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THE UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG YOUNG PEOPLE: A CROSS-SECTIONAL STUDY IN GREECE

Theodora Zoitaki[1], Christina Dimitrakaki[2], Venetia Notara[3,4], Evanthia Sakellari[3,4], Areti Lagiou[3,4]

1. Saint Panteleimon General Hospital of Nikaia, Piraeus, Athens, Greece
2. Centre for Health Services Research, Department of Hygiene, Epidemiology and Medical Statistics, University of Athens Medical School, Athens, Greece
3. Laboratory of Hygiene and Epidemiology, University of West Attica, Athens, Greece
4. Department of Public and Community Health, University of West Attica, Athens, Greece

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Corresponding author*
Theodora Zoitaki[1]

Aim: To explore young people's experiences of public or private services received for their sexual and reproductive healthcare.
Materials and Methods: A cross-sectional study was carried out involving 358 students from vocational post-secondary education during the academic year 2018-2019, using a questionnaire based on the directions of the Youth Friendly Sexual and Reproductive Health Services (SRHS) proposed by the International Planned Parenthood Federation (IPPF).
Results: Out of 358 students, only 35(9.78%) visited public health services, while 85 (23.74%) visited both public and private services. Gynecologists, in private sectors, were visited by 127 students of whom 34.6% and 33,1% were between the ages of 18-20 and 21-30 years, respectively. 111 students (31.01%) did not use any service. A slight difference between the staff friendliness and the services received between the public and private sectors was observed. Similarly, a marginal lead was apparent in the private sector with regards to the availability of appointments, emergencies, and privacy. In the public sector, fewer participants were informed of the abortion services available.
Conclusions: The satisfaction rate was quite high regarding healthcare consultation, in both sectors. However, counseling on contraceptive methods, information on the prevention of sexually transmitted infections, and other aspects of sexual and reproductive health were not satisfactorily covered. Finally, participants wished for more counseling and a greater focus on personal concerns.

INTRODUCTION

Good Sexual and Reproductive Health (SRH) among young people is an important factor for personal development and prosperity, in modern societies. Informing young people about SRH will assist in the reduction of maternal mortality, the improvement of maternal and newborn care, as well as in the prevention and treatment of sexually transmitted infections (STI's), as part of the 2030 Agenda for Sustainable Development adopted by the UN Member States.[1,2] However, SRH, also includes safe abortion services, treatment of infertility and cervical cancer, counseling for gender-based violence, and care for sexual health and well-being. Sustainable Development Goals (SDG) support the quality of maternal and newborn health but also uphold gender equality so that every person understands his/her Sexual and Reproductive Health and Rights (SRHR). [1] Utilization of Sexual and Reproductive Health Services (SRHS) contributes to the systematic use of modern contraceptive methods, to the reduction of unwanted/unplanned pregnancies, and to decrease the risk of sexually transmitted infections (STI). However, partner and sexual violence remain critical issues that must be incorporated into preventive strategies. [2]

These services reinforce critical thinking and skills against problems that are, to a large extent, avoidable. However, the usefulness of the SRHS is not only limited to the prevention of threatening health conditions among young adults but also enhances their ability to distinguish between practices that promote health as opposed to practices that are detrimental to both physical and mental health. This enables them to resist violent behavior and create healthy and equal relationships. [3,4]

International studies have demonstrated the way SRHS encourages young people to consult public or private health services and thus help to alleviate problems, which are harmful to their social and emotional development. [5] However, in Greece, the relevant information has not been recorded.

The present study has followed the main guidelines set by the World Health Organization (WHO) on Youth-friendly Health Services in terms of accessibility, acceptability, equity, and appropriateness, the need for confidentiality, anonymity, safety, and privacy, as well as the behavior and competence of health professionals.[4] It has also investigated the quality of services provided in both public and private sectors, and whether they meet young people's needs and fulfill the social goals of the Sustainable Development Agenda for 2030.[4,5] These goals include quality improvement in maternal and newborn health care while ensuring gender equality.

The study aimed to assess young people's satisfaction and to explore any apparent differences and similarities in the available services between the public and private sectors. Also, the purpose was to demonstrate the importance of information and counseling on issues related to young people's sexual and reproductive health and rights (SRHR), as presented by the W.H.O.[4,5]

MATERIAL AND METHODS

A cross-sectional study was conducted from November 2018 to March 2019 at seven Public Post-Secondary Vocational Training Institutes in the Athens area. To collect the data, a structured questionnaire based on the directions of the Youth Friendly Sexual and Reproductive Health Services suggested by the International Planned Parenthood Federation.[6] The questionnaire was available online and was back-translated and adapted into Greek conditions. Statistical analysis was performed using SPSS v.25.

The questionnaire included five sections: a) Socio-demographic characteristics (age, sex, marital status, number of children, education), b) Utilization of SRHS in the public sector, c) Utilization of SRHS in the

private sector, d) Utilization of SRHS in both private and public sectors and e) No use of any SRHS. Each section included nineteen questions about the type of offered services, eight questions on accessibility, two questions on effectiveness, and twenty questions on equity (yes/no) were also included. Moreover, there were questions about the acceptability of the SRHS such as the right to safety, privacy, and confidentiality, the right to dignity and comfort and the right to the continuity of care (yes/no), and questions on the behavior of the staff in both sectors (i.e. "did the staff treat you in a friendly manner (yes/no)"; questions about staff communication skills, whether choices were given to see the same person at each return visit and questions about the right to express their opinion, as an acceptability measurement, and about their knowledge on the available services for their SRH in both sectors.

STATISTICAL ANALYSIS

The survey was based on a quantitative methodology. Absolute (n) and relative (%) frequencies were used for the description of qualitative variables. The variables are non-normally distributed and a non-parametric test was chosen to find the differences. Bivariate analyses between dependent and independent variables were performed using chi-square ($\chi 2$). Independent variables included public and private sector and dependent variable included questions about Sexual and Reproductive Health Services. For the final interpretation of statistical significance, p=0.05 was used. Also, the SPSS 25.0 (Statistical Package for Social Sciences) was used for the statistical analysis.

Ethical considerations

Ethical approval was obtained from the hospitals' scientific councils where the Post-Secondary Vocational Training Institutes belong and the study was carried out according to the Declaration of Helsinki (1989). Anonymous questionnaires were used. All participants were in advance informed about the objectives of the study and their voluntary participation. Submission of the completed questionnaire was considered as informed consent. Withdrawal from the study did not affect their academic achievement.

RESULTS

In **Table 1**, out of 162 participants, 45,2% had visited either the public and/or the private sector; 126 (99.2%) females and 1 (0.8%) male had visited the private sector, of whom 52(2.3%) were between the ages of 18-20 (p=0.001) and 111 participants had visited any SRHS, of whom 69 (62,2%) were between the ages of 18-20 (p=0.001).

Regarding equity of access to SRHS, 80% of the participants from both sectors revealed that youth-friendly SRHS were available for men and women, regardless of whether they were sexually active, while 75.7% of those who did not visit either sector replied that SRHS is open for individuals regardless of marital status (married, unmarried with or without children). With regards to the knowledge of SRHS in the public sector, 61.1% who visited private sectors answered that they were aware of the SRHS in the public sector. Out of those who visited any services to receive SRH information, 54.8% replied that they knew about such facilities in the public sector. As for the main reasons for visiting SRHS, 53.3% was for Pap smears, in the public sector, while 80.3% visited the private sector for the same reason (**Table 2**).

Comparing public and private services, the results differ depending on the type of service provided. Specifically, 42.9% from the public sector compared to 37% from the private sector answered they received information on STI's/HIV protection and prevention. Regarding the waiting time, most of the participants replied a reasonable lag time from the scheduled appointment, in the private sector compared to the public one (66.45% vs 50%).

In terms of accessibility, 94.5% were more satisfied with the private sector compared to 65,6% from the public sector. In emergency cases, 67,9% experienced long waiting periods and 25% managed to see a health professional without having an appointment, in the public sector, compared to 42.4% and 38.2% respectively, in the private sector (p=0.023).

As for the effectiveness of the services they received, the proportion of positive answers/feedback was higher among the participants who visited the private sector (98.4% vs 82.4%). About safety issues, in both sectors, more than 90% answered they did not have any problems or difficulties with the services they received in the clinics. Concerning privacy concerns, 76.6% answered they were alone at the time of receiving their physical examination, in the private sector compared to 74.3% in the public one (p=0.008). About knowledge on available services, 60.7% of the participants were not aware of the existence of abortion services, in the public sector (p=0.010).

Regarding confidentiality, in health professional behavior and communication skills no statistical differences were observed between the sectors. However, in the private sector, the proportion of positive answers was higher.

Responses on the ability to choose a healthcare professional and to offer feedback on the services received, or to recommend the services to relatives or friends, were not statistically different between the two sectors. Among the participants who had never visited any SRHS, 57.3% answered that it was not necessary to receive any sexual and reproductive consultations. The most common reasons for future visits were to receive information on HIV, to have STI/HIV testing, for a vaginal ultrasound and Pap smears, while 45.9% were for contraceptive methods. The majority of the participants 75 (67.6%) reported internet/websites, as the main source of information (**Table 2**).

DISCUSSION

The current study tried to assess the utilization of SRHS in public and private sectors according to the W.H.O. guidelines for Youth-Friendly Family Planning Health Services. The main aspects under consideration were accessibility, acceptability, equity, appropriateness, and effectiveness in promoting sexual and reproductive health, in young people. Regarding equity, most of the participants had positive experiences regardless of gender, sexual orientation, marital, and family status. Equity in SRHS is an intrinsic policy, which should be applied to everyone no matter sex differences.[1] Traditionally, while males are less inclined to consult these types of services, there is also a "never-before" opportunity for SRH services to address the needs of both sexes. Such an initiative would help to achieve the goals of the Agenda for Sustainable Development 2030 which promotes gender equality regardless of sexual orientation or gender identity.[7,8]

In this study, the participants used both sectors mainly for Pap tests. The preference to schedule Pap tests privately, even though there was a fee, was convenient as it allowed for simultaneous gynecological ultrasound tests and clinical breast examinations. However, in the public sector, the scheduled appointments are not so flexible. According to a study at the family planning services in the USA, Pap tests were the main reason for visiting private or public SRHS. It was argued that the lack of counseling on STI's/HIV tests was the main reason for young people neglecting to take the necessary tests.[9] A substantial number of studies identified that SRHS should be incorporated in every sector so that young people can have examinations and counseling at the same place.[9,10,11]

The counseling rates were the same in both sectors. Considering the relatively recent guidelines for Family Planning Units in

Greece, healthcare providers need the knowledge to apply specific issues on protection and prevention not only on STI's/HIV but also for intimate partner violence (IPV) and gender equality.[12] A positive approach to young people's sexuality, including aspects of well-being, body image, and positive sexual experiences through the perspective of acceptance and pleasure, boosts young people's self-confidence, self-esteem, and personal development.[13] In similar studies it was noted that communication and counseling conducted by health providers in clinical settings increased the intention of young people to choose the appropriate contraceptive method, to use condoms regularly, minimizing the rates of unintended pregnancies and STI/HIV.[14]

According to several surveys, waiting rooms cause great stress to visitors due to the fear of being noticed by acquaintances. [15] Another barrier could be the fear of passive/unintentional disclosure for the reason of visiting these services, caused feelings of discomfort, great distress, and anxiety.[16] Regarding the waiting time in public services, about half of the participants stated that the waiting time was long. According to another study, it was found necessary to have a flexible schedule and to expand the operation of the services offered during the afternoon hours (as already proposed by the participants in this study).[17] Studies have observed long waiting times as being synonymous with a lack of respect for young people, which often prevents them from visiting SRH services.[18]

Regarding the regularity of health check-ups, in the public sector only half of the participants answered that they received information about their next appointment, while in the private sector, most of the participants were well informed for their follow-up visit. Moreover, there was little information on the existing services in the public sector and most of the participants were unaware of the public SRHS for young people (61,1% out of those who had visited private facilities were informed of SRHS public services while 54.8% were unaware of public SRHS services and had never visited them). Therefore, providing more information on these free services on sexual and reproductive issues would be beneficial. [19,20]

The respondents were greatly satisfied with regards to the respect and the anonymity of their data by the health professionals. The idea of securing confidentiality and therefore anonymity was the most important element in young people's evaluation, even more than the friendly behavior of the staff, flexible working hours, and easy access to the service.[15] In our study, the participants were satisfied with the health providers' communication skills. The most important issue was the use of simple language, which helped them feel comfortable enough to return for their next visits. However, the time to express their concerns was not sufficient. This is consistent with another study regarding the time available to clients who did not receive all the information for their treatment and had concerns on issues relating to sexual activity and relationships. Additionally, they were not given all of the information on their treatment because of lack of time and therefore did not follow any instructions they were given.[17] Due to strictly clinically-centered orientation, communication between the health provider and the client is limited.[17,18]

An interesting finding was that more than half of the participants who had visited both private and public sectors did not know about additional services provided, such as safe abortion services, services related to experiences of sexual abuse, physical, or emotional violence, emergency contraceptives, contraception counseling. Recently, the WHO set certain guidelines about the concept of appropriateness which also applies to the referral system and referral linkages aiming to fulfill the needs of young people. [21] However,

according to the research results, the referral process did not seem to exist or function, at the expense of young people's SRH, since participants did not seem to know they could use these services even if they had been abused.

In the public sector, regarding the choice of healthcare providers, the majority of the participants stated that they did not have the opportunity to choose a man or woman staff member, nor to choose the same healthcare provider in future visits. It has been pointed out that it is particularly difficult and uncomfortable for anyone to recount his/her health concerns to different health professionals, not only in subsequent visits but also during the same visit. [15]

It has been reported that health professionals recognize the value of young people's comments about the services they have received, but they do not ask about the quality of these services.[18] The responses from our survey regarding the possibility of commenting on the services received were negative, at a rate of 90.9-92.7%, in both sectors. Young people's participation in the design and implementation of programs for their sexual and reproductive health acts as a way of communicating and interacting with health professionals. As the literature suggests, further interaction between visitors and health providers could increase the degree of responsiveness to these programs by young people.[22,23]

Participants were not adequately informed about the existence of public SRH services. It is observed that the 15-19 and 20-24 age groups have the highest rates of STI/HIV infections and unwanted/unplanned pregnancies. [24,25,26] Therefore, knowledge of the existence of these services is essential to these age groups for making responsible decisions about their health, avoiding unwanted situations against their physical and mental well-being.[26] As for the participants who did not visit any sector for their SRH, they received information mostly online and from friends. Many studies agree that youth information sources are derived mainly from the internet, friends, and relatives. Therefore, building stimulating and up-to-date websites with reliable data are of paramount importance. [27,28,29]

Limitations

The study sample was relatively small and the survey was carried out in the metropolitan area of Athens. Therefore, it is rather difficult to generalize the results in a certain age-group.

However, the study provides valuable information on the existing difficulties that health care services are confronted with, to alter them from youth-friendly to youth-responsive.

CONCLUSION

Regardless of the general satisfaction with the sexual and reproductive health services, in both public and private sectors, several concerns arose about the services given by the healthcare providers, who only gave clinical instructions and did not respond to their client's needs. Moreover, participants chose the private sector for their SRH, although no differences were observed in the availability of services and health professionals' competence in the public sector.

Healthcare professionals need to have enough time for young people to express their personal views and feelings. Personalized counseling on modern contraceptive methods, combined with the encouragement to use a condom, and prevention of STI's/HIV, must be provided in every sexual and reproductive health care sector.

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CONFLICTS OF INTEREST

None to declare

REFERENCES

[1]. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, Coll-Seck AM,

Grover A, Laski L, Roa M, Sathar ZA, Say L, Serour GI, Singh S, Stenberg K, Temmerman M, Biddlecom A, Popinchalk A, Summers C, Ashford LS. Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. Lancet. 2018;391(10140):2642-92. doi: 10.1016/S0140-6736(18)30293-9, PMID 29753597.

[2]. Boyer JA. Time to lead: A road map for progress on sexual and reproductive health and rights worldwide. Guttmacher Institute; 2018. Available from: https://www.guttmacher.org/sites/default/files/article_files/gpr2103518x.pdf [cited 10/12/2020].

[3]. Michielsen K, De Meyer S, Ivanova O, Anderson R, Decat P, Herbiet C, Kabiru CW, Ketting E, Lees J, Moreau C, Tolman DL, Vanwesenbeeck I, Vega B, Verhetsel E, Chandra-Mouli V. Reorienting adolescent sexual and reproductive health research: reflections from an international conference. Reprod Health. 2016;13:3. doi: 10.1186/s12978-016-0117-0. PMID 26758038.

[4]. World Health Organization (WHO). Making health services adolescent friendly: developing national quality standards for adolescent-friendly health services; 2012. Available from: https://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf;jsessionid=C1ABA87FD9A81722108896C7F79E5690?sequence=1https://apps [cited May 20, 2020].

[5]. Sustainable development goals; 2015 [cited Jul 13 2020]. Available from: https://www.un.org/sustainabledevelopment/sustainable-development-goals/.

[6]. International Planned Parenthood Federation (IPPF). Springboard: A hands-on guide to developing youth-friendly services. London: INTERNATIONAL PLANNED PARENTHOOD FEDERATION EUROPEAN NETWORK; 2008 [cited Jul 13, 2020]. Available from: https://www.ippf.org/sites/default/files/inspire_springboard.pdf.

[7]. Chandra-Mouli V, Parameshwar PS, Parry M, Lane C, Hainsworth G, Wong S, Menard-Freeman L, Scott B, Sullivan E, Kemplay M, Say L. A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it. Reprod Health. 2017;14(1):85. doi: 10.1186/s12978-017-0347-9, PMID 28728586.

[8]. Munea AM, Alene GD, Debelew GT. Quality of youth-friendly sexual and reproductive health services in West Gojjam Zone, northwest Ethiopia: with special reference to the application of the Donabedian model. BMC Health Serv Res. 2020;20(1):245. doi: 10.1186/s12913-020-05113-9, PMID 32209071.

[9]. Liddon N, Steiner RJ, Martinez GM. Provider communication with adolescent and young females during sexual and reproductive health visits: findings from the 2011-2015 National Survey of Family Growth. Contraception. 2018;97(1):22-8. doi: 10.1016/j.contraception.2017.08.012, PMID 28882681.

[10]. World Health Organization (WHO). Integrating sexual and reproductive health-care services. Vol. 2; 2006. Department of Reproductive Health and Research. Policy briefing [cited May 6, 2020]. Available from: http://whqlibdoc.who.int/policy_briefs/2006/RHR_policybrief2_eng.pdf.

[11]. Ketting E, Esin A. Integrating sexual and reproductive health in primary health care in Europe: position paper of the European Forum for Primary Care. Qual Prim Care. 2010;18(4):269-82. PMID 20836943.

[12]. Greek Ministry of Health. Family planning acts. 2015 [cited May 6 2020]. Available from:

https://www.moh.gov.gr/articles/health/dieythnsh-prwtobathmias-frontidas-ygeias/agogi-ygeias/programmata-prwtobathmias-frontidas-ygeias/3395-egkyklios-leitoyrgia-monadwn-oikogenei.

[13]. Chandra-Mouli V, Svanemyr J, Amin A, et al. S1-S6. http://doi:10.1016/j.jadohealth.2014.09.015. Twenty years after the International Conference on Population and Development: where are we with adolescent sexual and reproductive health and rights? J Adolesc Health. Vol. 56(1); 2015.

[14]. Slater C, Robinson AJ. Sexual health in adolescents. Clin Dermatol. 2014;32(2):189-95. doi: 10.1016/j.clindermatol.2013.08.002, PMID 24559553.

[15]. Bender SS, Fulbright YK. Content analysis: a review of perceived barriers to sexual and reproductive health services by young people. Eur J Contracept Reprod Health Care. 2013;18(3):159-67. doi: 10.3109/13625187.2013.776672, PMID 23527736.

[16]. Mazur A, Brindis CD, Decker MJ. Assessing youth-friendly sexual and reproductive health services: a systematic review. BMC Health Serv Res. 2018;18(1):216. doi: 10.1186/s12913-018-2982-4, PMID 29587727.

[17]. Alli F, Maharaj P, Vawda MY. Interpersonal relations between health care workers and young clients: barriers to accessing sexual and reproductive health care. J Commun Health. 2013;38(1):150-5. doi: 10.1007/s10900-012-9595-3, PMID 22782338.

[18]. Johnston K, Harvey C, Matich P, Page P, Jukka C, Hollins J, Larkins S. Increasing access to sexual health care for rural and regional young people: similarities and differences in the views of young people and service providers. Aust J Rural Health. 2015;23(5):257-64. doi: 10.1111/ajr.12186, PMID 25809380.

[19]. Thomée S, Malm D, Christianson M, Hurtig AK, Wiklund M, Waenerlund AK, Goicolea I. Challenges and strategies for sustaining youth-friendly health services — a qualitative study from the perspective of professionals at youth clinics in northern Sweden. Reprod Health. 2016;13(1):147. doi: 10.1186/s12978-016-0261-6, PMID 28003025.

[20]. Hultstrand Ahlin CH, Carson D, Goicolea I. 'There is no reward penny for going out and picking up youths': issues in the design of accessible youth healthcare services in rural northern Sweden. BMC Res Notes. 2019;12(1):74. doi: 10.1186/s13104-019-4108-4, PMID 30717774.

[21]. World Health Organization. Improving the quality of care for reproductive, maternal, neonatal, child, and adolescent health in the WHO European region.; 2016 [cited 20 May 2020]. Available from: https://www.euro.who.int/__data/assets/pdf_file/0009/330957/RMNCAH-QI-Framework.pdf?ua=1 [accessed 20 May, 2020].

[22]. Villa-Torres L, Svanemyr J. Ensuring youth's right to participation and promotion of youth leadership in the development of sexual and reproductive health policies and programs. J Adolesc Health. 2015;56(1); Suppl: S51-7. doi: 10.1016/j.jadohealth.2014.07.022, PMID 25528979.

[23]. Braeken D, Rondinelli I. Sexual and reproductive health needs of young people: matching needs with systems. Int J Gynaecol Obstet. 2012;119; Suppl 1:S60-3. doi: 10.1016/j.ijgo.2012.03.019. PMID 22884824.

[24]. Apter D. Contraception options: aspects unique to adolescents and young adults. Best Pract Res Clin Obstet Gynaecol. 2018.

doi: 10.1016/j.bpobgyn.2017.09.010, PMID 29032945.

[25]. Bersamin M, Fisher DA, Marcell AV, Finan LJ. Reproductive health services: barriers to use among college students. J Commun Health. 2017;42(1):155-9. doi: 10.1007/s10900-016-0242-2, PMID 27604424.

[26]. Yared A, Sahile Z, Mekuria M. Sexual and reproductive health experience, knowledge and problems among university students in Ambo, central Ethiopia. Reprod Health. 2017;14(1):41. doi: 10.1186/s12978-017-0302-9, PMID 28292296.

[27]. Coronado PJ, Delgado-Miguel C, Rey-Cañas A, Herráiz MA. Sexual and Reproductive Health in Spanish University Students. A comparison between medical and law students. Sex Reprod Healthc. 2017; 11:97-101. doi: 10.1016/j.srhc.2016.11.004, PMID 28159136.

[28]. Nair M, Baltag V, Bose K, Boschi-Pinto C, Lambrechts T, Mathai M. Improving the quality of health care services for adolescents, globally: A standards-driven approach. J Adolesc Health. 2015;57(3):288-98. doi: 10.1016/j.jadohealth.2015.05.011, PMID 26299556.

[29]. Brittain AW, Loyola Briceno ACL, Pazol K, Zapata LB, Decker E, Rollison JM, Malcolm NM, Romero LM, Koumans EH. Youth-friendly family planning services for young people: A systematic review update. Am J Prev Med. 2018;55(5):725-35. doi: 10.1016/j.amepre.2018.06.010, PMID 30342635.

Table 1. Participant's socio-demographic characteristics (n=162)

	Public Sector		**Private Sector**		**Nowhere**		**P-value**
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**	
Sex							
Male	9	25,7	1	0,8	47	42,3	**0.001**
Female	26	74,3	126	99,2	63	56,8	
No answer	-	-	-	-	01	0,9	
Total	35	100	127	100	111	100	
Marital status							
Married	3	8,6	26	21,1	50	4,9	**0.001**
Divorced	1	2,9	10	8,1	3	2,9	
Single	22	62,9	52	42,3	71	69,6	
Permanent partner	3	8,6	26	21,1	10	9,8	
Other	5	14,3	9	7,3	13	12,7	
Age							
18-20	15	42,9	44	34,6	69	62,2	**0.001**
21-30	16	45,7	42	33,1	30	27,0	
31+	4	11,4	41	32,3	12	10,8	
Children							
Yes	3	8,6	33	26,0	6	5,4	**0.001**
No	32	91,4	94	74,0	101	91,0	
No answer	-	-	-	-	4	3,6	

Educational Status							
Secondary education	12	34,3	48	37,8	53	47,7	0.247
College	16	45,7	59	46,5	47	42,3	
University	7	20,0	16	12,6	6	5,4	
MSc	-	-	3	2,4	3	2,7	
PHD	-	-	1	0,8	2	1,8	

Table 2. Participants views and experiences of available Sexual and Reproductive Health Services

	Public sector n=35	**Private sector n=127**	**P value**
Equity			0.159
Boys and girls	28 (80%)	100 (80,0%)	
Knowledge of SRHS in public facilities	-	77 (61,1%)	-
Main reasons to visit SRHS	**Yes**	**Yes**	
Pap test	19 (54,3%)	102 (80,3%)	0.782
STI/HIV testing	14 (40,0%)		
HPV vaccination	10 (28,6%)		
Ultra sound		76 (59,8%)	
Mammalogical		59 (46,5%)	
Gynaecological issues		55 (43,3%)	
Information-Counseling	**Yes**	**Yes**	
STI/HIV protection	15 (42,9%)	47 (37,0%)	0.163
Body image, genital hygiene	14 (40,0%)	42 (33,1%)	0.782
Contraceptive methods	10 (28,6%)	50 (39,4%)	0.668
Emergency contraception	06 (17,1%)	20 (15,7%)	0.973
Relationships and sexual enjoyment	04 (11,4%)	15 (11,8%)	0.430
Unavailable services	04 (11,4%)	10 (07,0%)	0.515
Waiting room	**Yes**	**Yes**	
Just waiting	21 (60,0%)	79 (62,7%)	0.392
Listen to health talks	11 (31,4%)	18 (14,2%)	0.560
Talk to other clients	07 (20,6%)	22 (17,3%)	0.324
Read educational material	06 (17,1%)	36 (28,3%)	0.282
Watch an educational video	-	06 (04,7%)	-
Waiting time	**Yes**	**Yes**	
Acceptable	18 (50%)	(66,4%)	0.348
Accessibility	**Yes**	**Yes**	
Appointment availability	19 (57,6%)	103 (85,1%)	0.462
Easily get an appointment	23 (69,7%)	118 (95,2%)	0.493
In case of emergency:			
Available appointment	08 (25,0%)	47 (38,2%)	***0.023***
Opportunity to meet a health provider	19 (67,9%)	39 (42,4%)	0.348

Effectiveness	**Yes**	**Yes**	
Receive effective services/improve their health	28 (82,4%)	122 (98,4%)	0.965
Affordable service	27 (84,4%)	96 (78,0%)	0.912
Safety	**Yes**	**Yes**	
Problems/difficulties because of services they received	03 (09,1%)	10 (08,1%)	0.645
Confusion of participants	14 (46,7%)		-
Privacy	**Yes**	**Yes**	
Other people present in the examination room	09 (25,7%)	29 (23,4%)	***0.008***
Important to the participants the presence of a friend or relative during the physical examination	16 (47,1%)	43 (40,2%0	0.337
Confidentiality	**Yes**	**Yes**	
A separate room to receive medical and counseling services	21 (60,0%)	-	
Talk without being overheard	24 (68,6%)	106 (88,3%)	0.814
Re-examination	**Yes**	Yes	
Follow-up visits	19 (54,3%)	101 (81,5%)	0.096
Urged to use service when relevant problems occur	22 (64,7%)	104 (88,1%)	0.909
Health professional behaviour	**Yes**	**Yes**	
Friendly staff	28 (82,4%)	118 (97,5%)	0.492
Respectful staff	28 (82,4%)	117 (96,7%)	0.229
Secure personal data	27 (81,8%)	118 (99,2%)	0.965
Communication personnel skills	**Yes**	**Yes**	
Intelligibility of language used by health providers	33 (94,3%)	123 (97,5%)	0.923
Levels of empathy regarding sexuality and sexual relationships	30 (88,2%)	121 (99,2%)	0.856
Answered questions adequately/detailed answers	28 (80,0%)	121 96,0%)	0.847
Reassured participants if they felt uncomfortable and embarrassed	24 (68,6%)	121 (97,6%)	0.560
Comprehensive services	**Yes**	**Yes**	
Pap test	24 (77,4%)	117 (93,6%)	0.732
HIV counseling	18 (62,1%)	82 (65,1%)	0.633
Treatment of gynaecological matters	18 (62,1%)	109 (87,9%)	0.728
Pregnancy testing	13 (50,0%)	89 (71,8%)	0.537
Participants were not aware of:	**Not aware of**	**Not aware of**	
Abortion services	17 (60,7%)	71 (58,2%)	***0.010***
Services related to the experience of sexual, physical or emotional violence	20 (69,0%)	77 (62,9%)	0.394
Emergency contraceptives	20 (66,7%)	76 (61,8%)	0.762
Contraceptives (pills, IUD etc.)	19 (57,6%	54 (43,5%)	0.222
	16 (55,2%)	75 (64,1%)	0.297

Reference to other services			
Choice of who to see in public facility	**Yes** 07 (20,0%)	-	
Feedback	**Yes** 03 (09,1%)	**Yes** 09 (07,4%)	0.558
Recommend this service to a friend or relative	**Yes** 22 (66,7%)	**Yes** 119 (93,5%)	0.605