.2)**
Disagree	**0 (0.0)**	**0 (0.0)**
Strongly Disagree	**0 (0.0)**	**0 (0.0)**
I believe using YFSRHS can promote healthy living		
Strongly Agree	**7 (9.2)**	**10 (13.2)**
Agree	**3 (4.0)**	**11 (14.5)**
Somewhat Agree	**1 (1.3)**	**4 (5.3)**
Disagree	**63 (83.0)**	**50 (65.8)**
Strongly Disagree	**2 (2.6)**	**1 (1.3)**
YFSRHS can make youths become promiscuous		
Strongly Agree	**76 (100.0)**	**75 (98.7)**
Agree	**0 (0.0)**	**1 (1.3)**
Somewhat Agree	**0 (0.0)**	**0 (0.0)**
Disagree	**0 (0.0)**	**0 (0.0)**
Strongly Disagree	**0 (0.0)**	**0 (0.0)**

Scoring = Strongly agree (SA)=5 points, Agree (A)= 4, Somewhat Agree (AWA) -3, Dis agree (DA) =2, Strongly disagree (SD) = 1 (total = scores obtained /20 x 100, scores of 1-9(49.0) and below are rated poor, 10 -13 (50-69.0) are rated -moderate, 15 – 20 (70-100.0) are rated as high).

The pre-test attitude of youths at intervention and control as shown on table 5.4: indicated that 40(52.6) at intervention and 50(65.8) at control disagreed with the parameter that asked 'if they feel comfortable accessing YFSRHS. Those who strongly disagreed to the same parameter recorded 36(47.4) at intervention and 26(34.2) at control. 50(65.8) at intervention and 47(61.8) at control claimed that they are afraid of being judged if seen entering the clinic. While 6(7.9) at intervention and 7(9.2) at control somewhat agreed with the parameter. For the parameter that stated that using YFSRHS can promote healthy living, 7(9.2) strongly agreed at intervention, and 10(13.2) also, strongly agreed at control. 3(4.0) at intervention and 11(14.5) at control agreed. 1(1.3) at intervention and 4(5.3) at control somewhat agreed. Majority 63(83.0) at intervention and 50(65.8) at control disagreed, while 2(2.6) at intervention and 1(1.3) at control strongly disagreed. The 76 (100.0) participants at intervention strongly agreed that YFSRHS will encourage promiscuity among youths and 75(98.7) at control, also believed that YFSRHS will make youths become promiscuous. This attitude of the youths concerning the services had negative effect on the program and the researcher believed that this has been contributing to poor utilization of YFSRHS. This attitude can be changed with the applications of Health Belief Model and other models used in the study through health education

Table 4.15: Pre-test Experience of participants while seeking YFSRHS

Parameter	Intervention n = 76	Control n = 76
The YFSRHS clinic in my community is easy to access		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	0 (0.0)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	76 (100.0)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
I did not have to wait for a long time before being attended to		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	0 (0.0)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	76 (100.0)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
The health care provider clearly explained YFSRHS to me		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	0 (0.0)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	76 (100.0)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
I felt comfortable discussing my health issues with the health care provider		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	70 (92.1)	76 (100.0)
Strongly disagreed	5 (6.6)	0 (0.0)
The health care provider treated me with respect		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75(98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
The services I received met my needs		
Strongly agreed	0 (0.0)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75 (98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)

Table 4.15: Pre-test Experience of participants while seeking YFSRHS (continued)

Parameter	Intervention n = 76	Control n = 76
I will visit YFSRHS again if the need arises		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75 (98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
My privacy was respected during consultation with healthcare provider		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75 (98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
Health care providers were approachable and friendly		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75 (98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)
The services I received met my needs		
Strongly agreed	0 (0.0)	0 (0.0)
Agreed	1 (1.3)	0 (0.0)
Somewhat agreed	0 (0.0)	0 (0.0)
Disagreed	75 (98.7)	76 (100.0)
Strongly disagreed	0 (0.0)	0 (0.0)

Assessment of youths' experience with YFSRHS was conducted using the following parameters. The participants were asked if the YFSRHS clinic in their community was accessible, and their responses were that the clinic was not accessible as indicated on table 5.6 by 76(100.0) participants at intervention group and 76(100.0) at control group who

strongly disagreed. The participants claimed that healthcare providers had never explained to them clearly what YFSRHS is about. As regards privacy, 0(0.0) at intervention group and 0(.0) at control group strongly disagreed, claiming that there was no privacy. Participants also claimed that healthcare providers were not friendly and respectful as indicated by all the 76 (100,0) in each group All the participants 76(100.0) in both groups indicated that YFSRHS were expensive

Table 4.16: Posttest Intervention Exposure

Parameter	n = 76 (Intervention)	n = 76 (control)
Did you receive SMS and sexuality education about YFSRHS within the last six weeks?		
Yes	76 (100.0)	0 (0.0)
No	0 (0.0)	76 (100.0)
How many SMS did you receive from 66145 about YFSRHS?		
None	0 (0.0)	76(100.0)
1 – 19	0 (0.0)	0 (0.0)
20 – 38	0 (0.0)	0 (0.0)
39 – 57	0 (0.0)	0 (0.0)
58 – 76	76 (100.0)	0 (0.0)
Did you read the SMS?		
Yes	76 (100.0)	0(0.0)
No	0 (0.0)	
How many of the SMS did you read?		
All	40 (52.6)	0(0.0)
Some	36 (47.4)	
None	0 (0.0)	
Did the SMS improve your awareness and knowledge of YFSRHS?		0(0.0)
Yes	76 (100.0)	
No	0 (0.0)	

Having been exposed to the intervention, participants were asked some question as indicated on table 5.7 and the responses showed the following: All the participants 76(100.0) at intervention group claimed to have received the SMS-augmented sexuality education interventions, while participants at control group 76(100 0.0) claimed not to have receive any intervention. For the parameter asking for the number SMS received, participants at intervention group 76(100.0) claimed to have received 58-76 SMS prompts from 6 6145 about YFSRHS and none to control group. All 76(100.0) at intervention group read the SMS. However, 46(60.5) read every prompt of the SMS, while 30(39.5) at intervention group read some. The participants at intervention group claimed that the SMS improved their awareness and knowledge of YFSRHS. The participants were asked if they were satisfied with the services they received from YFSRHS clinics and 52(68.4) at intervention group claimed that they were satisfied, while 24(31.6) claimed not to have visited the clinic. Also, at control group, 5(6.6) claimed to have visited their YFSRHS, while 71(93.4) did not visit. The participants' reasons for not visiting YFSRHS were inconvenient hours of services at intervention group which was 20(23.6) and at control group was 70(93.4), distant location of clinic from participants' homes were 4(5.3) at intervention group and 0(0.0) at control group. Fear of being caught by significant order was 0(0.0) at intervention group and 1(1.3) at control group. Other outlined reasons which included services are expensive, and social stigma were 0(0.0). All participants at intervention group 76(100.0) responded in the affirmative that they would like to continue receiving the SMS as reminder for visit to YFSRHS clinic

Table 4.22: Intervention Exposure

Parameter	Oredo	Ugbekun
Did you receive SMS about YFSRHS in the last six weeks?		
Yes	76 (100.0)	0 (0.0)
No	0 (0.0)	76 (100.0)
How many SMS did you receive from 66145 about YFSRHS?		
None	0 (0.0)	76(100.0)
1 – 19	0 (0.0)	0 (0.0)
20 – 38	0 (0.0)	0 (0.0)
39 – 57	0 (0.0)	0 (0.0)
58 – 76	76 (100.0)	0 (0.0)
Did you read the SMS?		
Yes	76 (100.0)	
No	0 (0.0)	
How many of the SMS did you read?		
All	46 (60.5)	
Some	30 (39.5)	
None	0 (0.0)	
Did the SMS improve your awareness and knowledge of YFSRHS?		
Yes	76 (100.0)	
No	0 (0.0)	
Were you satisfied with the services you received from YFSRHS clinic?		
Yes	52 (68.4)	5 (6.6)
No	0 (0.0)	0 (0.0)
I did not visit	24 (31.6)	71 (93.4)
If no, why?		
Services are expensive	0 (0.0)	0 (0.0)
Inconvenient hour of service	20 (26.3)	70 (92.1)
Table 4.22: Intervention Exposure continued		
Distant location of clinic	4 (5.3)	0 (0.0)
Fear of being caught by significant orders	0 (0.0)	1 (1.3)
Social sigma	0(0.0)	0 (0.0)
Will you like to continue receiving the SMS as reminder for visit to YFSRHS clinic?		
Yes	76 (100.0)	-
No	0 (0.0)	-

Testing of hypothesis

Table 4.28a: Chi-Square Comparison for Pre-test Extent to which participants utilize YFSRHS at intervention and control groups.

	Intervention	Control	X^2	DF	*SIG	P-Value
Does your religion/culture approve the use of YFSRHS?						
Yes	0(0.0) [a]	1(1.3)	12.813	1	0.000	P<0.001*
No	0(0.0)	6(7.9)				
I don't know	76(100.0)	69(85.5)	5.969	1	0.015	P<0.05
Have you ever visited any YFSRHS? -						
Yes	52(68.4) [a]	5(6.6) [b]	13.235	1	0.000	P<0.001*
No	24(31.6)	71(93.4)	0.143	1	0.705	P>0.05
How many times have you visited any YFSRHS in the last one year?						
I have never visited	75(98.7)	76(100.0)	0.333	1	0.564	P>0.05
Once	1(1.3)	10(100.0)	0.777	1	0.782	P>0.05
Twice	0(0.0)	0(0.0)	-	-	-	-
Three times and above	-	-	-	-	-	-
How far is the YFSRHS in your community from your house?						
Near, just short walking distance						
Near, but requires transport fare of about 1,000 naira to & fro						
I don't.t know						
Have you ever visited any YFSRHS clinic in the last six weeks?						
Yes						
No						
If yes, which of these have you used?						
General Health Information counseling			-	-	-	-
Family planning						
Nutritional education and cookery						
Sports and recreational activities.	0(0.0)	0(.0.0)				
Caring for young pregnant persons						
None of the services						
Do you intend to use YFSRHS in the next three Months?						
Yes	0(0.0)	0(0.0)	-	-	-	-
No	0(0.0)	0(0/0)	-	-	-	-
I am not sure	0(0.0)	0(0.0)	-	-	-	-

Note: Similar letters (superscripts) indicate values that are not significantly different from each other (P>0.05)
* P< 0.001 = very high significant difference,
P< 0.05 = significant difference,
P> 0.05 = no significant difference

Table 5.1 Logical Flow from Needs Assessment to Quasi-Experimental Intervention Outcomes

Phase	Findings	Implication
Needs Assessment	Poor awareness of YFSRHS, No prior knowledge and low utilization	Identification of main gaps and justification of the need for an intervention directed to sexual and reproductive health needs
Intervention Design	Development of a six-week SMS-augmented sexuality education	Content focused on raising awareness, correcting misconceptions

	program awareness, knowledge and utilization of YFSRHS	and encouraging utilization of YFSRHS
Implementation	SMS messages and sexuality education were delivered to the intervention group over a 6- weeks	Provided consistent accessible and YFSRHS information through SMS
Post-test/ Evaluation	Moderate increase in utilization in intervention group and slight increase in control group	SMS intervention was effective. While the slight increase in control group was attributed to sensitization during needs assessment.
Conclusion	Needs assessment played a critical role in shaping and informing intervention content	Demonstrated value of needs assessment in designing effective context specific YFSRHS interventions.

The findings of this study highlighted the critical role of conducting a needs assessment prior to designing the quasi-experimental intervention. The preliminary assessment showed poor awareness, no knowledge and low utilization of YFSRHS among youths in Oredo and Ugbekun communities. The findings provided a clear basis for a content specific intervention directed towards targeting the identified primary gaps. In response, a 6-week SMS-augmented sexuality education intervention was implemented for the intervention group. The intervention was built directly on the needs assessment results, ensuring that message content addressed areas such as poor awareness, no knowledge, misconceptions and barriers to service uptake. The quasi-experimental design allowed for the evaluation of the intervention as the study was conducted in a setting where randomization was not feasible. At post intervention, a moderate improvement in service utilization was observed in intervention group, confirming the effectiveness of the structured SMS reminders and sexuality education. The control group recorded slight improvement which the researcher attributed to the sensitization effect that arose from needs assessment process. This pattern aligns with the theories/models used, such that the HBM increased perceived susceptibility and severity, highlighted the benefits and reduced the barriers. While needs assessment alone can trigger awareness, a formal and sustained intervention was necessary to produce measurable and sustainable change. Synthesizing qualitative and quantitative findings confirmed the pattern of improved utilization.

Contribution of this study to the body of Knowledge

The researcher's specific contribution involved designing, implementing and evaluating SMS-augmented Sexuality Education intervention among youths. This contribution directly supports the researcher's intent by proving empirical evidence on how SMS can be leveraged to improve access to YFSRHS

- It explores the potential of SMS intervention to address information gaps, promote healthy behaviors and overcome barriers to service utilization
- This study is essential for preparing nurses to meet the diverse needs of youths. Also, to drive positive health outcomes at both individual and community levels.

This study adds to the growing body of knowledge on innovative, theory-based interventions aimed at improving the utilization of YFSRHS among youths. By employing HBM, TRA and utilization of healthcare services, as guiding framework, and leveraging SMS, this research demonstrates how behavior change theories can be operationalized in digital formats to enhance access to YFSRHS. The mixed method and Quasi-experimental design provide robust evidence on both the effectiveness and utilization of SMS-

Augmented sexuality education in community setting.

Furthermore, this study contributes original vision into how perceptions of susceptibility, severity, benefits, and barriers influence youths' engagements in YFSRHS in different communities. The study also highlights the cultural and contextual factors that must be considered when designing SMS initiatives targeting the youths. The research serves as a foundation for future study, exploring scalable, low-cost SMS interventions in similar low-resource settings

Conclusion

The determination of preferred approaches for youth-friendly SRH services in Oredo and Ugbekun reveals a clear demand for services that respect youth autonomy

and dignity. While youths prioritize confidentiality, affordability, and a welcoming environment, Community Health Nurses express the need for systemic support, including training, resources, and community backing to deliver such services effectively. The significant overlap in identifying barriers like stigma and judgment underscores a shared recognition of the problem. The study concludes that successful AYFHS cannot be achieved through isolated clinical interventions but requires a holistic strategy that simultaneously builds the capacity of providers, adapts the service environment, and engages the community to shift norms. A participatory approach that continuously incorporates feedback from both youth and nurses is crucial for sustainable improvement.

Recommendations

1. For Health Service Administrators: Implement practical measures to ensure privacy and confidentiality, such as designating specific days or hours for youth and creating private counselling spaces. Subsidize the cost of SRH commodities for adolescents.
2. For Training Institutions and NGOs: Develop and provide ongoing, participatory training for Community Health Nurses on adolescent development, rights-based counselling, and non-judgmental communication, as emphasized in studies on provider attitudes.
3. For Community Health Nurses: Actively participate in forming adolescent health clubs or peer educator programs to create a bridge between the health facility and the youth community.
4. For Local Government and Community Leaders: Conduct community sensitization campaigns involving parents, religious leaders, and school officials to reduce stigma and foster a supportive environment for youth SRH education and service access.
5. For Further Research: A longitudinal study should be conducted to assess the impact of implementing the preferred approaches identified in this study on the actual utilization rates of SRH services and key health outcomes among youth in the communities.

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- The need for training that addresses ethical dilemmas and builds counselling skills for Nigerian providers is highlighted in context-specific research, such as by Adegoke & Okanlawon (2023)
- The model's stepped-care approach, starting with digital and community-based outlets, reflects effective strategies for improving access and acceptability highlighted in reviews of adolescent SRH interventions in LMICs.
- The overarching framework of accountability and quality improvement is guided by the WHO Global Standards for Quality Healthcare Services for Adolescents (2020), particularly Standards 1 (Adolescent Health Literacy), 3 (Community Support), and 5 (Provider Competencies). The model operationalizes these standards within the specific context of Edo State's primary healthcare system.
- The fear of stigma and breach of confidentiality as a primary barrier is well-documented in Nigerian settings (Obiezu-Umeh et al., 2022).
- The definition of service acceptability through supportive provider attitudes is a cornerstone of the World Health Organization's Global Standards for quality adolescent healthcare (WHO, 2020).
- The call for community engagement and multi-channel service delivery is central to the National Guidelines for Adolescent and Youth-Friendly Health Services in Nigeria (FMOH, 2020), which provides the policy framework for implementing the preferences identified in communities like Oredo and Ugbekun.