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The Role of Health Leadership Commitment in Shaping Adolescent-Friendly Sexual and Reproductive Health Service Quality in Pastoral Ethiopia

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Abstract

Adolescents require sexual and reproductive health services that are both accessible and of high quality. Nonetheless, there is still limited evidence on how leadership affects the quality of these services in Ethiopia, where adolescents represent a considerable segment of the population. When adolescent-friendly services are poorly delivered, their utilization tends to decline, potentially leading to higher occurrences of unintended pregnancies and sexually transmitted infections. This study, therefore, investigated the influence of leadership and assessed the quality of adolescent-friendly health services in the pastoral areas of the East Guji Zone, Ethiopia. This research used in-depth interviews and focus group discussions involving eight key informants and fifty participants. Study design: a programmatic qualitative approach was applied. Data collection was carried out using 22 semi-structured interview questions, and analysis was performed using ATLAS.ti7. Limited leadership engagement in the health sector and generally poor-quality adolescent-friendly sexual and reproductive health services were revealed. The inability to adequately fulfill key quality-of-care dimensions—such as accessibility, equity, availability, acceptability, and appropriateness—was identified as a major factor contributing to the weak service quality. The study found that insufficient leadership commitment within health facilities negatively affected the quality of adolescent-friendly sexual and reproductive health services in the pastoral communities of East Guji Zone. It is recommended that improvements be made in organizational preparedness and provider capacity, equity in service delivery be strengthened, and service models be redesigned through stronger leadership involvement, which is essential for enhancing service quality. The Ministry of Health, Ethiopia, and relevant stakeholders are advised to incorporate these recommendations to improve adolescent-friendly health services nationwide.

Keywords: Leadership commitment, Adolescent, Sexual and reproductive health, Health services quality, Health facilities, Pastoral community

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Introduction

Existing scientific literature highlights the critical need for high-quality sexual and reproductive health services for adolescents [1]. Within the Sustainable Development Goals (SDGs), quality health care is reflected in the objective to "achieve universal health coverage, including access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines for all" [2, 3]. In frameworks for improving healthcare quality, three core dimensions are commonly identified: effectiveness, safety, and patient-centeredness/responsiveness. Additional components, such as appropriateness, continuity, timeliness, and acceptability, are often incorporated into these core domains [4]. In this study, emphasis is placed specifically on patient-centeredness and effectiveness as primary dimensions, along with equity, acceptability, and satisfaction

as supplementary quality sub-dimensions, and on key drivers of quality improvement, particularly leadership and leadership commitment [4, 5].

Adolescent-friendly health services are designed to ensure that young people can access care without facing barriers related to health system structures, sociocultural norms, or personal characteristics. According to WHO service standards, quality-friendly healthcare should be available to all adolescents regardless of financial status, sex, age, marital condition, educational background, ethnicity, sexual identity, or any other distinguishing factor [6]. Despite this, persistent challenges remain in delivering high-quality sexual and reproductive health services worldwide, even following the implementation of the International Conference on Population & Development agenda [7]. Recent findings from the Ethiopian Mini Demographic and Health Survey (EDHS 2019) show that adolescents account for 26.9% of the national population. Although this group represents a large share of the population, the quality of adolescent-friendly health services remains inadequate across key dimensions, with reported levels of 58.8%, 46.4%, and 47.2%, respectively [8–10].

In contrast, global evidence indicates that only a limited number of health facilities provide adolescent reproductive health services of sufficient quality [1]. Existing literature emphasizes that adolescent-friendly services should be characterized by accessibility, acceptability, equity, appropriateness, and effectiveness [11]. Furthermore, sexual and reproductive health care is expected to comply with human rights principles, ethical medical practice, and technical standards, particularly those related to availability, accessibility, acceptability, and quality of care. Every individual is entitled to the highest attainable standard of health services, based on the four human rights principles of availability, accessibility, acceptability, and quality [7]. When adolescent-friendly sexual and reproductive health services are of high quality, they enhance patient safety, increase service utilization, strengthen trust in the health system, and reduce the likelihood of sexual and reproductive health complications. Public health facilities are more likely to attract adolescent clients when they deliver high-quality services.

Nevertheless, many low- and middle-income countries, including Ethiopia, still face significant challenges in improving the quality of these services [1, 12, 13]. For instance, evidence from South Africa revealed that district-level health facilities did not meet the minimum standards required for adolescent-friendly health services. This highlights the necessity for health facilities to understand adolescents' specific needs and to ensure strong commitment to delivering high-quality care [14]. However, without strong leadership commitment across different levels of the health system, achieving quality adolescent-friendly services in public health facilities is not feasible. Additionally, effective budgeting, development of client-friendly infrastructure, and ensuring the availability of essential medicines, supplies, and equipment cannot be achieved without leadership involvement in decision-making regarding human and material resources.

The Ethiopian health system is organized into an administrative hierarchy consisting of the Ministry of Health, Regional Health Bureaus, Zonal Health Departments, and Woreda Health Offices. The service delivery structure is organized into a three-tier system comprising primary healthcare units, general hospitals, and specialized hospitals. Primary healthcare units comprise health posts staffed by health extension workers, health centers, clinics, and primary hospitals staffed by frontline healthcare professionals. These primary healthcare units deliver the majority of adolescent-friendly health services. Evidence from Southern Ethiopia indicates that youth-friendly service delivery in public health facilities is inconsistently organized and poorly coordinated, largely due to weak leadership commitment within health institutions.

Furthermore, the same study highlighted a continued lack of sufficient evidence regarding the quality of youth-friendly services in Southern Ethiopia [15]. In addition, the Ethiopian government has invested substantially over the past two decades in strengthening health system infrastructure and expanding the health workforce, resulting in increased coverage of primary healthcare units, general hospitals, and tertiary-level facilities. However, despite these efforts, significant inequalities in both access and quality of healthcare services persist across and within regions [13].

This study was carried out in two primary healthcare units, specifically type "A" and type "B" health centers (Wadara & Harekelo). Adolescent-friendly health services are widely recognized as cost-efficient approaches for addressing major sexual and reproductive health (SRH) challenges such as HIV/STIs, unsafe sexual behavior, unintended pregnancies, unsafe abortion, and complications related to pregnancy. Ethiopia remains one of the sub-Saharan African countries with the highest rates of adolescent and youth mortality worldwide [16]. The elevated burden of illness and death among Ethiopian adolescents is largely attributed to low uptake of SRH services. One key underlying reason for this low utilization is the poor quality of adolescent-friendly SRH services [17]. Against this background, the present study investigates the quality of adolescent-friendly health service delivery and examines the contribution of leadership within pastoral communities of East Guji Zone, Ethiopia. The results are intended to contribute to the academic literature as a reliable source of evidence and to provide detailed insights into service quality in public health facilities serving pastoral populations. In addition, the study aims to generate useful information for policymakers and stakeholders to support improvements in adolescent-friendly health service provision.

Research question: To what extent does leadership commitment affect the quality of adolescent-friendly sexual and reproductive health services in public health facilities in pastoral districts of Guji Zone?

Materials and Methods

Study settings and participants

Focus group discussions

Two districts in pastoral settings were purposively selected for this research. Gorodola and Wadara districts were included because of their known low utilization of adolescent-friendly sexual and reproductive health (AFSRH) services in East Guji Zone. These districts were also chosen because they have relatively large adolescent populations, linked to their wide service catchment areas. Participants for the focus group discussions (FGDs) were adolescents who had been using adolescent-friendly services at health centers for at least six months. In addition, representatives from youth centers within the same catchment areas were included. Each focus group consisted of 8–12 participants.

In-depth interviews

In-depth interviews (IDIs) were conducted with individuals who had direct exposure to adolescent-friendly health services either as health system decision-makers at different administrative levels or as service providers working in health facilities. Senior-level informants included experts and coordinators who were involved in designing adolescent and youth health strategies and overseeing program implementation. These participants were considered important sources of information regarding service quality. IDI participants were recruited from the Federal Ministry of Health (FMoH), the Oromia Regional Health Bureau (ORHB), the Zonal Health Department (ZHD), health center (HC) leadership, and healthcare providers (HCPs) with at least 1 year of experience in FHS units.

Study design

A programmatic qualitative design was used in this study. Both in-depth interviews (IDIs) and focus group discussions (FGDs) were employed to explore how leadership commitment influences the quality of adolescent-friendly sexual and reproductive health services in pastoral areas of East Guji Zone, Ethiopia. The use of both methods allowed the study to capture perspectives from two sides: policymakers and service providers through IDIs, and service users (adolescents and youth accessing services in public health facilities) through FGDs, enabling a more comprehensive understanding of the issue.

Sampling and recruitment

A stratified purposive sampling strategy guided both recruitment and selection of study participants. Seven individuals were included as in-depth interview (IDI) informants, consisting of FHS coordinators from the Ministry of Health (MoH), the FHS focal person at the Oromia Regional Health Bureau (ORHB), the FHS focal point at the Guji Zone Health Department (GZHD), the heads of Wadara and Harekello health centers (HCs), and one healthcare provider (HCP) from each of the two facilities (Wadara and Harekello). The selection process was designed to ensure representation of adolescent-friendly health service (FHS) coordinators and technical experts operating across multiple tiers of Ethiopia's health system. All IDI participants had hands-on exposure to adolescent-friendly services, either through managerial/technical responsibilities or direct clinical service provision. For example, senior-level contributors were actively engaged in drafting adolescent and youth health policy documents and overseeing program implementation processes.

For the qualitative component, six separate focus group discussions (FGDs) were conducted, categorized by gender composition: male-only, female-only, and mixed groups, all involving adolescents aged 15–24 years. Participants for both IDIs and FGDs were selected based on prior interaction with FHS programs and fulfillment of the study's eligibility criteria. Participant recruitment followed a stratified purposive approach for both data collection methods. Further details on inclusion and exclusion criteria are presented in **Table 1**.

Table 1. Socio-demographic characteristics of adolescents' friendly health services quality, FGD and KII participants, MoH, ORHB, GZHD & HCs, East Guji Zone, Ethiopia. Nov. 2021.

Characteristics	Adolescents and youths (n = 50)	HCs (n = 4)	GZHD (n = 1)	ORHB (n = 1)	FMoH (n = 2)	Total (n = 58)	
						n	%
Type and number of sessions	FGD-6	KII-4	KII-1	KII-1	KII-1		
Age group (years)	15–19	48				48	82.8%
	20–24	2				2	3.4%
	> 25 years		4	1	1	2	8
Sex	Male	26	3	1		1	31
	Female	24	1		1	1	27
Marital status	Single	50					50
	Married		4	1	1	2	8
Educational level	Secondary education	48					48
	Tertiary education	2					2

Graduate	4	1			5
General practitioner				1	1
Postgraduate			1	1	2

Fieldwork team recruitment and training

The qualitative fieldwork team comprised two research assistants and three facilitators, all selected based on demonstrated experience in qualitative research methodologies. Academic backgrounds varied: two held BA degrees in social sciences, two held BSc degrees in natural sciences, and one facilitator was a first-year university student specializing in social sciences. Both research assistants had prior extensive experience conducting qualitative interviews and were fluent in Oromiffa, the local language of the study area.

Field supervision was provided by an MPH-qualified researcher who oversaw data collection activities and ensured adherence to study protocols. Before data collection, all research assistants underwent a structured four-day training program. The training covered the study objectives, interview guides, informed consent procedures, and qualitative data collection techniques. Capacity building for both data collectors and facilitators was conducted by the principal investigator.

IDI and FGD guide

Data were collected using open-ended semi-structured interview guides supplemented with probing questions for both in-depth interviews (IDIs) and focus group discussions (FGDs). The instruments were designed to allow participants to provide direct responses while also expanding on related issues, such as healthcare providers' perceptions and attitudes toward adolescent-friendly health services (FHS). A total of 22 guiding questions were developed, structured around five WHO-defined quality domains for FHS: availability, accessibility, acceptability, equity, and appropriateness [18].

Coding book and measurement

The analysis was guided by Donabedian's conceptual framework, which evaluates healthcare quality through the interrelated domains of structure, process, and outcome. The underlying assumption is that service quality is produced through the interaction of these three components [19]. This framework was applied to assess adolescent-friendly health services in pastoral communities of Guji Zone. The evaluation focused on five key dimensions: accessibility, equity, acceptability, appropriateness, and effectiveness. Data from both IDIs and FGDs were used to assess and compare perceptions of these dimensions and determine the overall level of service quality.

Structure

In this study, the "structure" dimension refers to organizational and systemic conditions within the health system, such as accessibility, equity, and institutional readiness. It reflects the overall capacity of healthcare institutions—including infrastructure, workforce, and management systems—to deliver quality adolescent-friendly services. Structural elements also include governance mechanisms such as leadership structures across all levels of the health system (e.g., directorates, technical teams, focal persons), availability of adequately functioning service units, adherence to established standards, resource availability, and the extent to which equitable service delivery is ensured for adolescents.

Process

The "process" dimension represents a broad analytical category that encompasses elements such as availability, appropriateness, effectiveness, and service providers' readiness. It mainly focuses on how adolescent sexual and reproductive health needs are addressed through service delivery mechanisms. This includes the existence and implementation of relevant policies, effective planning processes, budgeting systems, reporting mechanisms, monitoring and evaluation activities, and the use of evidence-based research and the engagement of service users in decision-making. It also covers capacity-building efforts such as staff training, improvement of provider competencies, provision of tailored services based on client needs, adherence to ethical medical practice, and protection of confidentiality.

Outcome

The "outcome" category is a broad construct that includes elements such as acceptability. In general, outcomes refer to the effects and consequences of adolescent-friendly health service interventions, which may include observable changes in the service environment as well as shifts in adolescents' physical health status, functional abilities, and psychosocial wellbeing. It also reflects experiential dimensions such as trust in services and user satisfaction **(Figure 1)**.

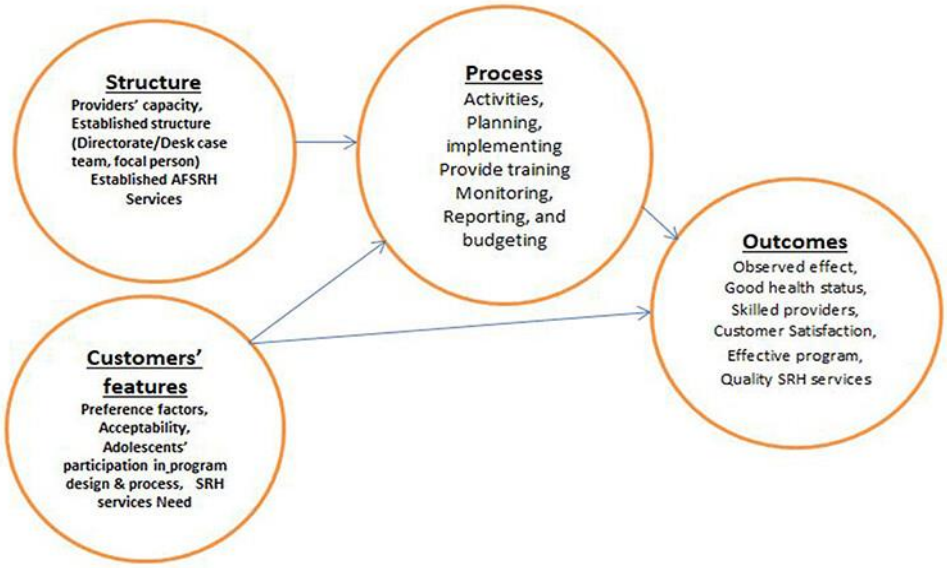

Figure 1. Sexual and reproductive health services quality Model adapted from Donabedian's structure, process, and outcomes model. Wadara and Harekello Health centers, Guji zone, Ethiopia. November 2021.

Data collection and management

The study instruments were initially prepared in English and subsequently translated into the local language (Oromiffa). A pretesting phase was conducted in October 2020 to evaluate the tools for validity, reliability, clarity, logical flow, internal consistency, and comprehensibility. The pilot testing took place in Shakiso town, and the tools were revised and refined based on the feedback obtained before the main data collection commenced.

To promote ethical transparency and ensure informed participation, standardized recruitment scripts were used to clearly explain the study objectives, procedures, and participants' rights. Oral informed consent was obtained from all IDI participants before data collection. For adolescents aged 18–19 and emancipated minors, written informed consent was obtained. For adolescents aged 15–17, parental consent was secured alongside participant assent.

Data collection was conducted through in-depth interviews (IDIs) and focus group discussions (FGDs) in comfortable, appropriate settings. Each FGD session was facilitated by designated organizers, while trained interviewers conducted the IDIs and key informant interviews (KIIs). Audio recordings and field notes were collected throughout the process. Continuous communication between supervisors and research assistants (RAs) was maintained during fieldwork to ensure quality and consistency.

Data analysis

All data collection guides were developed in English and later translated into Oromiffa for field implementation. FGDs and IDIs were conducted primarily in Oromiffa, except for interviews at the Federal Ministry of Health (FMoH), which were conducted in English. Audio recordings were transcribed verbatim from the original recordings in the language in which they were conducted. Transcripts produced in Oromiffa were carefully reviewed to ensure that the original meaning and context were preserved. In addition, handwritten field notes were used to complement and fill gaps in audio recordings.

A total of 13 transcripts were analyzed using Atlas.ti7 software, which facilitated coding, categorization, labeling, and conceptual organization of the data. The analysis followed a six-phase thematic approach: (1) repeated reading of transcripts to achieve data familiarization; (2) generation of initial codes and grouping of similar codes; (3) identification of themes by clustering codes and assigning relevant data extracts to each theme; (4) review and refinement of themes and development of a thematic map; (5) definition and naming of finalized themes; and (6) production of the final analytical report [20]. Through this process, 30 initial codes were generated and refined into 18 final codes. These refined codes were further organized into six sub-themes, which were subsequently consolidated into three overarching major themes.

Results and Discussion

Characteristics of study participants

A total of 58 participants were included in the study. Of these, 25 focus group discussion (FGD) participants were recruited from Harekello and another 25 from Wadara health center. The age range of FGD participants was 15-24 years, and all were unmarried youths. In contrast, all in-depth interview (IDI) participants were older than 25 years. Accordingly, eight key

informant interviews (KIIs) were conducted with participants from the Ministry of Health (MoH), the Oromia Regional Health Bureau (ORHB), the Guji Zone Health Department (GZHD), and the Harekello and Wadara Health Centers.

Regarding gender distribution, approximately 53% of participants were male, while 47% were female. In terms of educational status, about 86.2% were high school or university students, whereas 13.8% were postgraduate or graduate-level professionals. These findings are situated within public health facilities serving pastoral communities in East Guji Zone, Southern Ethiopia **(Table 1)**.

Major findings

A total of eight key informant interviews and six FGDs were conducted. The findings were organized according to six thematic categories derived from qualitative data analysis (QDA): (1) organizational readiness, (2) provider readiness, (3) equity, (4) leadership commitment, (5) evidence-based service delivery, and (6) adolescent acceptability of services.

Organizational readiness

The results indicated that the quality of adolescent-friendly sexual and reproductive health (AFSRH) services in the pastoral districts of East Guji Zone is generally below acceptable standards. Participants described the service environment as poorly accessible, with weak confidentiality measures that reduce trust among clients, alongside shortages of essential supplies and materials. Similarly, most adolescents who participated in FGDs perceived the services as unappealing and difficult to access.

One respondent stated that the overall quality of the FHS system in the Oromia Region is unsatisfactory. Despite multiple challenges, those who intentionally seek care at health facilities still utilize available services. It was suggested that FHS delivery should be integrated within general services rather than operated separately. (ORHB KII 2 Focal person)

Another participant noted that adolescent-friendly health services initially performed well but have since declined due to inadequate funding, weak supervision, and an ineffective monitoring and feedback system. As a result, the adolescent and youth health program at the Guji Zonal Health Department has weakened (GZHD, KII Focal person).

At Harekello Health Center, adolescent-friendly services were reported to be largely dependent on external partners. Whenever partners provided support, noticeable improvements were observed; however, after project completion, service continuity deteriorated. It was suggested that the Ministry of Health (MoH) and ORHB should establish dedicated budget lines to ensure sustainable service provision (Harekello HC Head KII).

In Wadara Health Center, respondents reported that FHS provision had been discontinued approximately two years earlier due to a shortage of trained personnel. Although awareness activities such as posters and banners were used within the facility, outreach activities beyond the health center were not implemented (Wadara HC Head KII).

One healthcare provider expressed that adolescent-friendly reproductive health services were not being implemented effectively, emphasizing that leadership attention and administrative oversight were lacking. Reporting of activities did not appear to influence follow-up actions (Wadara HC, KII HCP-1).

Participants in FGDs also highlighted that, due to the small size of health facilities, all services are delivered in shared spaces, which can create embarrassment among adolescents who fear being seen by parents or community members while seeking care (FGD-1, 3, male & female).

Other participants described FHS as largely theoretical rather than practically implemented, noting that there is little evidence of actual service delivery in their health centers, despite a strong need for functional adolescent-friendly services (FGD 2 & 6, female & male).

Findings further revealed that service delivery does not comply with established adolescent-friendly health service standards. In addition, some providers were unaware of the existing standards, while others noted that the standards themselves had not been updated for approximately 15 years.

According to a Ministry of Health expert, Ethiopia has adopted eight youth-friendly service standards from the WHO and added one additional standard to suit the local context (MoH/MCH Expert KII 1).

Another respondent from ORHB emphasized that while adolescent and youth FHS standards are clearly defined and useful for program implementation, they are not being followed in any of the health facilities (ORHB Focal person KII).

Similarly, it was reported that, according to national FHS guidelines, service delivery units should have at least two dedicated rooms, including spaces for consultation and examination, possibly with additional amenities, such as televisions, to enhance engagement. However, none of these requirements are currently met in Harekello Health Center (Harekelo HC & HCP).

The findings indicated that adolescent-friendly health services (FHS) do not consistently receive supply support or programmatic materials from the Ministry of Health (MoH), the Oromia Regional Health Bureau (ORHB), or the Zonal Health Department (ZHD). As a result, the continuity of FHS activities largely depends on external partners, without whom service delivery becomes unsustainable.

One respondent noted that neither the MoH nor higher administrative levels regularly provide supplies or programmatic materials to health facilities or zonal structures. Previously, some implementing partners provided essential inputs; however, this support is currently absent (ORHB Focal person KII).
Similarly, it was reported that no dedicated supplies or programmatic materials are allocated for FHS at the zonal level due to the absence of a specific budget line for the program (GZHD, KII Focal person).
Healthcare providers from Wadara and Harekello health centers also stated that no direct material support has been received from any source, and no dedicated budget exists for FHS. Consequently, they rely on supplies from other programs, such as condoms, to support FHS activities (Wdara and Harekello HC HCPs).
A participant from FGD noted that although providers occasionally prescribe or make condoms available within FHS units, adolescents often do not access them when needed, resulting in unmet demand (Harekello FGD 5 male).
The health system was described as lacking a well-established structural framework for adolescent and youth FHS at all administrative levels, leaving a large proportion—estimated at 42%—of adolescents and youth in Ethiopia underserved.
Previously, only a single focal person was responsible for coordinating adolescent and youth FHS. Although the Ministry of Health later upgraded this arrangement to a case team structure, this was still considered insufficient to meet the needs of approximately 42% of the adolescent and youth population.8 It was suggested that elevating the structure to a dedicated Adolescent and Youth-Friendly Health Services Directorate (AYFHSD) would be more appropriate (MoH/MCH Expert KII 1).
At the regional level, ORHB also reported having only one focal person responsible for FHS coordination. Given that Oromia is the largest region in Ethiopia, respondents emphasized that a single focal person is inadequate and that at least a case team structure is required to effectively support service delivery. (ORHB Focal person KII)
Similarly, the respondent from GZHD expressed uncertainty about the adequacy of one focal person to coordinate services across multiple health facilities, stating that effective coordination under such conditions is practically unfeasible (GZHD, KII Focal person).

Providers' readiness

Most FGD participants expressed that adolescents and youth are willing to use FHS, but service providers are not adequately prepared, largely due to the absence of accountability mechanisms.
Participants emphasized that if healthcare providers treated adolescent clients respectfully, utilization of FHS would likely increase significantly; however, services are not consistently delivered in line with adolescents' needs (Wadara & Harekello HC HCPs).
From the service user perspective, participants reported that healthcare workers often fail to create a welcoming environment. In some cases, adolescents felt uncomfortable or even mocked when seeking services (FGD 2&6 female & male).
At the national level, the Federal Ministry of Health (MoH) reported that training of trainers (ToT) had been provided to staff in health facilities, zonal health departments, and regional bureaus. However, concerns were raised about whether trained personnel remain in relevant positions, given that staff rotation is common. Additionally, some health center managers were described as lacking sufficient commitment to oversee program implementation.
It was further noted that many trained healthcare providers had been transferred to other departments, creating service continuity gaps and requiring new staff to be trained (GZHD, KII Focal person).
One health center head explained that although staff were initially trained, many were reassigned to other units, and new staff were not being allocated to FHS due to a lack of applications, noting that staff mobility is a professional right (Wadara KII HC Head).
Participants further indicated that skilled providers play a key role in building trust and ensuring adolescent service utilization. However, gaps in skills and competencies remain, particularly regarding confidentiality and psychological understanding of adolescent clients (Wadara HC KII HCP).
FGD participants also noted that adolescents are more likely to use FHS when services are delivered by competent, trained healthcare workers. However, such conditions are not consistently available (FGD 4 & 6, female & male).
Some adolescent participants highlighted that healthcare providers often bring personal beliefs and values into service delivery; however, they emphasized that providers should adhere to professional ethics and deliver services objectively, regardless of personal views. At the same time, there was a perception that healthcare workers are not always respected for their professional conduct.
One participant stated that while healthcare providers have personal belief systems, they are expected to prioritize professional ethics and ensure unbiased service delivery (Wadara FGD-6 male).
Another respondent expressed concern that healthcare providers often fail to fulfill their professional responsibilities, leading to dissatisfaction, frustration, and emotional distress among clients (Harekello FGD-1 female).
The study findings also revealed that adolescents require a high level of confidentiality when accessing sexual and reproductive health services. However, the existing FHS environment was reported to be inadequate in ensuring privacy.

One provider noted that adolescents prefer to seek services discreetly, often visiting health facilities in the evening to obtain condoms or emergency contraceptives (Harekello HC KII HCP).
Similarly, participants indicated that maintaining confidentiality is difficult at their health center due to limited infrastructure, including a single room for service provision (Harekello FGD-3 male & female).

Equitable

Findings from the study indicated that adolescent and youth-friendly health services (FHS) are unevenly distributed across regions, zones, and health facilities, as well as between male and female service users.
The level of preparedness for FHS implementation across different regions and city administrations was also found to be unequal. For example, Addis Ababa and Dire Dawa have achieved more than 85% staff training coverage, whereas the Oromia and Somali regions have reached only 30% to 35% (MoH/MCH Expert KII 1).
It was further reported that some zones benefit from stronger partner support, while others receive little or none. As a result, the readiness of services, staff capacity development, and overall performance of FHS implementation vary significantly and lack uniformity (ORHB KII Focal).
From the perspective of service users, one participant explained that unmarried adolescent girls are less likely to access FHS compared to males, mainly due to negative attitudes from healthcare providers that lead to embarrassment and stigma, forcing some to seek services from unregulated private facilities (Wadara FGD-2 female).

Leadership commitment

The evidence suggests that the Ministry of Health (MoH) has given considerable attention to adolescent-friendly health services at the policy level. However, the level of leadership commitment at regional, zonal, and health facility levels—including the Oromia Regional Health Bureau (ORHB), Guji Zonal Health Department (GZHD), and heads of Wadara and Harekello Health Centers—has significantly affected the quality of adolescent-friendly sexual and reproductive health services in pastoral districts of Guji Zone. Additionally, a lack of accountability mechanisms was identified across all levels of the health system.
As part of national leadership initiatives, Ethiopia has developed a national youth-friendly health services strategy. In this framework, a national adolescent and youth health strategy covering 2016–2020 was also developed, along with guidelines for health extension workers (MoH/MCH Expert KII 1).
Some motivated healthcare providers were reported to go beyond their formal responsibilities to improve FHS delivery; however, there is no structured reward or recognition system to encourage high performance. Therefore, it was recommended that both the MoH and ORHB establish formal mechanisms for incentives and accountability (GZHD, KII Focal person).
The findings also revealed the absence of harmonized planning for youth-friendly health service programs, with planning limited mainly to case teams or individual-level efforts at the Ministry of Health.
One respondent stated that although individual annual plans exist for case team experts, there are no comprehensive or coordinated plans at the regional and zonal levels (MoH/MCH Expert KII 1).
Another participant noted that, while a reproductive health annual plan exists at the regional level, there is no separate, dedicated plan for youth-friendly health services (ORHB KII Focal).
Similarly, it was reported that there is no specific adolescent-friendly health service plan at zonal or facility levels, aside from general primary health care unit (PHCU) planning, which does not specifically address FHS activities (GZHD, KII, Harekello & Wadara HC heads).
The study identified a critical funding shortage for adolescent- and youth-friendly health service programs. As a result, implementation largely depends on external partners, and activities tend to cease when donor-supported projects end. One of the key responsibilities of health sector leadership is to allocate sufficient and sustainable budgets for adolescent-friendly sexual and reproductive health services. However, most IDI participants reported that leadership at all levels fails to allocate adequate funding to these programs.
One respondent explained that budget constraints remain the most persistent challenge, noting that even the limited funding received through SDG support covers only about 20% of actual needs (MoH/MCH Expert KII 1).
Another participant stated that there is no dedicated budget for adolescent and youth FHS, making it impossible to conduct even basic activities, such as orientation training for health extension workers (ORHB KII Focal).
It was also observed that FHS programs show improvement when external partners are involved, but these gains are not sustained once NGO-supported projects are phased out (GZHD KII Focal-1).
At the health facility level, respondents confirmed that no specific budget is allocated for FHS, except for staff salaries. As a result, resources from other programs are often used to support FHS activities (Wadara & Harekello HC Heads).
The Federal Ministry of Health reported conducting targeted supervisory visits to regional health bureaus, woreda-level offices, youth centers, and industrial parks to assess compliance with FHS standards (MoH/MCH Expert KII 1).

However, at the regional level, ORHB reported that supervision and monitoring activities are not being implemented due to a lack of dedicated funding for FHS programs. Communication with zonal offices is therefore limited to telephone contact rather than structured supervision visits (ORHB KII Focal).

The study revealed the absence of a well-organized system for the routine collection and compilation of adolescent-friendly health service (FHS) reports. Although the Ministry of Health (MoH), Oromia Regional Health Bureau (ORHB), and Guji Zonal Health Department (GZHD) have collected limited reports related to adolescent age groups, most health facilities do not consistently report adolescent and youth health (AYH) service data. This indicates a need to establish a structured reporting mechanism specifically dedicated to FHS activities.

One respondent explained that no direct FHS reports are received from regional levels; instead, data are extracted indirectly from the District Health Information System (DHIS) and then forwarded under broader adolescent program categories. However, DHIS data elements do not explicitly capture adolescent-friendly health service reporting (MoH/MCH Expert KII 1).

Another participant noted that there is no routine submission of FHS performance reports and emphasized the need to incorporate FHS indicators into DHIS to strengthen program monitoring (ORHB KII Focal).

At the zonal level, it was reported that regular submission of FHS-specific reports is not practiced. Participants stressed that a functional accountability and feedback mechanism is necessary to ensure consistent reporting, although a few health facilities occasionally submit reports (GZHD KII Focal-1).

At the facility level, one respondent indicated that their health center does not submit regular FHS reports to the zonal office, mainly because such reports are not formally requested (Wadara HC Head KII-1).

Evidence-based services

At the national level, experts indicated that young people have been involved in the design of adolescent and youth FHS programs. However, participants from youth centers in FGDs reported that neither the Guji Zonal Health Department nor local health facilities had engaged them in program planning or design over the past 2 years.

One national-level respondent stated that youths were invited to participate in the national FHS program design and were able to provide feedback during implementation (MoH/MCH Expert KII-1).

In contrast, youth center participants reported expecting invitations to participate from the zonal health department or local health facilities. Still, such invitations have not occurred in recent years (Wadara FGD 4 Female and male).

The study further identified significant gaps in the evidence base on adolescent- and youth-friendly health services in Ethiopia, particularly regarding service quality, demand patterns, and existing service delivery gaps. It was emphasized that generating evidence is essential for strengthening program design and implementation.

One expert noted that program coordinators require solid evidence to support strategic planning and program improvement; however, current evidence on FHS is insufficient. Therefore, there is a strong need for targeted research on adolescent-friendly health services in Ethiopia (MoH/MCH Expert KII 2).

Acceptability of friendly health services

The study revealed that adolescents and youth are not regarded as reliable users of friendly health services (FHS) and require a more welcoming attitude when attending health facilities. In addition, adolescents' confidence in healthcare providers is limited, largely due to concerns about confidentiality.

One respondent stated that when healthcare providers adopt a welcoming and approachable attitude, adolescents become more open to discussing sexual and reproductive health issues; however, in practice, providers are often perceived as uninviting (Wadara HCP, KII-1).

Another participant argued that married women are unlikely to seek services at these facilities because of low trust in healthcare providers regarding privacy and confidentiality concerns (Wadara FGD-2 female).

The findings further confirmed that users of sexual and reproductive health (SRH) services are largely dissatisfied with the manner in which services are delivered within FHS units. As a result, many opt for unregulated private health providers rather than using formal public services.

Participants noted that dissatisfaction is so strong that adolescents often become frustrated with FHS services at health centers and subsequently turn to informal private providers (Harekeko FGD 3 male & female).

One respondent added that the way healthcare providers deliver services does not create a sense of comfort and suggested that care is often provided as a formality rather than a reflection of professional ethics, primarily in exchange for salary (Wadara FGD-5 male).

This study aimed to explore how leadership commitment influences the quality of adolescent-friendly sexual and reproductive health services in health facilities within the pastoral communities of East Guji Zone. The findings identified multiple constraints across six key thematic areas: (1) organizational readiness, (2) provider readiness, (3) equity, (4) leadership commitment, (5) evidence-based service delivery, and (6) service acceptability.

Overall, the study found that both the quality of adolescent-friendly health services and leadership commitment in pastoral settings of East Guji Zone were suboptimal. These results are consistent with findings reported by Homer *et al*. (2018), Chandra-Mouli *et al*. (Tanzania, 2013), and Olijira L. (Ethiopia, 2016), which emphasized that poor service quality among adolescents is often linked to limited availability, restricted access, weak infrastructure, and insufficient regulatory systems [12, 21, 22]. In contrast, the findings differ from those of Hoopoes *et al*. (India, 2016) and Pilgrim *et al*. (USA, 2019), as well as from research in Mexico, which reported higher service quality, with 86.1% of adolescents receiving medium- to high-quality FHS [1, 23, 24].

Key barriers to organizational readiness included the largely inaccessible adolescent-friendly services in East Guji Zone, due to shortages of supplies and materials, limited awareness of service standards, and weak leadership structures supporting FHS implementation across the health system. These findings align with studies by Ngwenya S. (Zimbabwe, 2016) and Mazur *et al*. (systematic review, 2018), which highlighted challenges in accessing contraception and reproductive health services, as well as the lack of adolescent-specific service design and adherence to basic FHS standards [25–27]. However, these results differ from findings by Bukenya *et al*. (Uganda, 2018) and Andersen *et al*. (Nepal, 2015), which reported adequate supply availability and improved access to essential reproductive health services in health facilities [28, 29].

Barriers under provider readiness indicated that healthcare providers were not adequately prepared to deliver FHS due to insufficient training, reassignment of trained staff to unrelated roles, weak confidentiality practices, and strong influence of personal beliefs and values over professional ethics. These findings are consistent with studies by Godia *et al*. (Kenya, 2013), Jonas *et al*. (Sub-Saharan Africa, 2017; South Africa, 2018), and Kennedy *et al*. (Vanuatu, 2013), which reported inadequate training, negative attitudes, and tensions between professional duties and personal, cultural, or religious beliefs [13, 30–33]. However, the findings differ from those of Z. Esseck *et al*. (KwaZulu-Natal, South Africa, 2016), in which providers reported maintaining professional standards despite their personal views [34].

The study also identified major inequities in adolescent- and youth-friendly health service provision across regions, zones, and health facilities, as well as between male and female users. This is consistent with findings from Godia *et al*. (Kenya, 2014), studies in India (2015), Thin Zaw *et al*. (Myanmar, 2013), and IPPF & UNFPA (2017), all of which reported unequal access to FHS between rural and urban populations and between genders [35–38]. These studies also noted that FHS programs are often designed primarily for women and children, resulting in the marginalization of males and adolescent girls in service delivery.

Key obstacles within the leadership commitment domain revealed that adolescent-friendly health services (FHS) are not adequately ensured for adolescents due to the absence of harmonized operational plans at the facility level. Insufficient budgeting, weak routine reporting systems, and inconsistent program evaluation largely drive this situation. The only partial exceptions were activities at the Ministry of Health/MCHD level, which demonstrated relatively stronger engagement through targeted supervision efforts. However, even at this level, data collected from adolescent age groups were often aggregated and redirected for broader administrative purposes rather than direct program improvement.

These findings are consistent with ODO *et al*. (Nigeria, 2018) and Sivagurunathan *et al*. (India, 2015), who reported substantial deficiencies in adolescent healthcare service delivery [39, 40]. In contrast, the results diverge from those of Geary *et al*. (South Africa, 2015) and Huaynoca *et al*. (Colombia, 2015), who emphasized that strong monitoring and evaluation systems can enable healthcare providers to better respond to adolescents' needs [41–43].

Significant barriers were also identified regarding evidence-based service delivery. The findings showed that adolescent-friendly health services would be more effective and contextually appropriate if grounded in robust empirical evidence; however, such evidence is largely lacking in Ethiopia due to limited research on service quality. Although adolescents and youth have been involved in designing FHS programs at the national level, the overall evidence base remains weak.

This aligns with Mulugeta *et al*. (Ethiopia, 2019), who reported that insufficient research evidence has hindered the assessment and improvement of youth-friendly service quality in southern Ethiopia [15]. Consequently, there is a strong need for expanded research and systematic documentation on youth involvement in sexual and reproductive health (SRH) programming [44].

The study also identified major challenges within the acceptability dimension of service delivery. Adolescents reported low trust in FHS providers, largely because healthcare workers were perceived as unwelcoming. As a result, dissatisfaction with FHS units was widespread among adolescent users.

These findings are in agreement with Godia *et al*. (Kenya, 2014), who reported that male adolescents often feel uncomfortable when attempting to access FHS [45]. However, the present results are inconsistent with findings from Tangut *et al*. (Ethiopia, 2015), Pilgrim *et al*. (Atlanta, GA, 2018), and Schmidt *et al*. (Germany, 2016), all of whom reported high levels of adolescent satisfaction with timely and responsive FHS delivery [10, 24, 46].

In summary, the study concludes that weak leadership commitment significantly constrains the quality of adolescent-friendly sexual and reproductive health services in public health facilities within the pastoral communities of Guji Zone, Southern

Ethiopia. This has important policy implications. Ethiopia continues to face a high burden of adolescent mortality, ranking among sub-Saharan African countries with significant adolescent health challenges globally [47].

The National Adolescents and Youth Health Strategy (2016–2020) sets ambitious targets, including reducing overall adolescent mortality and morbidity by 50%, decreasing pregnancy-related deaths by 50%, and reducing HIV incidence by 75% as key national priorities [47, 48]. Achieving these goals requires stronger and sustained leadership commitment to improve access to high-quality sexual and reproductive health services.

In alignment with the updated Adolescent and Youth Health Strategy and Sustainable Development Goal 3, target 3.7, Ethiopia is expected to continue efforts to reduce adolescent morbidity and mortality by ensuring equitable access to high-quality adolescent and youth-friendly health services [45]. However, current strategy targets indicate that additional efforts are still required to improve service utilization. Therefore, strengthening the quality of adolescent-friendly health services in public health facilities remains essential for increasing utilization rates. This study is expected to contribute meaningful policy-relevant evidence to support improvements in adolescent-friendly health service delivery.

This study presented several notable strengths. It generated rich, in-depth insights from key informants at the Ministry of Health (MoH), the Oromia Regional Health Bureau (ORHB), the Guji Zone Health Department (GZHD), health centers (HCs), and experts involved in adolescent- and youth-friendly health services (FHS) programs. In addition, including multiple categories of respondents contributed to a more comprehensive understanding of the quality of adolescent-friendly sexual and reproductive health (AFSRH) services. Furthermore, the deliberate selection of Harekello and Wadara health centers strengthened the study, as both facilities actively implement adolescent and youth FHS and serve large adolescent populations within the pastoral districts of Guji Zone.

Conversely, the study also had certain limitations. The purposive sampling approach used for participant selection may have introduced selection bias. In addition, focus group discussion (FGD) participants had limited depth of information regarding FHS implementation at the health facility level, which may have contributed to potential information bias in the findings.

Conclusion

The study concluded that the quality of adolescent and youth-friendly sexual and reproductive health services in public health facilities within the pastoral areas of East Guji Zone is inadequate. This substandard quality is largely attributed to weak leadership commitment within the health system, particularly in relation to ensuring service quality. All identified thematic areas were found to be directly or indirectly influenced by poor leadership engagement, which ultimately contributed to the overall low quality of adolescent-friendly health services in these settings.

Based on the findings, four key recommendations are proposed to improve service quality in pastoral communities. First, accessibility should be strengthened by enhancing both organizational and provider readiness. Second, service availability should be improved through stronger leadership commitment, particularly by allocating sufficient budgets and reinforcing monitoring and evaluation (M&E) systems. Third, the implementation of adolescent-friendly health services should be expanded across all regions, zones, and health facilities to ensure equity. Fourth, it is strongly recommended that adolescent FHS be restructured into an integrated service model under a unified framework such as “Maternal, Child, and Adolescent Friendly Health Services.”

Accordingly, the Ministry of Health (MoH), Regional Health Bureaus (RHBs), health facilities, and interested researchers are encouraged to consider these recommendations to enhance the quality of adolescent-friendly health services in pastoral communities in Ethiopia.

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