Norges miljø- og biovitenskapelige universitet

Master's thesis 2023 30 credits
Faculty of Landscape and Society

Youths' perceptions and experiences of sexual and reproductive health services received from health workers trained as part of a package of interventions to improve motivation, skills, and performance in the Democratic Republic of the Congo.

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Acknowledgements

There are a few people who have been crucial in the creation of this master thesis that I need to thank.

First the deepest of thanks are in order for my wonderful supervisor, Sheri Lee Bastien. Thank you! You have tirelessly guided me through this past year, I am sure it has been a challenge, but I don't know that anyone else could have gotten me here. Thank you for your patience, your clear and thorough feedback and your countless edits of mistakes and English. Lastly thank you for your kind words when I needed them, I do love sending emails with smileys. Thank you for letting me be a small part of this amazing project!

I also want to extend particular thanks to Drs. Landry Egbende and Benito Kazenza. Getting to meet you both was an absolute joy, and the important insights and contextual information you provided made me more confident in my analysis of the data. Our meeting was also some much-needed motivation in the home stretch of the writing process.

Thank you to my fellow students in the master's office, Ahmed, Emilie, Emaediong, Sangee, Kristine and Inga. You have made what I've heard is supposed to be the toughest semester of the degree thoroughly enjoyable.

I want to thank my family for support, care and check ins. Not just this semester, but all my life. I love you all dearly!

Finally, I want to thank my grandfather, Torbjørn Omholt, who has read every important paper I've written since I learned how. No one else uses more commas, and I am now convinced no one else use them right. Thank you for your patience, love, wisdom, and friendship. Send my love to grandma.

Ane Skagestein Omholt

Bakgrunn: Ungdom er en alder der seksuell og reproduktiv helsehjelp av høy kvalitet er av særlig betydning. I Den demokratiske republikken Kongo (DRC), hvor unge jenters seksualitet og seksuelle aktivitet ofte er stigmatisert, kan dårlig seksuell og reproduktiv helse (SRH)-omsorg begrense bruken av SRH-tjenester, og dermed føre til dårlige helseutfall. Denne oppgaven er basert på en bredere studie finansiert av Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) og Verdens helseorganisasjon (WHO) som utviklet og implementerte en pakke med intervensjoner rettet mot helsearbeidere og helseledere. Studien inkluderte testkunder og utgangsintervjuer med ungdommer. Denne oppgaven tar sikte på å forstå ungdommers oppfatninger og opplevelser av omsorg og tjenester levert av helsearbeidere som er opplært som en del av intervensjonen ved å analysere disse intervjuene. Analysen vil være basert på WHOs standarder for kvalitetshelsetjenester og de seks veiledende prinsippene for SRH.

Metoder: Denne studien analyserte sekundærdata samlet inn fra semistrukturerte intervjuer av både mysterieklienter (n=16) og ungdomsutgangsintervjuer (n=16). Disse intervjuene ble gjennomgått, kodet og analysert ved hjelp av tematisk analyse. Analysen ble basert på WHOs standarder for kvalitetshelsetjenester og de seks veiledende prinsippene for SRH.

Resultater: Flertallet av deltakerne rapporterte at de følte seg enten fornøyde eller svært fornøyde med tjenesten, hvordan de ble tatt imot og måten helsepersonell mottok dem. Et mindretall av ungdommene sa at de ikke var fornøyde og forlot anlegget med følelsen av at de ikke hadde fått svarene, omsorgen eller behandlingen de håpet på. Funn tyder på at kontekstuelle faktorer som streiker, antall klienter og mangel på medisinsk utstyr kan hindre helsepersonell i å levere tjenester av høy kvalitet til ungdom. Noen ungdomsklienter ble møtt av helsearbeidere som kom med dømmende og upassende kommentarer.

Konklusjon: Funnene viser at det er et kontinuerlig behov for innsats for å adressere helsearbeidernes holdninger, kompetanse og ferdigheter for å møte ungdommens behov og for å sikre at helsearbeidere har et muliggjørende miljø som motiverer dem til å yte kvalitetsomsorg til ungdom. Ved også å implementere et fokus på de åtte standardene for kvalitetshelsetjenester for ungdom og de seks prinsippene for SRH i fremtidige intervensjoner, kan engangs mangefasetterte intervensjoner forbedre SRH-resultatene i Afrikanske land sør for Sahara og hjelpe til med å oppfylle SDG 3.7 innen 2030.

Stikkord: Ungdom, SRH-tjenester, DRC, intervensjon, helsearbeidere.

Background: Youth is an age where access to quality sexual and reproductive health services and care is of particular importance. In The Democratic Republic of Congo (DRC) where young girls' sexuality and sexual activity are often stigmatized, poor sexual and reproductive health (SRH) care can limit the utilization of SRH services, thereby leading to poor health outcomes. This thesis is based on a broader study funded by the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the World Health Organization (WHO) which developed and implemented a package of interventions aimed at improving the knowledge, attitudes, skills and competencies of health workers and health managers. The study included mystery client assessments and exit interviews with youth. This thesis aims to understand youths' perceptions and experiences of care and services delivered by health workers trained as part of the intervention.

Methods: This study analyses secondary data collected from semi-structured interviews with both mystery clients (n=16) and youth exit interviews (n=16). These interviews were reviewed, coded, and analysed using thematic analysis. The analysis was based on the WHO standards of quality health care and the six guiding principles for SRH.

Results: The majority of the participants reported that they felt satisfied or very satisfied with the services including how they were welcomed and received by health workers. A minority of the youth indicated they were not satisfied and left the facility feeling that they had not received the answers, care, or treatment they hoped for. Findings indicate that contextual factors such as strikes, heavy workload and lack of medical equipment and supplies may hinder health workers in delivering high quality services to youth. A few of the youth clients reported that health workers made judgemental and inappropriate comments.

Conclusion: The findings show there is an ongoing need for efforts to improve health worker attitudes, competencies, and skills to meet the needs of youth, but also to ensure health workers have an enabling environment that motivates them to provide quality sexual and reproductive health care to youth. An explicit focus on ensuring the eight standards of quality health care and the six principles of SRH in future comprehensive interventions may lead to improvements in the SRH outcomes for youth in sub-Saharan Africa and aid in fulfilling SDG 3.7 by 2030.

Keywords: Youth, SRH services, DRC, intervention, health workers.

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List of abbreviations

DRC	Democratic Republic of Congo
ERC	Ethical Review Committee
GFATM	The Global Fund to Fight Aids, Tuberculosis and Malaria
ICPD	International Conference of Population and Development
MC	Mystery Client
NMBU	Norwegian University of Life Sciences
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHO AFRO	World Health Organization Regional Office for Africa

1 Introduction

1.1 Thesis structure

This is an article-based master thesis, where the article will be submitted for publication. Though the mantel and the article address the same research questions, they can be read independently of each other. This thesis will begin with a short overview of the background of the project and research questions, followed by general information on why this topic was chosen. The background chapter will give an in-depth summary of policies relevant to the study, along with previous research, necessary information about this study and the conceptual framework. The end of the background chapter will give a thorough presentation of the study this thesis is largely based on, which is a jointly funded initiative by the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the World Health Organization (WHO). The methodology chapter will detail the study design and sample, as well as give a detailed description of how the transcribed interviews were analysed. Ethical considerations will be discussed thereafter. A short summary of the findings will lead up to the discussion with these findings in relation to both previously presented empirical studies and the study's underlying conceptual framework.

1.2 The research questions

The aim of this thesis is to conduct secondary analysis on the qualitative data previously gathered as part of the ongoing GFATM/WHO implementation research study to gain insight into how youth perceive and experience the quality of sexual and reproductive health (SRH) services and care provided by health workers trained as part of the package of interventions. The experience of the health workers, however important, will not by itself give a comprehensive understanding of how the intervention impacted their knowledge, skills, attitudes, and motivation to provide quality SRH care to youth. Data gathered from youth mystery client (MC) interviews and youth exit interviews will be analysed to fill this knowledge gap and ensure youth voices and perspectives are considered in future iterations of the intervention. Full details will be provided in the methodology chapter, but in brief, mystery clients are youth that are trained before visiting facilities as clients where they enact scenarios such as requesting information or advice, and following their visit they report on the experience through an interview or a survey (Boyce & Neale, 2006). The youth exit interviews were gathered from youth visiting the health facilities who gave their informed

consent to participate after they had received services and care from trained health workers (GFATM et al., 2021). The MC interviews and youth exit interviews will be analysed to develop an in-depth perspective of youths' experiences of care through the following research questions:

How do youth who receive services from health workers who have been trained through a package of interventions regarding the provision of sexual and reproductive health, perceive and experience the quality of care?

Do these youth perceive that the health workers have treated them with respect, empathy, and in a non-judgmental manner during their visits to the health facility?

Are these youth satisfied with the services they received regarding their sexual and reproductive health?

1.3 Rationale for the thesis

In the sub-Saharan Africa youth and in particular girls are vulnerable to poor SRH outcomes. This is due to a plethora of reasons such as forced sexual debut, transactional sex, unprotected sexual activity, violence, and sexual violence (Wado et al., 2020). GFATM collaborated with the Ministry of Health, WHO and implementing partners Cordaid and Santé Rural to implement a multisectoral approach to improving SRH of girls and young women in two regions of the Democratic Republic of Congo (DRC). The objectives of the project were to improve the provision of youth friendly health services in terms of both quality and access. The objective of the implementation study is to evaluate the package of interventions by reviewing the acceptability, feasibility, and effectiveness when it comes to improving health workers skills, knowledge, and attitudes in providing SRH services to youths (Bastien et al., 2022).

The package of interventions was tailored to the local context and primarily targeted health workers and health managers. It included the provision of job descriptions, training and refresher training, desk reference tools, supportive supervision and collaborative learning (Bastien et al., 2022). As will be shown in the background chapter, these are all common implementation strategies, and the combination of several implementation strategies as part of one large intervention aligns with the findings of Denno et al. (2021) which highlight the fact that multifaceted implementation strategies rather than one-off standalone approaches are more likely to be effective.

To improve the SRH of youth, it is essential to ensure access as well as improve the sexual and reproductive health services available to them (WHO & Unaids, 2015). One must also address factors on individual, community, institutional and structural levels (Dieleman et al., 2009). Studies conducted among health workers in low- and middle-income countries find that they may have gaps in their competencies, have poor attitudes and behaviours, and suffer low motivation, all factors which may serve as barriers for providing quality SRH services to youth (Corley et al., 2022; Newton-Levinson et al., 2016). Improving these factors and delivering high quality youth SRH services could lead to increased use of services and improved SRH outcomes. To do this, more comprehensive approaches must be adopted. Multifaceted interventions that include implementation strategies such as job aids, supportive supervision, collaborative learning, and the combination of interactive and participatory training are thought to be more effective than one-off trainings (Denno et al., 2021; Dieleman et al., 2009).

This thesis aims to develop an in-depth understanding of the perceptions and experiences of youth after their interactions with the health workers that have been trained as part of the package of interventions. Through the understanding of how youth experience the quality of care, if they are satisfied with the services provided, and if they perceive that they were treated with respect, empathy and in a non-judgemental manner during their visit to the health facility, the quality of care and by extension the quality of the package of interventions can be evaluated. This information will be supplemented by the conceptual framework presented in the background chapter. This knowledge will be useful in further refining the package of interventions and contributing to the evidence base which focuses on youth friendly health services. Through this analysis of youths' voices and perspectives, this thesis will aid in further improving intervention implementation regarding SRH care services in Sub-Saharan Africa as well as the SRH services provided to youth in that same region.

2 Background

2.1 Policies related to youths reproductive and sexual health.

The WHO defines adolescents as those between the ages of 10 and 19 years old (WHO, n.d.-a; WHO & Unaids, 2015, p. vii). In this thesis, and to ensure the ethical aspects of the implementation study, all included interviewees are above the age of 18. WHO defines the age group that ranges from 15-24 as youth and the range from 10-24 as young people (WHO,

n.d.-a). Therefore, this thesis will use the term youth, since the study sample includes youth up to the age of 25.

In 1994, the 4th International Conference of Population and Development (ICPD) was held in Cairo. It was here that the rights of youth to safe, accurate and affordable contraceptive services, safe abortions and non-judgemental counselling was first acknowledged (United Nations, 1995). Following the ICPD, the WHO published the Global standards for quality health care services in 2015. These standards aim to ensure that facility managers and health workers know how to offer quality health services to adolescents (WHO & Unaids, 2015). At the ICPD in 2014, the previously ratified commitments from 1994 were expanded upon, with attention directed towards access to comprehensive SRH services and information, as well as the significant gender disparities in access (ICPD, 2014).

2.1.2 Sustainable Development Goals

UNs Sustainable Development Goals (SDGs) are 17 goals, ratified in 2015 to be reached by 2030. Each goal has several targets and indicators and focuses on different global challenges to be addressed in order to achieve a better and more sustainable future (UNFPA, 2022a; United Nations, n.d.). Through the SDGs, the health of adolescents and youth has become a global priority as an important issue on its own, as well as a key to improve overall health and wellbeing (Herat et al., 2018). With only seven years to go there has been a need to accelerate progress, and the goal of fulfilling the SDGs by 2030 is at risk (United Nations, 2022). The UNFPA is the sexual and reproductive health agency of the United Nations (UNFPA, 2018). The UNFPA specifically focuses on SDG 3, 4 and 5, which relate to health, education and gender equality (UNFPA, 2022a). SDG 3 focuses on good health and wellbeing, with the target 3.7 aiming to reach universally available SRH care including information, education, family planning and the integration of SRH into national policies (UNFPA, 2022a; WHO, n.d.-b). The progress towards SDG 3 was heavily impacted by the covid 19 pandemic (United Nations, 2022).

In the DRC, the government has made several commitments to aid in reaching the SDGs. One example of this is the voluntary national review report for the sustainable development goals (République Démocratique du Congo Ministère du Plan, 2020). This report lays out the progress made on each of the 17 SDGs. A recent study invited experts from different fields to participate in a discussion about how the SDGs are interlinked. This study found that for the

DRC to achieve SDG 3, the most impactful and cost effective SDG to focus on would be SDG 16; Peace, justice and strong institutions (Egbende et al., 2023).

2.2 Research problem

Common SRH issues faced by girls and young women in middle- and low-income countries are an early sexual debut, lack of information on contraceptives and protective behaviours, experiences with sexual coercion and violence, unsafe sex, early and unintended pregnancies, morbidity and mortality related to pregnancies and sexually transmitted infections (STIs) (Santhya & Jejeebhoy, 2015; Sogarwal et al., 2013; Wado et al., 2020). Despite the commitments made at the ICPD, Melesse et al. (2021) found that 28% of girls in sub-Saharan Africa were married before the age of 18, with 54% of girls having their sexual debut before 18. 47% of girls gave birth by the time they were 20. These levels are declining, but remain high, especially in rural and poor areas with less education (Melesse et al., 2021).

Several factors contribute to high fertility rates among youth in sub–Saharan Africa. Some of these factors are limited access and use of contraceptives, condoms, poverty, cultural practises such as child marriage, traditional attitudes, cultural norms, and lack of SRH services and education (Melesse et al., 2021; Yaya et al., 2019). Other challenges related to SRH in sub-Saharan Africa are gender-based violence, unsafe abortions, taboos surrounding sexuality, family planning and limited access to youth friendly services. These factors have resulted in high-risk sexual behaviour leading to high STI and HIV prevalence, early pregnancies and increased risk of delivery complications resulting in high death rates and disability (Ninsiima et al., 2021).

2.3 Previous studies concerning the quality of youths SRH services.

A systematic review of monitoring and evaluating SRH services across countries of high-, middle- and low- income provides an overview of the state of SRH services from several countries around the world (Chandra-Mouli et al., 2018). Although reports are generally positive, there are reports of negative experiences in relation to SRH services provided to youth. The findings indicated shortcomings regarding issues related to privacy, staff-competency, and staff encounters. The level of privacy and respect shown by staff was reportedly lower in the middle- and low-income countries, where the youth reported experiencing less autonomy over counselling and treatment (Chandra-Mouli et al., 2018).

Melesse et al. (2020) found that girls in West and Central Africa are more likely to face issues such as those mentioned above than girls of a similar age in East and South Africa. A

study previously conducted in Kinshasa documents a high level of sexual double standard among youth in this region. This was measured by a difference in normative expectation for romantic activity, where boys were rewarded for romantic activity, but girls were devaluated for engaging in the same behaviours. The study found that puberty was associated with changes in sexual double standard perceptions for all youth. However, boys were more influenced by media and family, while girls were more influenced by interactions with their peers (Cislaghi et al., 2021).

In a study from 2015 that used a youth MC approach to examine the state of sexual health services in Tanzania, it was found that the reception of MCs by health workers often was inadequate or even hostile. Additionally, MCs reported that health workers were rude, that there were long waiting times, inadequate information, lack of knowledge regarding condom use by health workers, and unprofessional behaviour. Along with this were reports of health workers personal views on family planning and intercourse before marriage affecting the care they provided to youth (Mchome et al., 2015).

In a similar study conducted in India, the quality of sexual and reproductive health services delivered to youth was assessed using data gathered from MCs and interviews with the health counsellors. This study based its assessment of the SRH services on WHO's global standards for quality health care 1, 3, 4, 5 and 6 (Dayal & Gundi, 2022). These cover youth health literacy, appropriate package of services, providers competencies, facility characteristics and equity and non-discrimination (WHO & Unaids, 2015). The study found that some of the challenges were rooted in sociocultural norms related to SRH and gender bias. This reduced the effectiveness of youth friendly health clinics. Dayal & Gundi (2022) suggest remedying this by training the counsellors to increase visibility of the SRH services offered, providing infrastructural and logistical support to the youths, and create dialogue about the SRH services in the community.

2.4 Previous studies on health worker interventions regarding SRH.

2.4.1 What constitutes an effective intervention?

In Moldova, an initiative was taken to improve the youth-friendly health services available through the Healthy Generation project (Carai et al., 2015). This study also uses the WHO standards of quality healthcare to measure the standard of care offered to youth. Similar to this thesis, the Moldova study is part of an ongoing project and the assessment done will be used to further refine and improve youth-friendly health services. The study suggests

collaborative learning and job shadowing to further the improvements at newly implemented youth-friendly health service facilities (Carai et al., 2015).

A review conducted by Denno et al. (2021) of intervention implementation strategies aimed to determine which strategies are more effective for improving health workers delivery of youth friendly SRH services. They show that multifaceted implementation strategies are more likely to be effective. With training and supervision being the most widely used strategies. Although their findings do not offer conclusive data on what combination of strategies offer the best results, they highlight that job aids and collaborative learning work best as a part of a multifaceted intervention. Several individual interventions do not seem to yield substantial results, even though these are one of the more common intervention strategies (Denno et al., 2021).

As well as employing different strategies of implementation in the interventions, careful consideration of the context in which the intervention is implemented is also considered to be crucial in order to be effective (Dieleman et al., 2009). This review looks at several previously conducted health worker interventions and concludes that the interventions containing strategies such as interactive training, job aids and strengthening health systems may be effective. Effective interventions also take into consideration the context around the health facility and workers to review how surrounding factors might affect the performance and motivation of the workers (Dieleman et al., 2009). An example of such a context can be found in Wado et al. (2020) where they look particularly at the urban slums of sub-Saharan Africa, and show that the interventions conducted were adapted to fit the demographic of youth in these particular areas.

2.4.2 In what way can health workers and facilities impact the quality of service?

The job of health workers involves more than their ability to share knowledge and conduct tests. Their attitudes and behaviours can impact the quality of the SRH services they provide, when it comes to youth SRH (Jonas et al., 2017). Provider bias is one of the most decisive barriers in quality SRH services to youths. Health workers have been known to deny SRH service, contraceptives and care based on age, number of children, marital status, and partner approval. These attitudes can also result in poor behaviour toward clients, and there are reports of health workers chastising, yelling at, scolding and stigmatising youths seeking SRH health services. Health workers relaxed attitudes and their not precisely making a statement of confidentiality, can lead to youth being uncertain that the issues discussed will

remain private (Corley et al., 2022). Other factors at the health care centres such as irregular supply of medical supplies can also impact the quality of care (Jonas et al., 2017). Health worker attitudes that strengthen utilization of SRH services include knowledge and skills of obstetric care, and positive, non-judgemental attitudes toward those seeking SRH services (Corley et al., 2022). Positive attitudes and behaviours are thought to encourage youth and young women to utilize the health care services available. This is likely to reduce some of the SRH risk factors these groups face (Jonas et al., 2017).

In early youth, one starts to develop increased privacy needs and experience the enforcement of gender and social norms (Corley et al., 2022). Stigma, shame, culture, and embarrassment can cause youth to avoid seeking SRH services, due to fear that the community or family will find out. The layout of the health facilities and how it is utilized is also a factor. Lack of privacy in the waiting room, health providers sharing information without consent, lack of private consultation rooms or consultations being interrupted are all factors that contribute to poor confidentiality and privacy practices (Corley et al., 2022). This is connected to how the relationship between a building and its users can impact it's usability (Ryhl & Høyland, 2018). An example of such a lack of privacy due to changed use of the facility came from the Covid-19 pandemic. With restrictions such as social distancing healthcare facilities were forced to have lines outside of the building, reducing privacy and reinforcing the perceived stigma mentioned above (Kelly et al., 2022).

2.5 GFATM/WHO implementation study and the package of interventions

2.5.1 Baseline

The baseline of the overall project was conducted in November of 2017, where interviews and assessments were carried out in 30 health facilities, 15 in Kasai Oriental and 15 in Kinshasa. This baseline included in-depth interviews and focus group discussions with health workers and health managers, field notes, monitoring reports, costing sheets, health worker surveys, youth mystery client assessments, and exit interviews with youths (Bastien et al., 2022). This baseline assessment show that most health workers had not undergone training related to the provision of SRH services to youths. Although it was reported that health workers respected the youths that visited due to SRH reasons, and that they were confident in the services they provided, there were no facilities that offered a fully comprehensive service tailored to youths (Ministere de la Sante Publique, 2017a, 2017b).

2.5.2 Intervention

The first round of implementation of the intervention of the overall study took place in 2017 led by WHO AFRO in Kinshasa, closely followed by Mbuji Mayi, Kasai Oriental in early 2018. These interventions focused on creating a shared understanding of youth, health needs specific to youths and awareness on how to deliver SRH services to this group with respect and dignity. Interventions also included job descriptions, training and refresher training, supportive supervision and collaborative learning. At the end of the intervention, the health workers were provided with desk tools for easier reference and demonstration when providing SRH services (Bastien et al., 2022).

2.7 Conceptual framework

2.7.1 Sexual health

The UNFPA defines sexual and reproductive health as follows:

> *"Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to skilled health care providers and services that can help them have a fit pregnancy, safe birth and healthy baby. Every individual has the right to make their own choices about their sexual and reproductive health. […]" - (UNFPA, 2022b, para. 1)*

Naidoo and Wills (2016) define sexual health as the acceptance and ability to achieve satisfactory expressions of one's sexuality. The WHO states that a key component in an individual's sexual health is their access to information about sex and sexuality, and that this information is correct and of a high quality (WHO, 2022).

2.7.2 Standards for quality health care services

The WHO published the standards for quality health care services in 2015. These standards aim to guide service delivery and improve quality in SRH facilities. They set standards that, if met, will secure youths right to effective, accessible and acceptable health care through improvement of quality of care at these facilities (WHO & Unaids, 2015). The main standards relevant to the analysis in this study are standards 3, 4 and 6, with aspects of standard 1 and 5. Standard 2 (community support), 7 (data and quality improvement) and 8 (youth participation) are not relevant to the research questions or the data and are not included in the data analysis (WHO & Unaids, 2015).

Figure 1: Standards for quality health care for adolescents (WHO & Unaids, 2015)

Adolescents' health literacy	**Standard 1.** The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	**Standard 2.** The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	**Standard 3.** The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.[1]
Providers' competencies	**Standard 4.** Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	**Standard 5.** The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	**Standard 6.** The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	**Standard 7.** The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	**Standard 8.** Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Standard 3 – Appropriate package of services

This standard requires health facilities to provide information, counselling, diagnostics, care, and treatment that fulfil the needs of youth. This standard highlights that youth health care encompasses a range of different services, that the services offered at a facility should be tailored to the needs of the surrounding community and that the facilities have clear guidelines as to which services are offered on the premises and which services that require referrals (WHO & Unaids, 2015).

Standard 4 – Providers competencies

Standard 4 looks to the technical competencies required to provide youth with effective health services. These competencies regard both health workers and other staff at the facilities. It is required that staff can provide information, offer respect, and uphold a non-judgemental attitude, and ensure privacy, confidentiality, and non-discrimination. This

standard aims to ensure that youth receive services in a supportive, respectful, non-discriminatory and friendly manner (WHO & Unaids, 2015).

Standard 6 – Equity and non-discrimination

Similar to standard 4 standard 6 looks at non-discrimination. Where this is part of a general open and supportive welcome in standard 4 Standard 6 requires facilities to provide quality services to youth regardless of age, sex, education, marital status, and other characteristics. This standard aims to include vulnerable groups of youth and ensure that all youth receive the health care services they need (WHO & Unaids, 2015).

Standards 1 and 5 – health literacy among youth and facility characteristics

Standard 1 aims to ensure health literacy among youth, through information, communication and education materials at the facilities and outreach strategies. This however is not relevant to the gathered data, and therefore standard 1 is included under the theme connected to standard 3. This due to one of its components regarding health workers abilities to communicate with youth and provide health education. Standard 5 is included under the theme connected to standard 4. Standard 5 looks at the actual characteristics of the building the facility uses, such as appropriate waiting areas, opening hours and that the building facilitates the ability to uphold confidentiality and privacy (WHO & Unaids, 2015).

2.7.3 WHO's six principles for delivering quality SRH care

In their report from 2017, WHO emphasised the inextricable link between sexual health and reproductive health. In this report they present an operational approach for conducting interventions regarding SRH. As a part of this, they present six principles that set the foundation for the model they present. The principles must be incorporated into all sexual health interventions, as they provide a strong foundation for sexual health to be achieved (WHO, 2017). These six principles will be included in the conceptual framework of this thesis to triangulate the standards presented above and offer up the view of SRH care to the standards for quality health care for youths. The six principles will be presented in brief.

The first principle is a holistic approach to sexual health. This focuses on the part of the WHO definition of sexual health that states it is more than the absence of ill health. Research, health services and other sexual health programming should focus on promoting positive sexual health and general wellbeing, as well as the prevention of disease. The second principle relates to the overlapping nature of sexual health and reproductive health. One cannot focus on one without also addressing the other. Preventing the spread of STIs and

working to treat them will have an impact on fertility rates. This link between sexual and reproductive health is the foundation of the report (WHO, 2017). These first two principles will not be explicitly mentioned in the results or discussion chapter, but they are an integral part of the understanding of SRH.

The third principle touches on the issue of health as a human right, and that sexual health is an integral part of our health. One has the right to decide freely and responsibly on matters of one's sexuality and SRH, without being discriminated against, coerced or experience violence. This principle cements that sexual rights are necessary to achieve sexual health. The fourth principle discusses the many levels of influence that can affect sexual health on an individual level. Things such as family, community, peers, law, policies, and other structural factors (WHO, 2017). The fifth principle addresses the fact that our SRH and our SRH needs change through the course of a lifetime. The different times might make people more vulnerable and susceptible to poor SRH. For example, as an adolescent or youth. The sixth and last principle states that interventions must meet standards for quality care, such as the ones presented above, be evidence based and be provided in a respectful and positive manner. This includes maintaining privacy and confidentiality, ensure that health workers are trained, competent and non-judgemental, that information is presented clearly, without coercion and that facilities should stock adequate quantities of supplies (WHO, 2017).

3 Methodology

3.1 Choice of research method

The implementation research study utilized mixed methods. The data material consists of the MC de-brief interviews and youth exit interviews along with the reports and publications related to this study (Bastien et al., 2022). The youth exit interviews will be triangulated to gain a comprehensive understanding of the perspectives and experiences of a youth client who received care from trained health workers at these facilities. Therefore, qualitative methods were used. The epistemology of this thesis falls within the interpretive paradigm with an ontology based in phenomenology. Phenomenology aims to capture the essence of peoples lived experience, which is what one aims to achieve within a qualitative study such as this (Malterud, 2017). As that is in alignment with the aims of this thesis phenomenology was a natural choice.

3.2 Mystery clients

Mystery clients have been used as an approach to gather data on the perspectives of youth regarding the sexual and reproductive health services they receive in several studies, including this one (Bastien et al., 2022; Chandra-Mouli et al., 2018; Dayal & Gundi, 2022; Mchome et al., 2015). MCs are individuals, often from the community, who visit an establishment as a customer or client and later report on the experience through an interview or a survey (Boyce & Neale, 2006). Mystery clients are often used to get an unbiased view of an establishment, in this case, a health facility, to identify areas for improvement. There is however an ongoing debate about the ethics of using mystery client, as it may in some studies entail a form of misrepresentation. The establishment/health facility is informed of the visits and required to give consent, but this is not always the case for the service providers. However, the use of mystery clients benefit both the clients and the service providers at the facility as MCs acts as a tool to evaluate and improve their work (Boyce & Neale, 2006). The use of mystery clients in this study underwent a thorough and rigorous ethical assessment to ensure safeguards for both youth and health workers were in place. This included consent by both health facilities and the health workers themselves (Bastien et al., 2022; GFATM et al., 2021).

3.3 Sample

The sample consists of the MCs (n=16) recruited as part of the GFATM/WHO implementation study along with the youth (n=16) participating through exit interviews. The participants range from 18-25 years old and were all female. The total number of youth participants included in this thesis is 32, there is no data on how this is divided between the two cities. There is no comprehensive sociodemographic information on the participants aside from this. The health workers the MCs visited were trained as part of the GFATM/WHO implementation study. The health facilities were purposefully chosen and then stratified to achieve adequate data from both rural and urban facilities (Bastien et al., 2022).

3.3.1 Mystery client recruitment and training

In the implementation research study, there were ten female MCs between the age of 18-25, five in Kinshasa and five in Kasai Oriental. MCs were recruited from The Congolese Youth Association Network. The recruitment was done by senior members of the GFATM/WHO implementation study research team. Factors such as literacy, professionalism, interpersonal skills, distance from residence to the relevant health facility and ability to take good field

notes were taken into consideration. Following an initial practice session, potential MCs were screened to identified who, if any, had previously been exposed to gender-based violence-related trauma. Any potential MCs who reported this were excluded from the study and referred to counselling. This was to be certain that they would not be exposed to psychosocial harm through their participation in the study (Bastien et al., 2022). Once the ten MCs had been recruited a three-day training ensued. This training was based on standardized training programs for MCs and included sessions on ethics and confidentiality, roleplay, expectations of standards of care, memory techniques, how to ask information, and how to conduct reports and observations (Bastien et al., 2022; GFATM et al., 2021). The same recruitment and training were done for the later MCs.

3.3.2 Mystery client scenarios

The scripts that detailed the different scenarios the MCs would play out for the health workers all included the MC asking for information about an SRH related issue for a friend or themselves. The different scenarios covered asking about STIs, asking about and requesting condoms, and sharing experience with gender-based violence from a boyfriend and asking the health worker for information on where to get help in the future. MC's were instructed to specify that they were only seeking information, and not to allow any invasive procedures such as pelvic exams or blood tests (GFATM et al., 2021).

3.3.3 Mystery client and exit interviews

All interviews were gathered using a semi-structured interview guide. The interviews and transcripts were originally done in French with some local phrases in Lingala, but the transcripts were transcribed and translated into English (GFATM et al., 2021). Immediately following the visit MCs made field notes, detailing waiting time, their perceptions of workers and facilities as well as on the information given. Along with this the de-brief interviews were conducted in French, as soon as possible to minimize recall bias. The interviews began with a quick introduction detailing the purpose of the interview and how the information would be used (GFATM et al., 2021). For the youth exit interviews, the health facility was informed of dates where the research team would be conducting these interviews. The first step when meeting potential interviewees was a quick introduction detailing the purpose of the interview and how any information they shared would be used. There was particular care given to the location of the interviews, and it was made sure the interviewee was comfortable (GFATM et al., 2021).

3.4 Data Analysis

3.4.1 Thematic analysis

In line with a phenomenological approach, the transcripts from the MC interview data and youth exit-interview data were analysed using thematic analysis (Braun & Clarke, 2006). For the first step of the thematic analysis the relevant interviews were read through. After having familiarized with the data it became clear the two categories of interviews offered different perspectives. As will become apparent in the results chapter, the MC interviews contain more rich data, and quotes from these interviews tend to be longer. Whereas the quotes from the exit interviews contain more concentrated information. This is likely due to the fact that MCs received training as research assistants, researchers knowing the scenario of the MCs and being able to ask more pointed questions. As there was a delay in receiving the official translations from French to English, the initial review was done using transcripts translated through a translation program. Therefore, not all meaning was correctly depicted in these translations. However, this was clarified with the correctly translated transcripts as this translation retained more of the meaning. Although there were still language barriers present. Through the second step of thematic analysis the initial codes were generated (Braun & Clarke, 2006). In this first round of coding there were 23 different codes assigned for the MC interviews, and 11 codes for the exit interviews.

For step three of this analysis, the codes and their corresponding meaning units generated in step two are reviewed to generate potential themes (Braun & Clarke, 2006). The codes generated correspond with standard 1, 3, 4, 5 and 6 of the WHO standards of quality healthcare, and these are linked to the themes used in analysis. These standards were chosen because they are the ones that are best represented in the data, whilst also answering the research problem. All these themes are directed at treatment of youth, the actual experience of general visits as well as the knowledge and competencies of health workers in providing quality SRH services. The standards not included in analysis were 2, 7 and 8. After the first readthrough of the transcripts it became apparent that these themes were not relevant to the data. However, they will be useful in the overall evaluation of the intervention.

With the units of meaning sorted into these five themes step four of the analysis works to review and refine these themes. Some themes may collapse into each other, while other themes might have to be divided. Reviewing the themes involves reviewing if they reflect the actual meaning units coded under each, and then refining the themes so that these reflect the data set as a whole (Braun & Clarke, 2006). Standard 1 and 5 were excluded after the first

round of coding, this because the codes sorted under these themes could be transferred to the other themes. The codes from standard 1 were included in theme 1 and the codes from standard 5 were included in theme 2. Along with this some of the codes were combined into sub-themes to create a better overview. For step five of thematic analysis, a satisfactory thematic map of the data was developed. Once this was done, themes were more carefully defined and refined, including defining sub-themes to offer additional structure to complex themes (Braun & Clarke, 2006). The final themes, sub themes and codes are presented in Table 1 in the results chapter. Step six of thematic analysis focuses on the report of the analysis (Braun & Clarke, 2006). This will be shared in the results chapter.

3.5 Ethical considerations

3.5.1 Fulfilment of requirements

This thesis has adhered to the ethical principles for medical research involving human subjects as laid out in the Helsinki Declaration (World Medical Association, 2022). Since all data used in this thesis is fully anonymized, applications for Regional Committees for Medical and Health Research Ethics (REK) and the Norwegian Centre for Research Data (NSD) were not required. The GFATM/WHO study adheres to the WHOs guidance on ethical considerations in planning and reviewing research studies on sexual and reproductive health among youth, as well as the Standards for operational guidance for ethics review of health-related research with human participants. Along with this the study's protocol has been approved by the University of Kinshasa's ethics review board and the WHO Ethical Review Committee (ERC) (ERC.0003228).

When presenting quotes in the results section, participants will remain anonymous apart from whether they were MCs or youth exit interviews. All MCs and youth participating in exit interviews signed an informed consent form (Bastien et al., 2022; GFATM et al., 2021). Finally, a Data Sharing Agreement has been signed between the University of Kinshasa and the Norwegian University of Life Sciences (NMBU). The transcripts and other documents were all saved on NMBUs password protected OneDrive platform.

3.5.2 Conducting the interviews

Seeing as the main part of the data material is sourced from individual interviews there are a few criteria to keep in mind through the analysis. The goal of such an interview is to gather information regarding the experiences, assessments, and considerations of the interviewee. For this to be successful there needs to be a safe space for sharing between the interview and

the interviewee (Malterud, 2017). In this case the MCs were already familiar with the interviewees as they were part of the research team present for the training. As for the youth exit interviews there were considerations taken into care to ensure their comfort during the interview, such as using a location acceptable to the interviewee. Before each interview the interviewer should provide a quick briefing of the theme of the discussion, this was done in every MC interview and youth exit interview conducted in the GFATM/WHO implementation study, as is evident from the interview guides provided (see Appendix 1 & 2) (Brinkmann & Kvale, 2005; GFATM et al., 2021).

3.5.3 Reflexivity and preconception

As a researcher analysing this data, yet not having been involved in collecting it and having no experience from the study setting, and indeed the contrast and limitations of understanding that are inherent with coming from a high income country and writing a thesis on a fragile low-income country, it is important to consider both cultural differences and previous personal experiences that may influence analysis and interpretation of study findings. One must be careful to be aware of preconceptions of how one personally would want to be treated by a health worker and let the transcripts and analysis speak for itself (Malterud, 2017). As a qualitative researcher one should be close to the data and preferably conduct or be present as the interviews are conducted (Malterud, 2017). However, for this thesis this was not an option as it is set within a limited time frame and is part of an ongoing study. To remedy the lack of involvement, efforts have been made to get as close to an understanding of the data material as possible through the available unpublished documents such as the data collection manual. Through a meeting with researchers from the DRC, who visited NMBU and knew the context and the GFATM/WHO study well, we tried to ensure that any gaps in interpretation of the transcripts have been filled. The researchers that collected the interview data reportedly had a difficult time recruiting youth for the exit interviews as there are few who utilize SRH services. This may cause these data to be lacking and a poor representation of the overall population of youth in the area. Due to the nature of the data, and possibly as a consequence of existing biases and lack of equity, as well as the still unstable nature of SDG 16 in the DRC, this thesis does not offer any information on the state of SRH services offered to lesbian, gay, bisexual, transgender and queer youth in the DRC (République Démocratique du Congo Ministère du Plan, 2020).

4 Results

This chapter constitutes step six of thematic analysis, where quotes from the analysed data are presented as part of a narrative (Braun & Clarke, 2006). Specific quotations from the transcripts that may aid in answering the research questions will be presented, highlighting the themes generated through the analysis process. The quotes will be presented according to the themes identified through analysis, as presented below, weaving in the WHO standards for quality health care, in particular standards 3, 4, and 6, standard 1 and 5 combined as well as the six principles for SRH. For the youth exit interviews when asked if they are satisfied with the service, the youth simply state to which degree they are satisfied with the service or not. For the MC interviews, there is much more rich data, due to the fact that the MC's were trained as research assistants and used specific scenarios, and the interview guide largely focused on this. By reviewing both types of interviews, it is possible to triangulate an understanding of overall youth satisfaction with the information and services they received from health workers trained through the package of interventions.

Table 1: Final themes, sub-themes, and codes as a result of data analysis

Themes	Sub-themes	Codes
Prevention of SRH issues and promotion of use of SRH facilities	Information provided by health workers	Information about condoms and condom use
		Information on alternatives and other available contraceptives
		Information on prevention and treatments of STIs and HIV/AIDS
		Information on menstrual hygiene
		Information on gender-based violence
	Making services accessible	Encourages youth to come for another visit and invite others to visit as well
		Provides a way of contacting the facility
		The services offered at the facility are available
		Ensures that services not offered the facility are accessible
Health workers' competencies and facility characteristics	Health workers' competencies in offering quality healthcare to youth	Health workers and other staff offer a warm welcome
		Health workers encourage youth to utilize SRH services
		Health workers ensure that youth are comfortable and feel safe
	Health workers' awareness of privacy	Health workers, staff and facility offers youth a sense of privacy
Treating youth with equity and non-discrimination	Health workers and staff treat youth with respect and in a non-judgemental manner	Health workers do not discriminate youth based on gender
		Health workers do not discriminate youth based on age
		Health workers do not discriminate youth based on clothes or appearance
		Health workers trust that youth are truthful
		Health workers do not discriminate youth based on personal bias

4. 1 Theme 1 – Prevention of SRH issues and promotion of use of SRH facilities

4.1.1 Information provided by health workers.

The requirement of providing information on SRH to youth is included in several of the WHO standards (WHO & Unaids, 2015). The sixth principle for SRH states that information should be provided clearly and without coercion, whilst promoting informed decision making (WHO, 2017). For this thesis, it has been coded under theme 1 correlating to standard 3, but information is also a key component of standard 1 and 4. Reviewing the transcripts from the MC interviews, the data shows that four MCs were given an in-depth explanation of use and benefit of condoms that fulfils the requirement of standards of quality health care and the sixth principle of SRH.

« He gave for the use. For the boys, he said: you get it out of the package first, before you use it. You hold the condom tip. Now the boy rolls it over the penis so that he can't touch the tip, because if he touches the tip in any movement, it can tear and there are those sperms that can come out and transmit diseases. […] He said, the feminine is worn like this: as soon as you take it out of the package, there is something inside in the form of a lace. You take this thing, you form the number 8. You introduce it into the vagina, if it progresses , it comes to the vagina and it fixes itself. When it fixes itself, now you take the thing out, you throw it away and it sticks to the lips." – Mystery client

The example above shows an in-depth explanation done concisely and clearly as the MC can recall the information. However, there are cases where information on condoms provided to youth does not meet either standard or the sixth principle as shown below.

"She didn't talk about kinds of condoms. She said that there are many methods to prevent infection, but only mentioned condoms. She didn't show me, she didn't say where to find its nor how to use its. […] She spoke just for the condoms. She advised and just said that if you want to have sex, you have to have condoms in order to avoid infections and also to avoid getting pregnant because we teenagers today like to have sex before marriage, which is not good, which is not worthy of a girl. So, we girls must be given values, we must give respect to our body, we must avoid sexual intercourse before marriage. That is what is not good.» - Mystery Client

Most clients report that the amount of information on condoms they received is somewhere in between these two examples.

4.1.2 Making SRH services accessible

According to standard 1, facilities and health workers are to make themselves accessible through outreach strategies, information, communication all to aid in promoting health literacy among youth. Standard 3 states that the facilities should provide information, counselling, diagnostic care and treatment. These standards link to the first and fourth principles of SRH. Regarding promotion of positive sexual health and general wellbeing, and

the levels of influence on sexual health. The accessibility is based on whether the services are made easily accessible and openly available to the clients after their visit. This could be through referrals, inviting them or others back, offering contact information or setting up another appointment. This quote from one of the youth exit interviews exemplifies what happens when this is not the case.

"He didn't give me a reference document, in my thoughts I thought that as he didn't fulfill well what was my desire for which I had gone, I thought he was going to send me even to someone else who could explain to me and fulfill what was my desire as I was looking for I asked him if there was anyone else he told me that there was no one else besides him in that structure." – Exit interview

The example above shows how the lack of information and counselling given, along with the lack of a referral leaves the youth feeling as if the health worker did not meet her needs. A different interview with an MC enacting the gender-based violence script exemplifies the health worker making themselves and their services available both to the MC and others.

«Yes, she told me that if in the future I encountered a similar situation, calling me a whore by wanting to use a condom or even if he hit me that I could not give in to these threats and insults. He may be a man who is sexually active and has his diseases that he wants to pass on to me, if I give in, I'll be at risk. And that if a man wants us to have unprotected intimate relations, to go to a hospital to be examined to know our health status, if he refuses, I should be constant and refuse too. Even if he started to insult me, calling me a whore, that I could refuse, because it is risky. […] She didn't tell me, she just told me to come back to her without hesitation if I have any problems in the future. And that she is there for us young people. And that if my boyfriend would get back together with me, that I would bring him to her, maybe he is just ignorant and lacking in information that this way protects him too. Maybe I am the one with the disease and using a condom will protect him from getting the disease. […] Yes, she did as I mentioned above. She is available at all times and if needed, she herself took my phone number to call me to check up on me."- Mystery client

As shown above there are examples where health workers make themselves and the facilities accessible and available to both the visiting youth client and potential other clients. This aligns with the requirements set in standard one and three as well as well as the first and fourth principle of SRH. However, this is not the norm, and many interviews recount experiences more closely related to the first quote presented.

4.2 Theme 2 – Health workers' competencies and facility characteristics

4.2.1 Health workers' competencies in offering quality healthcare to youth.

This section covers the theme relating to standard 4 and 5, health workers' competencies and facility characteristics. This theme covers health workers' being encouraging, welcoming, and ensuring that youth feel comfortable. As well as in what way the facility as well as the

workers facilitate and maintain a sense of privacy. This theme aligns with principle five of the SRH principles. This relates to the fact that our sexual health changes through our lives, as do we. Therefore, one might be more vulnerable and susceptible to ill health and experience barriers to SRH care. One MC recalls an experience that exemplifies a truly warm welcome. Where she is shown around the facilities and offered a drink and to charge her phone.

«Yes, I was welcomed very well. It was a young nurse and she immediately directed me to the doctor who in turn received me well and we talked. The whole team was ready to receive me, they were interested in me, presented me with a chair and were very kind to me. They even offered me a drink and even put my phone on charge to help me because I was lobbed, they were really nice" – Mystery Client

In contrast, there is one youth that waited 3 hours for a previously agreed upon appointment, without being notified of the wait or the reason behind it.

"We had made an appointment at 9am, I also went at 9am and she arrived around 11am. She apologized for the delay in the appointment time." - Mystery Client

In one youth exit interview the health workers were on strike and could therefore not provide the quality of care expected. However, through this interview it becomes apparent that the health workers try to offer her the care they can, exemplifying the importance of context and how one must take potential unrest into consideration. It also shows the importance of attitude and behaviour and how this can make a difference on impression even when the service provided is poor due to other factors.

"Yes, he listened to me attentively, he listened to me to understand everything I said when I was speaking, he paid attention to me, everything I explained to him he listened calmly until I finished speaking. After that he started to advise me he was not distracted at all but I had noticed that he was very afraid because they are on strike and he was afraid that he had someone spying on him to see if they have opened the centre or not. He was very afraid and that's why we were isolated I think that it was this fear that made him a bit distracted to other things that I was telling him." – Exit interview

"I am satisfied because I was welcomed, I was given a place despite it being closed and he also listened to me. I am not satisfied because the provider spoke so quickly because he was afraid that he would be caught consulting, for him what he was doing was against the norms. he told me that I came at a bad time, they are tailing us to see if we receive the patients or not. If you see, almost all the doors are closed. So I'm not satisfied because I didn't find the full solution to my problem." – Exit interview

The importance of welcome and comfort offered by both health workers and other staff is best illustrated by one of the MCs who points out the importance of a warm welcome, as well as positive attitude and behaviour from the health workers:

"But I wanted to add something, regarding the providers, they must be welcoming because we know that we young people are complicated. If we have to train them again, we have to insist on their attitude and welcome. When we go to them for advice and guidance, they must be attentive and open to the youths in order to better support us and solve our problems. From the attitude of the provider can decide to open up and expose his problem." – Mystery client

4.2.2 Health workers' awareness of privacy needs of youth

Privacy connects both to the structure of the facility such as the layout of the waiting room and offices, as well as the aforementioned vulnerability regarding sexual health that might occur during this time of heightened need for privacy (Corley et al., 2022; WHO & Unaids, 2015). The interviews do not offer a comprehensive description of the characteristics of the facilities. One interviewee state this when asked if offered a seat:

"At the reception, no. But there are benches for me to sit on. In the consulting room, he gave me a place to sit." – Exit interview

When it comes to privacy most of the interviews are conducted in an office under four eyes, in some cases there are three people in the room.

"No, she didn't tell us that. But there were only three of us in the room. But I know there's still what, I mean doctor-patient privilege." – Exit interview

On the matter of awareness of privacy, the layout and characteristics of the facility and how these are utilized by the health workers is interesting. As shown by Kelly et al. (2022) the suitability of a building or room may be altered by the quality of use. The usability of a building should be seen as a relationship between the building and its users (Ryhl & Høyland, 2018). The example below shows how meeting in an office might not be sufficient to evoke a sense of privacy if the health workers' awareness of the issue is lacking. This highlights the importance of providers competencies in standard 4 and their being aware of the surroundings and how different behaviours might affect the youth clients.

"Well with the environment like that you can't really concentrate because there were too many entrances there, so concentrating on one person, no, but he was attentive to what I was saying. People coming in would interrupt the discussion, they would ask for something." – Exit interview

Reviewing these findings connected to theme 2 we can see that the main issue here is health workers' competencies in offering comfort, awareness of privacy and their impact on the usability of the building. Regarding confidentiality the data did not show youth clients were assured of this, however, there seems to be an understanding of conversations being private as is shown in a previous quote as well as the following.

"*No, he did not reassure me. Well, he didn't tell me that, but this is from myself. I know that with a doctor and the patient there is always a secret*." *– Exit interview*.

4.3 Theme 3 – Treating youth with equity and non-discrimination.

4.3.1 Health workers and staff treat youths with respect and in a non-judgemental manner.

This section focuses on the theme based in standard 6. Specifically, that SRH services should be provided in a non-discriminatory and non-judgemental fashion. This aligns with the third principle of SRH regarding prospect, protection, and the fulfilment of human rights. One has the right to freely exercise control over matters regarding sexuality and sexual health.

One interview offers an example of how such discrimination and judgemental attitudes might occur. The following quote relates to when the MC is asked if the health provider made any inappropriate comments on her appearance.

"Yes, especially about my clothing and gender. He said to me: "you are old enough and your buttocks are much bigger, such buttocks are what boys are looking for. Furthermore, you should have bigger breasts". I told him: "that's not your problem, just answer me for what I came to look for". He said to me: "as you do not answer me, I also do not answer you" When I insisted, insisted on begging him, I told him to answer me a little, I'm in a hurry because I have class now, he started to answer me." – Mystery client

Several of the youth's recounted statements from the health workers that suggest. Here are two examples of such distrust:

"She also asked me if I was still a virgin. She had a hard time believing me when I told her I was still a virgin. She also asked why I wanted to start having sex with a man." – Mystery client.

"He asked me if I had ever slept with men, I am a girl who has not known men. He told me to tell the truth, I told him that I have not known men." – Exit interview.

In one instance, the youth client's final impression of the interaction differs from how she initially perceived the interaction. However, the hesitation the youth client expresses shows that health workers must be very conscious of how their tone and choice of words as this could easily be misinterpreted.

"He did not criticize me or say anything inappropriate. He respected me. Well! at first, I thought he was being insincere when he was comforting me, telling me I'm not married yet and I'm already pregnant, how I'm going to make it with the classes. But later I understood that he was not criticizing me, he was putting himself in my shoes and trying to help me." – Exit interview

There are examples of health workers generally making youth clients feel comfortable and safe, while also making statements brought up in the interviews that may seem judgemental

and show a lack of respect. In the quote below the two comments are made answering two different questions.

"When I told her it was for a friend she said: Hmmm, is it really for a friend? I said: Yes of course! if it was for myself I was going to say it; then she added you young people of today really! […] and then she said that you young people like to put too much stuff there (in the vagina), it's not good. On condoms, she mentioned, she said especially you young people, most of you don't know how to calculate your dates but even if you do, you should always use condoms, that's the best method I can suggest; because if I told you abstinence, I know you're not going to get it. She did not mention other contraceptive methods, only emergency pills and condoms. She added, you also protect yourself, can't you wait until marriage? "

– Mystery client

An example of lack of respect due to judgemental attitudes and behaviour connected to age that also infringes on the right to decide freely on matters of sexual health is when the following happens to an 18-year-old client visiting with her mother.

"The note was given to my mother. I don't know what was written in it. The provider told my mother to just bring the note here to Bakwadianga (Polymbu) hospital to have the ultrasound done." – Exit interview

4.4 Summary

Overall, across the interviews most youth seem to be satisfied with the information and services they received, with only a minority making it clear that the services did not satisfy what they came for and seven experiencing judgemental comments. However, analysis of the data reveals more nuances that suggest SRH services were not delivered according to the WHO standard requirements, nor aligned with the WHO principles of SRH as is illustrated in Table 2, inspired by a similar table by Carai et al. (2015), the findings in relation to the quality of service included a scope for improvement in relation to the standards for quality health care relevant to the data.

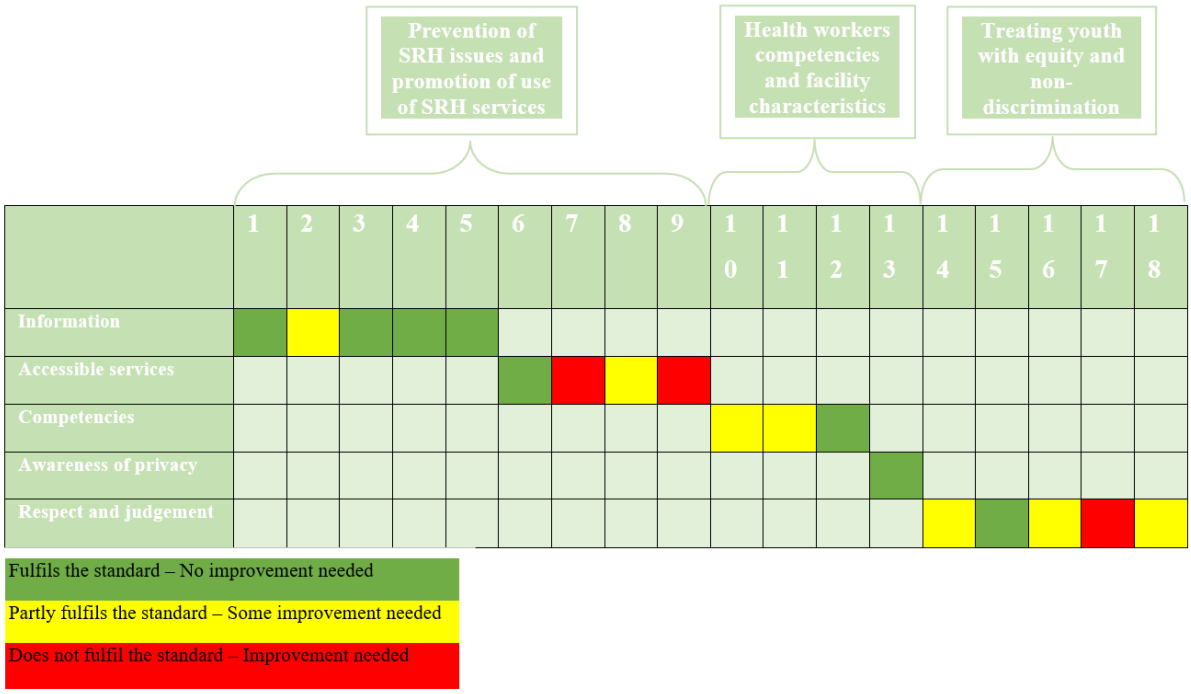

Table 2: An overview of how the codes have informed the sub-themes and themes. The individual codes are presented as numbers 1-18;1- Information about condoms and condom use, 2- Information on alternatives and other available contraceptives, 3- Information on prevention and treatments of STIs and HIV/AIDS, 4- Information on menstrual hygiene, 5- Information on gender based violence, 6- Encourages youth to come for another visit and invite others to visit as well, 7- Provides a way of contacting the facility, 8- The services offered at the facility are available, 9- Ensures that services not offered the facility are accessible, 10- Health workers and other staff offer a warm welcome, 11- Health workers encourage youth to utilize SRHS, 12- Health workers ensure that youth are comfortable and feel safe, 13- Health workers, staff and facility offers youth a sense of privacy, 14- Health workers do not discriminate based on gender, 15- Health workers do not discriminate based on age, 16- Health workers do not discriminate based on clothes or appearance, 17- Health workers trust that youth are truthful, and 18- Health workers do not discriminate based on personal bias.

5 Discussion

The findings generated through analysis of the data were presented according to each of the three sub-themes in the chapter above. This chapter will discuss the findings of the study in relation to other empirical studies and the underlying conceptual framework and specify how it is relevant to answering the research questions. For the discussion, all the eight standards as well as the six principles of SRH are included. This initial discussion will follow the same structure as the results chapter above whilst including the research questions. Following this, the broader implications of the study findings for public health and refining the intervention and future interventions will be discussed. Finally, possible changes and improvements will be presented.

5.1 Prevention of SRH issues and promotion of use of SRH facilities.

The data presented in the results chapter show that the quality and quantity of information made available to the different youths range from condoms being mentioned, to a walkthrough of use and benefit of both male and female condoms, with health care workers ensuring that the information they do provide is clear and understood. The quote displaying the lesser amount of information on condoms also exemplifies a health worker who clearly lets personal bias and judgement shine through when meeting with youth clients. This is not consistent with the third principle of SRH, nor standard 4 and 6 regarding providers competencies and equity and non-discrimination. Health workers' attitudes and behaviours play a crucial role in increasing or reducing the existing stigma around SRH for youth. Having positive attitudes and behaviours increases the likelihood of these types of services being used in the future (Jonas et al., 2017). Being greeted and treated in a respectful and helpful manner will further increase the benefits of quality SRH care among youth as it may result in youth recommending each other to visit and visit themselves if they ever are in doubt about an SRH issue (Jonas et al., 2017).

As for accessibility, the results chapter show facilities heavily relying on the health workers themselves promoting their services and encouraging youth to visit more frequently and to influence their peers to do so as well. As Cislaghi et al. (2021) state, the peer approach such as this will likely be more successful among girls as their study show that this group is more influenced by their peers than boys.

It is important that the health workers encourage youth to return. However, this should be implemented not only by health workers but also by the whole facility through readily available information about opening hours and services. The findings show examples of inappropriate and judgemental behaviour from staff as well as long waiting times. This also reduces accessibility and likely the utilization of services, therefore, making efforts to improve on behaviour among staff in general may aid in making SRH services more accessible (Jonas et al., 2017).

The results also show positive examples related to accessibility; however, this is also due to the health workers efforts of encouraging youth clients to return anytime, bring their friends and boyfriends and recommending regular visits. Looking to standards 2 and 7, as well as principle 4 implementing such behaviours on a larger scale will likely increase the utilization of health care facilities and services.

5.2 Health workers' competencies and facility characteristics

For this theme, the findings again show a range, from youth clients feeling unwanted, to feeling comfortable, to feeling they received a warm welcome and were made to feel very comfortable. The range typically stems from the behaviours and attitudes of health workers. However, in one instance the health workers wish to be of assistance, but due to the ongoing strike they cannot provide this. This example highlights the point made by Dieleman et al. (2009) about the importance of taking context into consideration when creating interventions. The voluntary national review report for the sustainable development goals issued by the DRC government states that the DRC struggles with corruption, high levels of violence and sexual violence and the people having low confidence in governmental institutions. This results in a complex and volatile context for providing quality SRH services (République Démocratique du Congo Ministère du Plan, 2020).

In addition to this, the second theme looks at health workers awareness of privacy. This is closely linked to the fifth principle of SRH, standard 4 and 5 as well as the heightened vulnerability experienced in youth mentioned by Corley et al. (2022; WHO, 2017; WHO & Unaids, 2015). Standard 4 focuses mainly on the health workers upholding and ensuring privacy, and that the youth clients feel comfortable and safe sharing their concerns. Standard five strictly relates to the characteristics of the facility and how they facilitate the feeling of privacy. It is included in the subtheme because, as we can see in the findings chapter the layout of the facility also has to be utilized by the health workers in a manner that promotes privacy. As shown in the findings an office with doors does not have privacy if other workers continuously enter the room asking questions and disturbing. This can relate to the experiences recounted by Kelly et al. (2022) where the facilities cater to privacy, but could not be used properly due to the Covid-19 pandemic. This exposure might increase the feeling of stigma and shame youth clients feel when visiting such facilities (Corley et al., 2022).

Another point of interest in the results is that there seems to be a lack of good information and updates in the waiting room, and often these questions do not get answered until the youth clients meet with the health worker, if they are answered at all.

5.3 Youths are treated with equity and non-discrimination.

This theme closely relates to standard 6, 4 and the third and sixth principles of SRH. According to the findings this is the theme that is furthest from fulfilling these requirements. The findings show some examples where the judgemental attitudes and discrimination from

health workers is explicit. There are examples of youth clients being treated with respect throughout, but there are several of the interviews where the health worker mentions something in passing that stem from provider bias and judgemental attitudes. The findings show how observant these youth are when it comes to social cues. The youth client who at first thought the health worker was ridiculing her, but later understood he was only trying to empathize exemplifies a case where the youth's awareness of the situation helped resolve what could have potentially been a very unfortunate reaction. However, health workers cannot rely on this level of emotional and social intelligence when delivering their care and will have to carefully manage both their tone and their mannerisms to not appear mocking or judgemental. There are also several examples of providers not trusting the statements provided by youth. Such attitudes and behaviours may reduce the utilization of SRH services and in turn increase the SRH risk factors in the area (Jonas et al., 2017).

5.4 Refining the intervention to amplify the public health impact

Following an intervention such as this, it is important to also consider the repercussions an effective intervention might have on the youth in the community. Although the focus of this thesis is on the experience of youth clients utilizing the health facilities, the end goal is ultimately to improve the SRH health outcomes of youth. To achieve this aim, thoroughly implementing interventions which seek to address all eight standards as well as the six principles is essential. This includes comprehensive interventions targeting structural, political, social, and individual levels (WHO, 2017). For example, to legislate these rights of youth in the DRC as well as making facilities and the ways to reach them more accessible through public transport, education, location, operating hours, and general health facility infrastructure changes to improve privacy (Denno et al., 2021; Engel et al., 2019; Ninsiima et al., 2021). This would be more focused on SDG 16, but as Egbende et al. (2023) suggests this will have a high impact on the provision of health services in the DRC. Standard 1, 2 and 8 focus on involving youth and the wider community in developing and evolving the SRH services in their area. Implementing this along with the experience the health workers gained with the collaborative learning approach through the intervention, may enhance the effectiveness of the intervention to improve the quality of SRH services and health outcomes among youths (Carai et al., 2015; Odimba et al., 2021). In the long run this could aid implementation and understanding of SRH issues in the community as well as decrease

perceived stigma regarding youths SRH which again would promote use of the SRH services available to them. This will aid in reaching the goals set at the ICPD as well as SDG 3 and 5.

5.5 Limitations

Due to the timeframe, scope, and design of this thesis there are some important limitations to consider in interpreting the findings. One limitation relates to the way in which the data were analysed in this thesis, both the fact that secondary analysis of qualitative data is challenging without knowledge and experience of the context to aid in interpreting the findings but also that the coding process was done by myself who has no prior experience analysing data. As Braun and Clarke (2006) specify, any thematic analysis should be a collaboration, and at the very least the data should be read and coded by more than one researcher. Due to the researcher being from a high-income country with openness around sexuality, SRH and readily available health services, the contrast when reviewing data from a low-income country, with a different culture and norms will likely make the impression of the data stronger than if the background of the participant and the researcher were more similar. There is a closeness in age between the participants and the researcher, however, one cannot attribute age to be a common denominator when the context surrounding differs to such an extent.

Another limitation is as mentioned previously the language barriers. There is also the matter of cultural and Lingala turns of phrase. There are sayings in Lingala that were not directly translatable to French nor English. After the discussion with Drs. Landry and Kanzeza it became clear that in Lingala, one uses the words for mother, father and other close relations as a sign of respect. Several of the transcripts contained such turns of phrase, making it challenging as a stranger to this culture to discern whether participants were actually related to the health workers or if it was, as Drs. Landry and Kanzeza could tell me that it was, a term of respect.

As a consequence of the researchers lack of involvement in data collection, the analysis is based primarily on the transcripts, the previous study and the data collection manual in addition to a discussion with two members of the local DRC research team who were in Norway as part of their Phd work. This results in lacking a depth of understanding of the context, and any details in the participants tone of voice for instance cannot be grasped. It also excludes the option for taking the wider context of the interview into account and the

option of using member checking to validate the interpretations made in analysis (Candela, 2019).

Further, a limitation is that as this is an ongoing study the researcher did not have access to all the data available. This resulted in some contextual information lacking, such as the duration of the MC interview and the ages of 11 of the 16 MCs. This impacts the reliability, credibility and confirmability of the interpretations of the data in this thesis (Malterud, 2017; Thomas & Magilvy, 2011). Finally, there is the matter of transferability and validity (Malterud, 2017; Thomas & Magilvy, 2011). The study remains ongoing, but for this thesis the number of participants is low and reduces the transferability of the research.

6 Concluding remarks

The results show health workers that, compared to previous similar studies, provide SRH services of a higher quality to youth comparing them to the standards for quality health care and the six principles of SRH. This is likely due to the intervention they were subject to, which supports the claim that multifaceted interventions are more effective. Youth utilizing the services of the health workers who took part in the intervention, experience less judgement and poor behaviour and attitudes from health workers. Youth are largely more satisfied with service from these health workers than previous studies suggest is typical without an intervention. There are still improvements to be made and some youths do report experiences of highly judgemental attitudes and poor behaviour from the health workers, whilst other left the facility dissatisfied with the service. Following this study one can work towards furthering the use of the standards of quality care as well as the six principles for SRH when shaping interventions. These are elements that, if thoroughly implemented, will not only improve the SRH in that area, but also the overall public health. In the future, a comprehensive multifaceted intervention rolled out to other areas of the country with a rigorous monitoring and evaluation component might make a larger impact.

7 Literature

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Appendix

Appendix 1: Interview guide Mystery Client interviews

- After training, mystery clients conduct visit to an assigned health facility/facilities using an assigned script/scenario.
- Mystery clients make field notes immediately after the visit on waiting times, what was discussed during the visit, and their perceptions of the health facility and worker and services/information given.
- Mystery clients are interviewed as soon as possible following their visit to minimize recall bias.

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain informed consent.

Step 2: Ask the participant to complete the table below on socio-demographic information prior to beginning the interview.

Step 3: Conduct the interview. Take detailed notes/Audio record the interview if participant agrees.

Socio-demographic information of participant:

Age:

Sex:

Highest level of education:

Profession:

Name of health facility that services were received at:

Interview date:

Start time:

End time:

Interviewers:

1. Could you please tell me about your visit to the health facility and how it unfolded from start to finish?
2. Probes if not addressed in the above question: Today, during your consultation or counselling session:

a) Did the health worker greet you?

b) Did the health worker make eye contact?

c) Did the health worker offer you a seat?

d) Did the health worker ask what the purpose of your visit was?

e) Did the health worker listen with attention?

f) Did the health care worker treat you in a friendly manner?

g) Was the health care worker respectful of your needs?

h) Did you feel that support staff were friendly and treated you with empathy and respect?

2. Did the health care worker assure you at the beginning of the consultation that your information will not be shared with anyone without your consent?

3. Do you feel that the health information provided during the consultation was clear and that you understood it well?

4. Did the health worker check to see if you understood the information correctly?

5. Did the health care worker give you a detailed referral note, if applicable, (stating the health condition, address of the referral, working hours and cost of services)?

6. How satisfied are you with the health services you received today?

7. Are there any other issues that came up during the consultation that you would like to discuss?

Thank you for your time and participation in this discussion.

Appendix 2: Interview guide Youth client exit interview

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain informed consent.

Step 2: Ask the participant to complete the table below on socio-demographic information prior to beginning the interview.

Step 3: Conduct the interview. Take detailed notes/Audio record the interview if participant agrees.

Socio-demographic information of participant:

Age:

Sex:

Highest level of education:

Profession:

Name of health facility that services were received at:

Interview date:

Start time:

End time:

Interviewers:

1. Could you please tell me about your visit to the health facility and how it unfolded from start to finish?

2. Probes if not addressed in the above question:

Today, during your consultation or counselling session:

a) Did the health worker greet you?

b) Did the health worker make eye contact?

c) Did the health worker offer you a seat?

d) Did the health worker ask what the purpose of your visit was?

e) Did the health worker listen with attention?

f) Did the health care worker treat you in a friendly manner?

g) Was the health care worker respectful of your needs?

h) Did you feel that support staff were friendly and treated you with empathy and respect?

2. Did the health care worker assure you at the beginning of the consultation that your information will not be shared with anyone without your consent?

3. Do you feel that the health information provided during the consultation was clear and that you understood it well?

4. Did the health worker check to see if you understood the information correctly?

5. Did the health care worker give you a detailed referral note, if applicable, (stating the health condition, address of the referral, working hours and cost of services)?

6. How satisfied are you with the health services you received today?

7. Are there any other issues that came up during the consultation that you would like to discuss?

8. Can you tell us about one aspect you liked about your experience in visiting the health facility?

9. Can you tell us about one aspect you did not like about your experience in visiting the health facility?

Thank you for your time and participation in this discussion.

Appendix 3: Research article, to be sent to PLOS ONE

RESEARCH ARTICLE

Youths' perceptions and experiences of sexual and reproductive health services received from health workers trained as part of a package of interventions to improve motivation, skills, and performance in the Democratic Republic of Congo

Youths' experiences of quality of sexual and reproductive health care in the DRC

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Abstract

In the Democratic Republic of Congo (DRC) girls and young women are vulnerable to poor sexual and reproductive health (SRH) outcomes. This due to early sexual debut, transactional sex, unprotected sexual activity, and violence, including gender-based and sexual violence. The attitudes, skills, and competencies of health workers impact the quality of sexual and reproductive health services (SRHS) and subsequent utilization and uptake of services. This study aimed to explore youths' perceptions and experiences with SRHS provided by health workers who have been trained as part of a package of interventions to improve motivation and performance to deliver SRH care and services to youth. A qualitative study was conducted as part of an ongoing study in two provinces in the DRC; Kinshasa and Kasai Oriental. 32 semi-structured interviews with 16 youth mystery clients and 16 youth who participated in exit interviews after visiting the health facilities were conducted. Data were analysed thematically according to the WHO Standards for quality health care for adolescents and the six principles of SRH. Youths' perceptions and experiences of the quality of care they received varied. The majority reported that they felt either satisfied or very satisfied with service, how they were welcomed and the way the health workers received them. A few of the youth indicated they were not satisfied and left the facility feeling as if though they had not received the answers, care, or treatment they hoped for. Findings indicate that contextual factors such as strikes, number of clients and lack of medical equipment may hinder health workers in delivering high quality services to youth. Several of the interviews indicate that health workers made judgemental and inappropriate comments to the youth clients. Despite the overall positive perceptions and experiences reported by youth, there are still improvements to be made in the SRHS and care delivered by the health workers. The findings show there is an ongoing need for efforts to improve health worker attitudes, competencies, and skills to meet the needs of youth and to ensure health workers have an enabling environment that motivates them to provide quality care to youth. By also implementing a focus on the eight standards of quality health care and the six principles of SRH in future interventions, comprehensive interventions may improve the SRH outcomes in sub-Saharan Africa and aid in fulfilling target 3.7 of the Sustainable Development Goals (SDG), which aims to reach universally available SRH care including information, education, family planning by 2030.

Keywords: Youth, mystery clients, Sexual and reproductive health, Health workers, Democratic Republic of Congo.

Background

In the sub-Saharan Africa girls are vulnerable to poor sexual and reproductive health (SRH) outcomes due to factors such as a forced sexual debut, transactional sex, unprotected sexual activity, violence, and sexual violence (1). To improve the SRH of youth, it is essential to ensure access as well as improve the sexual and reproductive health services (SRHS) available to them. Youth-friendly health services staffed with competent, empathetic health workers are needed to ensure utilization of health services by youth (2).

A collaborative study in the Democratic Republic of Congo (DRC) funded by the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and the World Health Organization (WHO) developed and implemented a package of interventions aimed at improving the knowledge, attitudes, skills and competencies of health workers and health managers. The package of interventions included the provision of job descriptions, training and refresher training, desk reference tools, supportive supervision and collaborative learning (3). Young girls' sexuality and sexual activity are often stigmatized and negative experiences with SRH care can limit the utilization of SRHS, leading to poor health outcomes (4, 5).

Although focus on SRH issues and provision of quality SRHS have increased in recent years the utilization of such services remains minimal in low- and middle-income countries. Barriers to providing quality SRHS to youth in these countries are low motivation among health workers, their environment not enabling them to perform their duties, lack of competencies needed to provide quality care and judgemental attitudes towards youth seeking SRHS (4, 6).

High fertility rates in sub-Saharan Africa can be attributed to limited access to and use of contraceptives and condoms, child marriage, traditional attitudes, cultural norms and poverty. A general lack of SRHS and education, along with health workers lacking competencies and behaving in a disrespectful manner are factors impacting the fertility rates (7-10). To improve SRH outcomes among youth, issues of access alongside quality of the SRHS available to them must be addressed (2).

Melesse et al. (7) found that 28% of girls in sub-Saharan Africa marry before the age of 18, with 54% of girls having their sexual debut before 18. Additionally, 47% of girls give birth by the time they reach the age of 20. These levels are declining, but remain high, especially in rural and poor areas with less education (7). SRH information is not readily available and often withheld by health workers resulting in youth not having access to quality information regarding their SRH (11). In Kinshasa youths' communications regarding SRH is

particularly low. This may be connected to a lack of knowledge and social barriers limiting the space to discuss such topics (12).

This is supported by a study using mystery clients (MCs) to evaluate SRHS at two different facilities in Tanzania. McHome et al. (13) found that the MCs experienced health workers' reception as inadequate and even hostile. The MCs reported health workers as being rude, lacking knowledge of condoms, behaving unprofessionally, and letting personal, judgemental attitudes influence the service they provided. Additionally, MCs experienced long waiting times and received inadequate information (13).

Other challenges related to SRH in sub-Saharan Africa are gender-based violence, unsafe abortions, taboos surrounding sexuality, lack of information and disrespectful treatment regarding family planning, and limited access to youth-friendly health services (9, 12, 14, 15). These factors may result in sexual risk behaviours leading high sexually transmitted infections (STI) and HIV prevalence, early pregnancies, and increased risk of delivery complications resulting in high morbidity and mortality (14).

SRH challenges can also be rooted in sociocultural norms related to SRH and gender bias (16). When seeking out SRHS, youth may experience less autonomy concerning treatment and counselling, as well as little regard for privacy, confidentiality, and respect shown by health workers (17). Stigma, shame, culture, and embarrassment can cause youth to avoid seeking SRHS, due to fear that the community or family will find out. This issue of privacy was heightened through the Covid-19 pandemic. With restrictions such as social distancing, healthcare facilities were forced to have lines outside of the building, reducing privacy and reinforcing the fear of stigma mentioned above (18). The Covid 19-pandemic had a large negative impact on Sustainable Development Goal 3 related to good health and wellbeing (19). Improving the peace, justice and strengthening institutions as in SDG 16 will likely make it easier for health facilities and health workers in the DRC to provide quality health services and aid in the DRCs government aim of fulfilling SDG target 3.7. SDG target 3.7 aims to reach universally available SRH care including information, education, family planning and the integration of SRH into national policies in the DRC (20-22).

To address SRH issues and improve the provision of SRHS, comprehensive approaches which address factors at the individual, community, institutional (health facilities) and structural levels are needed. Evidence suggests that training health workers as an approach on its own, is insufficient to catalyse sustainable improvement on all these levels (23). Multifaceted interventions that include strategies such the provision of job aids, supportive supervision, collaborative learning, and the combination of interactive and

participatory training may be more effective than one-off training (23, 24). Job aids such as desk reference tools, and collaborative learning work best as a part of a multifaceted intervention (24). A study done in Moldova suggests collaborative learning and job shadowing to further the improvements at newly implemented youth-friendly health service facilities (25). Health workers displaying positive attitudes and behaviours towards issues concerning sexuality among youth may increase the likelihood of youth and young women seeking and utilizing the health care services available. This in turn may lead to increased knowledge and contraceptive use among youth and reduce some of the SRH risk factors these groups face, such as early or unwanted pregnancies and unsafe abortions (5).

This study aims to develop an in-depth understanding of how youths receiving care from health workers trained as a part of the GFATM/WHO study experience the quality of care they receive, if they are satisfied with the services provided, and if they perceive that they were treated with respect, empathy and, in a non-judgemental manner during their visit to the health facility. This knowledge will indicate where the GFATM/WHO intervention succeeded and where improvements are still needed, which will be important for refining the package of interventions. In turn this will aid in ongoing research regarding health worker interventions focused on quality SRHS to youth.

Conceptual framework

The quality of care will be assessed using the WHO standards for quality health care services for adolescents, as well as the six principles of SRH (26, 27). The WHO standards for quality health care services aim to guide service delivery and improve quality in SRH facilities. The main standards relevant to the analysis in this study are standards 3 (Appropriate package of services), 4 (Providers competencies) and 6 (Equity and non-discrimination), with aspects of standard 1 (Adolescents health literacy) and 5 (Facility characteristics). The WHO emphasises the inextricable link between sexual health and reproductive health and presents an operational approach for developing interventions to improve SRH. Six principles form the foundation for the model presented in the operational approach (26). These six principles will be included in the conceptual framework of this study to triangulate the standards presented above and offer up the view of SRH care to the standards for quality health care aimed at adolescents and youth. The first principle focuses on sexual health as more than the absence of ill health. The second principle addresses the overlapping nature of sexual health and reproductive health. The third principle touches on the matter of health as a human right, and that sexual health is an integral part of our health. The fourth principle discusses how family,

community, peers, law, policies, and other structural factors can affect sexual health on an individual level (26). The fifth principle addresses the fact that our SRH and SRH needs change through the course of a lifetime. The sixth and last principle states that interventions must meet standards for quality care, such as the ones presented above, be evidence based and be provided in a respectful and positive manner. This includes maintaining privacy and confidentiality, ensuring that health workers are trained, competent and non-judgemental, that information is presented clearly, without coercion and that facilities stock adequate quantities of supplies (26).

Methods

Ethics statement

The study received ethical approval by the University of Kinshasa's ethics review board and the WHO ERC (ERC.0003228). When presenting quotes in the results section, participants remain anonymous apart from specification as to whether they were MCs or youth exit interviews. All MCs and youth participating in exit interviews signed an informed consent form (3). Before each interview the study purpose was described, and participants were given an informed consent form, which described the nature of their participation and how the data would be used.

Study design

A qualitative study based on a phenomenological approach among youth was conducted in order to develop an in-depth understanding of their perceptions and experiences of services they received from health workers (28-30). The data consists of two different types of interviews, the MC interviews, and the youth exit interviews.

Study site

Data were collected in two areas of the DRC, the capital Kinshasa and Mbuji Mayi, the largest city in the province Kasai Oriental. The geographical distribution of these sites were chosen based on HIV rates among adolescent girls and young women between 15-24 and the presence of health services already supported by the GFATM (3).

Participant recruitment

Young women between 18-25 from the study areas were eligible to participate as MCs and in the youth exit interviews. As there are few youths utilizing the SRHS available, the research group found it challenging to recruit participants for the youth exit interviews. MCs were recruited from The Congolese Youth Association Network. MCs were selected by senior members of the local research team at the University of Kinshasa. Factors such as literacy, professionalism, interpersonal skills, distance from residence to the relevant health facility and ability to take good field notes were taken into consideration. Potential MCs were screened to identify if any had previously been exposed to gender-based violence-related trauma. Any potential MCs who reported this were excluded from the study and referred to counselling. This was to be certain that they would not be exposed to psychosocial harm through their participation in the study (3). Youth exit interview participants were approached after their visits and asked to participate. The sample in this study consists of the MCs (n=16) along with youth (n=16) who were recruited at the health facilities to participate in exit interviews. The participants range from 18-25 years old and were all female. The full number of participants included in this study is 32. All health workers the youth received services from were trained as part of the GFATM/WHO implementation study.

Data collection

MCs participated in a three-day training. This training was based on standardized training programs for MCs and included sessions on ethics and confidentiality, roleplay, expectations of standards of care, memory techniques, how to ask information, and how to conduct reports and observations (3). The MCs were given different scenarios to role play when seeking services from the health workers. These all included the MC asking for information about an SRH related issue for a friend or themselves. The different scenarios covered asking about STIs, asking about, and requesting condoms, and sharing experience with gender-based violence from a boyfriend and asking the health worker for information on where to get help in the future. MCs were instructed to specify that they were only seeking information, and not to allow any invasive procedures such as pelvic exams or blood tests. Semi-structured interview guides were developed for each of the scenarios, as well as for the youth exit interviews. The MC interview guides consisted of seven main questions with suggestions for and possibility to ask follow up questions, the youth exit interview guides consisted of nine questions, also with suggestions for follow-up probes to obtain more in-depth information.

A total of 32 semi structured interviews were conducted with youth clients that had received services from the health workers trained as part of the study. The interviews were

conducted in French, with some local phases in Lingala, and later translated into English. All interviews were done individually and in a private setting. The youth exit interviews lasted from 12-45 minutes. There is no data on the length of the MC interviews, but these were likely slightly longer, as they contain more rich data.

Data analysis

The analysis was done using the English transcripts. The two types of interviews, MC and exit interviews, were triangulated to develop a comprehensive understanding of the experiences and perceptions of youth visiting the health workers who took part in the intervention. The analysis was informed by Braun and Clark's thematic analysis approach (29). General themes, sub-themes and codes were generated keeping the conceptual framework of the study in mind. After the initial coding process the transcripts were read again and themes, sub-themes and codes revised. This resulted in 18 different codes, sorted under 5 sub-themes with 3 overarching themes. Each of the three themes correspond with one of the WHO standards of quality health care. Theme 1 – Prevention of SRH issues and promotion of use of SRH facilities corresponds with standard 3, with elements of standard 1. It is also linked with the fourth and sixth principles of SRH. Theme 2 – Health workers competencies and facility characteristic corresponds with standard 4, with elements of standard 5. This theme aligns with the fifth principle of SRH. Lastly, theme 3 – Treating youth with equity and non-discrimination corresponds with standard 6 and the third principle of SRH.

Results

The results are presented according to the main themes that were generated through analysis. As mentioned previously, the two data sets were triangulated to develop an understanding of perceptions of quality of care and overall youth satisfaction with services received.

1 Prevention of SRH issues and utilization of SRH facilities

1.1 Information provided by health workers

The provision of information is included in several of the WHO standards (2). The sixth principle for SRH states that information should be provided clearly and without coercion, whilst promoting informed decision making (26). Findings from the MC interview data indicate that MCs were given an in-depth explanation of use and benefit of condoms that fulfils the requirement of standards of quality health care and the sixth principle of SRH.

«He gave for the use. For the boys, he said: you get it out of the package first, before you use it. You hold the condom tip. Now the boy rolls it over the penis so that he can't touch the tip, because if he touches the tip in any movement, it can tear and there are those sperms that can come out and transmit diseases. […] He said, the feminine is worn like this: as soon as you take it out of the package, there is something inside in the form of a lace. You take this thing, you form the number 8. You introduce it into the vagina, if it progresses, it comes to the vagina and it fixes itself. When it fixes itself, now you take the thing out, you throw it away and it sticks to the lips." – Mystery client

The example above shows an in-depth explanation done concisely and clearly as the MC can recall the information. However, there are cases where information on condoms provided to youth does not meet either standard or the sixth principle as shown below.

"She didn't talk about kinds of condoms. She said that there are many methods to prevent infection, but only mentioned condoms. She didn't show me, she didn't say where to find it nor how to use it. […] She spoke just for the condoms. She advised and just said that if you want to have sex, you have to have condoms in order to avoid infections and also to avoid getting pregnant because we teenagers today like to have sex before marriage, which is not good, which is not worthy of a girl. So, we girls must be given values, we must give respect to our body, we must avoid sexual intercourse before marriage. That is what is not good.» - Mystery Client

1.2 Making services accessible

According to standard 1, facilities and health workers should contribute to enhancing health literacy among youth by making themselves accessible through outreach strategies, information, and communication. Standard 3 states that the facilities should provide information, counselling, diagnostics, care, and treatment. These standards link to the first and fourth principles of SRH. Regarding promotion of positive sexual health and general wellbeing, and the levels of influence on sexual health. Accessibility is based on whether the services are made easily accessible and openly available to the clients after their visit. This could be through referrals, inviting them or others back, offering contact information or setting up another appointment. This quote from one of the youth exit interviews exemplifies what happens when this is not the case.

"He didn't give me a reference document, in my thoughts I thought that as he didn't fulfill well what was my desire for which I had gone, I thought he was going to send me even to someone else who could explain to me and fulfill what was my desire as I was looking for I asked him if there was anyone else he told me that there was no one else besides him in that structure." – Exit interview

The example above shows how the lack of information and counselling given, along with the lack of a referral leaves the youth feeling as if the health worker did not meet her needs. An interview with an MC enacting the gender-based violence script exemplifies the health worker making themselves and their services available both to the MC and others.

«Yes, she told me that if in the future I encountered a similar situation, calling me a whore by wanting to use a condom or even if he hit me that I could not give in to these threats and insults. He may be a man who is sexually active and has his diseases that he wants to pass on to me, if I give in, I'll be at risk. And that if a man wants us to have unprotected intimate relations, to go to a hospital to be examined to know our health status, if he refuses, I should be constant and refuse too. Even if he started to insult me, calling me a whore, that I could refuse, because it is risky. […] She didn't tell me, she just told me to come back to her without hesitation if I have any problems in the future. And that she is there for us young people. And that if my boyfriend would get back together with me, that I would bring him to her, maybe he is just ignorant and lacking in information that this way protects him too. Maybe I am the one with the disease and using a condom will protect him from getting the disease. […] Yes, she did as I mentioned above. She is available at all times and if needed, she herself took my phone number to call me to check up on me."- Mystery client

As shown above there are instances where health workers make themselves and the facilities accessible and available to both the visiting youth client and potential other clients. This aligns with the requirements set in standard one and three as well as well as the first and fourth principle of SRH. However, this is not the norm, and many interviews recount experiences more closely related to the first quote presented.

2 health workers' competencies and facility characteristics

2.1 Health workers' competencies in offering quality healthcare to youths.

Theme 2 covers health workers being encouraging, welcoming, and ensuring that youths feel comfortable. This theme relates to standard 4 and 5, health workers competencies and facility characteristics. The element included off standard 5 is in what way the facility as well as the workers facilitate and maintain a sense of privacy. This theme aligns with principle five of the SRH principles regarding the fact that our sexual health changes through our lives, as do we. Therefore, one might be more vulnerable and susceptible to ill health and experience barriers to SRH care. One MC recalls an experience that exemplifies a truly warm welcome:

> *«Yes, I was welcomed very well. It was a young nurse and she immediately directed me to the doctor who in turn received me well and we talked. The whole team was ready to receive me, they were interested in me, presented me with a chair and were very kind to me. They even offered me a drink and even put my phone on charge to help me because I was lobbed, they were really nice" – Mystery Client*

On the other hand, there is one interviewee that waited 3 hours for a previously agreed upon appointment, without being notified of the wait. "*We had made an appointment at 9am, I also went at 9am and she arrived around 11am. She apologized for the delay in the appointment time."* - Mystery Client

In one youth exit interview the health workers were on strike and could therefore not provide the quality of care expected. However, through this interview it becomes apparent that the health workers try to offer her the care they can, this exemplifies the importance of context and how one must take potential unrest into consideration. It also shows the importance of attitude and behaviour and how this can make a difference on impression even when the service provided is poor due to other factors.

> *"Yes, he listened to me attentively, he listened to me to understand everything I said when I was speaking, he paid attention to me, everything I explained to him he listened calmly until I finished speaking. After that he started to advise me he was not distracted at all but I had noticed that he was very afraid because they are on strike and he was afraid that he had someone spying on him to see if they have opened the centre or not. He was very afraid and that's why we were isolated I think that it was this fear that made him a bit distracted to other things that I was telling him." – Exit interview*

> "I am satisfied because I was welcomed, I was given a place despite it being closed and he also listened to me. I am not satisfied because the provider spoke so quickly because he was afraid that he would be caught consulting, for him what he was doing was against the norms. he told me that I came at a bad time, they are tailing us to see if we receive the patients or not. If you see, almost all the doors are closed. So I'm not satisfied because I didn't find the full solution to my problem." – Exit interview

The importance of welcome and comfort offered by both health workers and other staff is best illustrated by one of the MCs who points out the importance of a warm welcome, as well as positive attitude and behaviour from the health workers:

> *"But I wanted to add something, regarding the providers, they must be welcoming because we know that we young people are complicated. If we have to train them again, we have to insist on their attitude and welcome. When we go to them for advice and guidance, they must be attentive and open to the youths in order to better support us and solve our problems. From the attitude of the provider can decide to open up and expose his problem." – Mystery client*

2.2 Health workers' awareness of privacy needs of youth

Privacy relates both to the structure of the facility such as the layout of the waiting room and offices, as well as the aforementioned vulnerability regarding sexual health that might occur during this time of heightened need for privacy (2, 4). When it comes to privacy most of the interviews are conducted in an office without others present, in some cases there are three people in the room. This is either another nurse or a family member. The example below shows how an office, that may seem more private, might not be sufficient. This highlights the importance of providers competencies in standard 4 and them being aware of the surroundings and how different behaviours might affect the youth clients. *"Well with the environment like that you can't really concentrate because there were too many entrances there, so concentrating on one person, no, but he was attentive to what I was saying. People coming in would interrupt the discussion, they would ask for something." – Exit interview*

Reviewing these findings connected to theme 2 it is clear that the main issue here is providers competencies. Regarding confidentiality, the findings did not show youth clients were assured of this, however, there seems to be an implicit understanding of conversations being private. "*No, he did not reassure me. Well, he didn't tell me that, but this is from myself.*

I know that with a doctor and the patient there is always a secret." – Exit interview. That same interviewee mentions being reassured of confidentiality, but this was at a previous visit to the same doctor.

3 Treating youth with equity and non-discrimination

3.1 Health workers and staff treat youth with respect and in a non-judgemental manner.

This section focuses on the theme based in standard 6. Specifically, that SRHS should be provided in a non-discriminatory and non-judgemental fashion. This aligns with the third principle of SRH regarding prospect, protection, and the fulfilment of human rights. One has the right to freely exercise control over matters regarding sexuality and sexual health. One interview offers an example of how discrimination and judgemental attitudes might occur. The following quote occurs when the MC is asked if the health provider made any negative comments on her appearance.

> *"Yes, especially about my clothing and gender. He said to me: "you are old enough and your buttocks are much bigger, such buttocks are what boys are looking for. Furthermore, you should have bigger breasts". I told him: "that's not your problem, just answer me for what I came to look for". He said to me: "as you do not answer me, I also do not answer you". When I emphasized on my concern and told him that I had to attend the classroom, he started to answer me." – Mystery client*

Several of the participants recount statements from the health workers that suggest distrust such as in the example above. Another example of this is health workers not initially believing the youth's statements about their sexual activity. *"She also asked me if I was still a virgin. She had a hard time believing me when I told her I was still a virgin. She also asked why I wanted to start having sex with a man." – Mystery client*. Another example of distrust is this. *"He asked me if I had ever slept with men, I am a girl who has not known men. He told me to tell the truth, I told him that I have not known men." – Exit interview.*

In one instance the youth client's final impression of the interaction differs from how she initially perceived the interaction. However, the hesitation the youth client expresses show that health workers must be very conscious of how their tone and choice of words as this could easily be misinterpreted.

"He did not criticize me or say anything inappropriate. He respected me. Well! at first, I thought he was being insincere when he was comforting me, telling me I'm not married yet and I'm already pregnant, how I'm going to make it with the classes. But later I understood that he was not criticizing me, he was putting himself in my shoes and trying to help me." – Exit interview

There are examples of health workers generally making youth clients feel comfortable and safe, while also making statements brought up in the interviews that may seem judgemental and show a lack of respect. In the quote below the two comments are made answering two different questions.

"When I told her it was for a friend she said: Hmmm, is it really for a friend? I said: Yes of course! if it was for myself I was going to say it; then she added you young people of today really! […] and then she said that you young people like to put too much stuff there (in the vagina), it's not good. On condoms, she mentioned, she said especially you young people, most of you don't know how to calculate your dates but even if you do, you should always use condoms, that's the best method I can suggest; because if I told you abstinence, I know you're not going to get it. She did not mention other contraceptive methods, only emergency pills and condoms. She added, you also protect yourself, can't you wait until marriage? "– Mystery client

An example of lack of respect due to judgemental attitudes and behaviour connected to age that also infringes on the right to decide freely on matters of sexual health is when the following happens to an 18-year-old client visiting with her mother. *"The note was given to my mother. I don't know what was written in it. The provider told my mother to just bring the note here to Bakwadianga (Polymbu) hospital to have the ultrasound done." – Exit interview*

3.2 Assessment of experienced quality of care

Overall, findings indicate that most youth were satisfied with the information and services they received, with a minority making it clear that the services were not fully satisfactory, and several reported experiencing judgemental comments. With respect to the standards and principles, findings reveal more nuances that suggest SRHS were in general not delivered according to the WHO standard requirements nor aligned with the WHO principles of SRH. As is illustrated in Table 1, inspired by a similar table by Carai et al. (25), the findings in

relation to the quality of service included a scope for improvement in relation to the standards for quality health care relevant to the data.

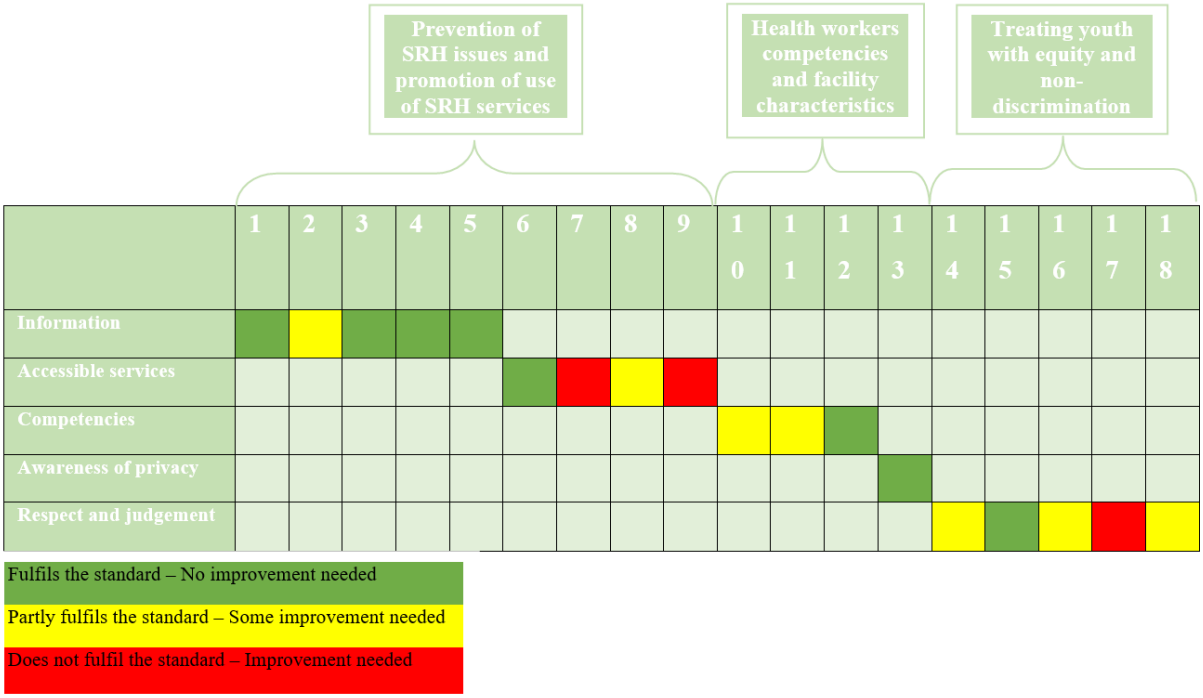

Table 1: An overview of how the codes have informed the sub-themes and themes. The individual codes are presented as numbers 1-18;1- Information about condoms and condom use, 2- Information on alternatives and other available contraceptives, 3- Information on prevention and treatments of STIs and HIV/AIDS, 4- Information on menstrual hygiene, 5- Information on gender based violence,6- Encourages youth to come for another visit and invite others to visit as well, 7- Provides a way of contacting the facility, 8- The services offered at the facility are available, 9- Ensures that services not offered the facility are accessible, 10- Health workers and other staff offer a warm welcome, 11- Health workers encourage youth to utilize SRHS, 12- Health workers ensure that youth are comfortable and feel safe, 13- Health workers, staff and facility offers youth a sense of privacy, 14- Health workers do not discriminate based on gender, 15- Health workers do not discriminate based on age, 16- Health workers do not discriminate based on clothes or appearance, 17- Health workers trust that youth are truthful, and 18- Health workers do not discriminate based on personal bias.

Discussion

This study, conducted in the capitol and one of the larger cities in the DRC using mystery clients and exit interviews, highlighted shortcoming in SRHS provided to youth, such as health workers not trusting the statements youth clients made and poor accessibility due to lack of information. This study contributes to the evidence base concerning youth perceptions and experiences of receiving SRHS and highlights the importance of addressing their needs in the provision of SRHS.

The triangulation of the interviews along with the triangulation of the WHO standards for quality health care and the principles of SRH enabled a close examination of SRHS aimed at youth, that revealed gaps in the provision of each of the relevant standards; Lacking opportunities to contact SRH facilities, services are not accessible and that health workers meet youth clients with distrust. Other findings corroborate previous findings regarding poor behaviours, judgemental attitudes, disrespect, discrimination. That these are present but not reported by a minority of participants is consistent with previous research (9-11, 17, 25). This is not consistent with the third principle of SRH, nor standard 4 and 6 regarding providers competencies and equity and non-discrimination (26, 27). Health workers attitudes and behaviours play a crucial role in increasing or reducing the existing stigma around SRH for youth. Having positive attitudes and behaviours increases the likelihood of youth seeking out and utilizing health services in the future (5). Being greeted and treated in an empathetic, respectful and non-judgemental manner will further increase the benefits of quality SRH care among youth as it may result in youth recommending each other to seek out SRHS and come back themselves if they ever are in doubt (5).

Consistent with other studies in low- and middle-income countries information regarding condoms and condom use as thorough and given in a clear manner that the youth clients understand (6, 13, 16, 31, 32).

The findings reveal that facilities rely on the health workers themselves promoting their services and encouraging youth to visit more frequently and to influence their peers to do so as well. As important as it is that the health workers encourage youth to return, a general sense of encouragement should be implemented at the facilities using clear opening hours, welcoming staff, and readily available SRH information (18). Inappropriate and judgemental behaviour from staff and long waiting times reduces accessibility and likely the utilization of services. Thus, reducing the quality of SRH in the area (5).

Reports of health workers competencies varied. Some youth felt as if they were unwanted at the facility, they reportedly felt unwelcome and hurried. Others were made to feel at home, referring to staff as friendly and treating them as family. These differences in experience are also in line with previous MC studies (13, 17, 25).The differences are largely due to the behaviours and attitudes of the health workers the youth meet. Ensuring that the youth client feels comfortable as well as a ensuring privacy is closely linked to the fifth principle of SRH, standards 4 and 5 as well as the heightened vulnerability experienced in adolescence mentioned by Corley et al. (2, 4, 26).

Standard 4 focuses mainly on the health workers upholding and ensuring privacy and

that the youth clients feel comfortable and safe sharing their concerns. This can relate to the experiences recounted by Kelly et al. where the facilities cater to privacy, but could not be used properly due to the Covid-19 pandemic (18). There are only a few participants who report experiencing a lack of privacy. This is not consistent with previous studies where a substantial number of MCs have reported lack of privacy (13, 16). There are no statements of confidentiality in our findings, yet youth clients feel that their information is safe. This disparity is likely due to youth clients meeting health workers in private consultation rooms, and the general feeling of comfort that is reported. One participant reports a lack of privacy due to several people entering the room during her consultation, such exposure might increase the feeling of stigma and shame youth clients feel when visiting facilities (4).

Further, one participant reports unsatisfactory SRHS due to an ongoing strike, and health workers therefore not being able to provide the youth client with comfort. This highlights the importance of taking context into consideration when developing interventions (1, 23). The voluntary national review report for the sustainable development goals issued by the DRC government states that the DRC struggles with corruption, high levels of violence and sexual violence and the people having low confidence in governmental institutions. This results in a complex and volatile context for providing quality SRHS (33). Several instances of discriminating and judgemental comments made by health workers were noted by participants. Reports show health workers judgemental remarks and discrimination due to gender and looks that stem from the health workers provider bias and judgemental attitudes. This is similar to findings done in previous studies where youths have been treated with judgmental attitudes and provider bias (6, 13, 16, 31, 32). Nevertheless, this did not seem to affect the youths' overall experience and perception of service, despite mentioning such comments and behaviours most of the affected participants still report being satisfied with service. In future interventions such behaviours and attitudes need to be addresses as evidence from other youth SRHS studies show that these may reduce the utilization of SRHS and in turn increase the SRH risk factors in the area (4, 5).

The findings of this study regarding youth perceptions and experiences of receiving sexual and reproductive health services from health workers provides valuable insight that will be used to further refine the package of interventions, as there are still several rounds of data collection planned in the study. Additionally, the study findings contribute to the evidence base which focuses on the provision of youth-friendly health services. To improve the quality of sexual and reproductive health services and increase health seeking behaviours among youth, which will ultimately improve health outcomes among this group, rigorous

development, implementation, and evaluation of interventions which seek to address all eight standards as well as the six principles of SRH is essential. Comprehensive interventions targeting structural, political, social, and individual levels will support change of SDG 16, and as Egbende et al. (2023) suggests this will have a high impact on SDG 3 and the provision of health services in the DRC (22). For example, to legislate these rights of youths in the DRC as well as making facilities and the ways to reach them more accessible through public transport, location, operating hours, and general health facility infrastructure changes to improve privacy (18, 26).

Limitations

This study was subject to limitations that should be considered when interpreting the results. Firstly, meaning may have been lost in the translation of transcripts from French and short phrases in Lingala to English. Discussions with Drs. Kazenza and Egbende, who are fluent in all three languages, aimed to minimize this issue. Additionally, while the study provides valuable insights into the experiences of youth in these two communities in the DRC, the findings may not be fully generalizable to other populations in other settings and further studies are needed to understand the needs and preferences of youth. Due to difficulty recruiting participants for the exit interviews, as few youths utilize SRHS, the sample might not be representative of the population of youth in these areas.

Conclusions

Findings show that overall youths' perceptions of and experiences with the care provided by the health workers who were trained as part of the GFATM/WHO intervention are positive. However, there are still improvements to be made, the findings suggest that continued efforts towards improving health workers, attitudes, competencies, and skill are essential to meet the needs of youth and the criteria set through the eight standards for quality health care, as well as the six principles for SRH. By creating an enabling environment where health workers feel motivated to provide quality care, whilst also implementing the standards and principles in future interventions, more comprehensive interventions may improve SRH outcome in sub-Saharan Africa an aid in fulfilling SDG 3.7 by 2030.

Acknowledgements

Particular thanks go to Drs. Benito Kazenza and Landry Egbende, local researchers from the DRC who provided important contextual information and insights in verifying the interpretation of the data.

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