A literature review on factors influencing young people's access to Youth Friendly Sexual and Reproductive Health service in Ethiopia

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Young people visiting Youth Friendly Health service in Bahir Dar, Ethiopia
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A literature review on factors influencing young people's access to youth friendly sexual and reproductive health service in Ethiopia

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By

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Signature……

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Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
AGYW	Adolescent Girl and Young Women
AU	African Union
AYH	Adolescent and Youth Health
AYRHS	Adolescent and Youth Reproductive Health Service
CRC	Convention on Rights of Children
CSE	Comprehensive Sexuality Education
DHO	District Health Office
EDHS	Ethiopian Demographic Health Survey
FMOH	Federal Ministry Of Health
GBV	Gender Based Violence
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immuno-Deficiency Virus
HSTP	Health Sector Transformation Plan
ICPD	International Conference on Population and Development
LARC	Long Acting Reversible Contraception
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MOE	Ministry Of Education
OKP	Orange Knowledge Program
OOP	Out Of Pocket
PEPFAR	Presidents Emergency Plan For AIDS Relief
RHB	Regional Health Bureau
RH/FP	Reproductive Health/ Family Planning
SEM	Socio-Ecological Model
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SYMPA	Supporting Youth and Motivating action
THE	Total Health Expenditure
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VU	Vrije Universiteit
WHO	World Health Organization
YPLWH	Young People Living With HIV
YFHS	Youth Friendly Health Services
YFSRHS	Young People Friendly Sexual and Reproductive Health Service

Glossary

Access	"[…] the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have the need for services fulfilled"(1).
Adolescent	Individuals who are age 10-19 years(2)
Adolescent Friendly Health Services (AFHS)	"[…] represent health services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right time at the right price (free where necessary) and delivered in the right style to be acceptable. They are equitable because they are inclusive and do not discriminate clients on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed they reach out to those who are most vulnerable and those who lack services. They are effective because they are delivered by trained and motivated health care providers who are technically competent, and who know how to communicate with young people without being judgmental"(3). This term is often used interchangeably with "**youth-friendly health services**" despite of their difference in age group they indicate.
Adolescent pregnancy	Women who are pregnant aged 10–19 years (4).
Comprehensive Sexuality Education (CSE)	In a formal educational setting, CSE is "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives(5)
Sexual and Reproductive Health (SRH) Services	Health services which include: "antenatal, perinatal, postpartum and new-born care; providing high quality services for family planning, infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health. Additionally it comprises preventing and responding to violence against women for improving reproductive health outcomes"(6).
Sexual and Reproductive Health and Rights (SRHR)	"Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. A positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights "(7).
Unintended pregnancy	"is one that occurred when a woman wanted to become pregnant in the future but not at the time she became pregnant ("wanted later") or one that occurred when she did not want to become pregnant then or at any time in the future ("unwanted")." (8).
Health care Utilisation	" …use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis." (9).
Young People	Belongs to individuals of 10-24 years(2).
Youth	Refers to age group of 15-24 years(2).
Youth Friendly Health Services	"it refers to services that are based on a comprehensive understanding of, and respect for, young people's rights and the realities of their diverse sexual and reproductive lives. They are services which young people trust and feel are there for them. To be considered youth friendly, health services should be accessible, acceptable, equitable, appropriate, and effective."(10).

Introduction

Although Human Immuno-Deficiency Virus (HIV) prevalence and incidence have progressively decreased in Ethiopia's general population, it is still unclear how prevalent the virus is in particular population groups that exhibit high-risk behaviours. Young females were especially included in key and priority populations of the most recent Ethiopia's National Strategic Plan (2021) due to their heightened vulnerabilities and challenges in accessing services. In addition, other Sexually Transmitted Infections (STI) and particularity adolescent unintended pregnancy remain a great public health challenge in Ethiopia. This highlights how crucial it is for young people to access sexual and reproductive health services, information, education, and counselling alongside the positive support and understanding of SRH from their families, schools, and the community environment(11, 12).

As a public health professional, I have worked at public health facilities and the district health office for over ten years, employed by Ministry of Health of Ethiopia. During this time, I have served in various roles; as the HIV prevention and control team leader, the maternal, neonatal, child, and adolescent health coordinator and the primary health care unit director.

In Lode Hetosa district of Oromia Regional State ; where I served, Youth Friendly Services are available in all health centres. This initiative program was largely dependent on donors fund. For example, Pathfinder and Korea International Cooperation Agency (KOICA) supported the district by training health service providers and peer educators, and providing supplies as well as conducting supportive supervision. From this, I did see some improvements in the quality of health services. But still, use of these service was remarkably low in this district and I have been perplexed to understand why. Why only a few young people in this district visited health facilities, even though health providers were trained and available to provide SRH services? Why many young people seem ill-informed about SRH issues and services while peer educators and health extension workers have been trained to counsel them? I have also witnessed a great number of pregnant adolescent girls who committed suicide. Likely, due to fear and shame of their parents and society for being pregnant out of wed-lock, - which is not culturally acceptable throughout Ethiopian society. I realise this is just one factor influencing access to SRH services – but what other influencing factors are there? And can learning about these factors help us better understand the problem and derive from this potential areas for improving SRH of young people and their access to Youth Friendly Sexual Reproductive Health Services (YFSRHS)?

Having pondered on these questions during my profession, doing this thesis created an exciting opportunity for me to explore what factors *are* influencing access to YFSRHR in Ethiopia and also learn from available best practices ways to improving access to YFSRHS.

Abstract

Globally, there are over two billion adolescents, two thirds of whom live in developing countries. Ethiopia is a country of young people, where adolescents constitute over a quarter of the population. Despite of Government of Ethiopia signing international agreements and instituting policy to improve young people's sexual and reproductive health, reality remains that young people's access to Youth Friendly Sexual and Reproductive Services (YFSRHS) is low in Ethiopia.

This study was based on a literature review using key words to retrieve articles through Libraries: Vrije Universiteit ,PubMed ,Medline and web search engines : Scopus and Google Scholar. Grey literatures from organisation's websites also used. To analyse findings , the Socio-Ecological Model (SEM) was adapted and used to answer the research objectives.

It was found that Ethiopia's policy environment regarding young people's Sexual and Reproductive Health (SRH) is promising, yet major gaps related to programmatic implementation surfaced. On the one hand, health service providers negative and judgmental attitude and lack of respect, privacy and confidentiality around SRH were main barriers. Similarly, restrictive and conservative socio-cultural and gender norms and intergenerational communication around SRH were found to greatly contribute to young people' lack of knowledge, skewed perceptions and misconceptions and poor attitude regarding access to and use of sexual and reproductive services.

Weak health system and socio-cultural issues are main reasons for low access to YFSRHS in Ethiopia . Therefore, Ethiopia could strength health system and focus on gradual change of socio-cultural and gender norms through implementing effective combinations of interventions learning from best practices in other African countries.

Key words:

young people, youth, youth friendly health services, sexual and reproductive health, effective intervention

Word Count: 13,112

Chapter 1: Background

This chapter presents the relevant background information on the geographical, demographic and socio-cultural context as well as the health system and service delivery set up in relation to the major health problems in Ethiopia.

1.1. Geography

Ethiopia is located in the centre of the Horn of Africa. Its neighbours to the west are Sudan and South Sudan, Eritrea to the north and northeast, Djibouti and Somalia to the east, Somalia and Kenya to the south, and Sudan and South Sudan to the west. Its surface are is about 1.14 million square kilometres (944,000 square miles). Despite Ethiopia's proximity to the equator (15 degrees), the country often has nice weather with average temperatures that rarely reach 20^{0}C (68^{0}F). This is due to the moderating effect of high altitude. However, parts of the Afar Regional State in the east of the country, which is below sea level, is thought to be the hottest area on Earth whose temperature reaches up to 50^{0}C. The sparsely populated lowlands often feature subtropical and tropical weather. The average annual rainfall for the country is around 850mm (34 inches), which is regarded as mild. The majority of the highland regions experience two separate seasons of rainfall: the light rains in February and March and the heavy rains in June through September. The longer and shorter rainy seasons in the southeast lowlands are from March to May, and the latter is from October to December(13).

1.2. Demography

According to the 2007 Population and Housing Census projection ,the total population of Ethiopia in 2022 was estimated to be 105,166,458 of which male are slightly higher than females ;52,724,268 and 52,442,190 respectively and large proportion of population; near 80 %, are residing in rural areas. According to this estimation population of 10-24 age groups of the country accounted for about 32% of total population while 15-24 age groups reach 20%(14).Other estimate also showed that population growth rate of the country is still high (2.46%) making it 25th from the world .The median age is 19.8 years with youth dependency ratio of 70.6% and currently more than 40% of the population are under the age of 15 while fertility rate is over 5 children per woman .This rapidly expanding population is becoming a pressure on its limited land resources, accelerating environmental degradation, and increasing susceptibility to food shortages. Therefore, Ethiopia will need to make more progress in addressing its family planning needs to achieve the age structure required in the coming decades to alleviate these problems(15).

Regarding ethnicity, from existing more than 80 ethnic groups in the country; the major are Oromo(35.8%), Amhara (24.1%),Somali (7.2%),Tigray (5.7%),and Sidama (4.1%). Official national language is Amharic while Afan Oromo, Tigrinya, Somali and Afar are also used as official working language in their respective states who speak them. The most common religion is Orthodox (43.8%) followed by Muslim (31.3%) and protestant (22.8%).Concerning literacy, about 51.8% can read and write with difference among male and female;57.2% and 44.4% respectively(15).

1.3. Socio-cultural context

Ethiopian culture is deeply rooted in a strong sense of community. People frequently rely on their friends, neighbors, and relatives in turn. When going through a particularly difficult time, people may also receive assistance from the public and the larger society on a social, emotional, and financial level. In order to mobilize community support, local churches and mosques frequently play a crucial role. In order to

contribute meaningfully to society, people must put others before themselves. In addition, Ethiopia is a patriarchal society, a system which values men over women. For instance, Women rarely make decisions about their own lives or those of their families. Instead, they are forced to let their husbands decide for them whether to use contraception, give birth in a health facility, or get professional help. Thus, gender inequality is common which is usually reflected in family, community and institutions(16-18).

1.4. Education System

Recently, the educational system is expanding. However, access to primary schools largely limited to in urban areas, where they are mostly run by the private sector or religious institutions. There are two cycles in primary school: grades 1 to 4 and grades 5 to 8. There are two cycles in secondary education as well: grades 9 to 10 and grades 11 to 12. Over 90% of 7-year-olds are enrolled in primary schools, but only approximately half finish both cycles. Fewer young people attend secondary school, and even fewer enroll in its second cycle. Although girls' access to school has increased, early marriage reduces their participation. Gender stereotypes, abuse, a lack of sanitary facilities, and the consequences of sexual activity all have a negative impact on girls' educational success(19).

1.5. Health care delivery system

The administrative structure of the government in line with this health care delivery system. The Federal Ministry of Health (FMOH) is a federal level authority that manage and finances at the highest level. Ethiopia uses a three-tiered health care delivery system to provide fundamental medical care and guarantee referral relationships. A primary care unit is made up of a primary hospital, a health center, and a health post at the primary care level. General hospitals are found at the secondary level. A general hospital serves as a referral hub for primary hospitals and offers both inpatient and outpatient services. Specialized hospitals are included in the tertiary care level and are referred to by general hospitals and financed by the FMOH. Secondary hospitals, the majority of which are regional hospitals, are financed and managed by the regional-level health authority known as Regional Health Bureaus (RHBs), while primary-level providers are financed and managed by the District Health Office(DHO). There are three types of providers at the district level: primary hospitals, which are expected to serve 60,000–100,000 people in each district, health centers, which are expected to serve 40,000 people in urban areas and 15,000–25,000 people in rural areas, and health posts, which are expected to serve 3,000–5,000 people. Health workers like physicians, nurses, and midwives work at hospitals and health facilities. Health officers are also trained to serve hospitals and health facilities as part of an innovative human resource program(20).

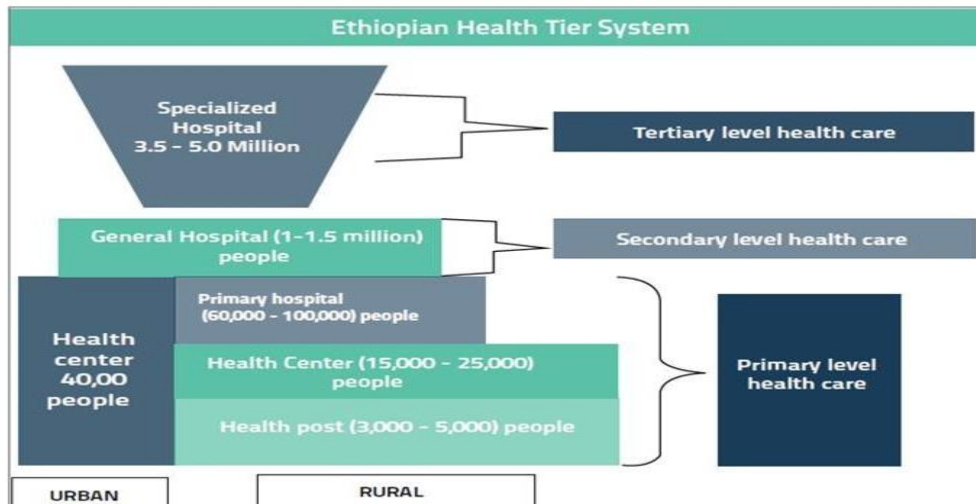

Figure 1: Ethiopian health care tier system(11).

1.6. Health Care Financing

According to World Health Organization (WHO) global health expenditure database, general government health expenditure(GGHE) of Ethiopia in 2019 accounted for 22.7% of total health expenditure(THE) which was below the 2016 government spending on health (32%) reported during the 7th National health account. Share of Out of pocket (OOP) spending reached 37.9% in 2019 which was much higher than the recommended target of 20%.External aid covered 34.1% of spending for health while community health insurance was only 1.04%. Social health insurance is not yet started in the country(21, 22). Health spending per capita was also only US $ 27 making it below the US $ 86 recommended for low income countries. Furthermore, GGHE as percent of General Government Expenditure (GGE) was only 4.8% which was also much lower than the 15% agreed during Abuja declaration(21, 23).

Chapter 2: Study objectives

This chapter introduces the problem to be studied on young people's access to YFSRHS in Ethiopia, the justification as to why focus on this topic and derived from this, what the study's main objective and specific objectives are.

2.1. Problem statement

According to World Health Organization (WHO), "adolescence ",refers to 10-19 age group, "young people" are 10-24years while "youth" defined as those 15-24 years(2). Globally, there are over two billion adolescents, two thirds of whom live in developing countries. Similarly, Ethiopia is a country of young people, where adolescents constitute over a quarter of the population(24).

Sexual and Reproductive Health (SRH) service was defined as interventions which involve maternal services like antenatal, delivery and postnatal care; family planning; infertility services; reduction of unsafe abortion; prevention of sexually transmitted infections including Human Immuno-Deficiency Virus (HIV) , management of reproductive tract infections, prevention of cervical cancer and promoting sexual health(6). However, this paper mainly focus on sexual and reproductive health services which target adolescent pregnancy, prevention of HIV and other Sexually transmitted infections (STI) among young people since they are priority problems in Ethiopia.

The 1994 International Conference on Population and Development (ICPD) and subsequent international meetings produced a global agreement on the significance of universal access to sexual and reproductive health care and the preservation of reproductive rights (SRHR). Governments have frequently recognized the importance of SRHR for the overall health and empowerment of women and girls. A fundamental package of sexual and reproductive health services (contraception, safe abortion when abortion is legal, maternity care, prevention and treatment of STIs and HIV) was agreed upon globally. As a result, significant progress has been made in achieving women's sexual and reproductive health, including in low- and middle-income countries, through increased access to and use of contraception and skilled maternity care, support for HIV prevention and treatment, and the relaxation or removal of legal restrictions. However, there are major disparities between and within countries so that at least 220 million young women in low and middle-income countries do not use modern contraception to avoid becoming pregnant. Every year, there are 30 million unintended pregnancies and over 40 million abortions, half of which are illegal and dangerous. An estimated 499 million new STIs arise each year, with nearly half of these occurring in girls and women(25).

Ethiopia also signed many international agreements to include SRHR of young people. The country's first Adolescent and Youth Reproductive Health Strategy (AYRHS) was developed in 2006. However, lack of multi-sectoral collaboration, poor stakeholder participation, and lack of involvement of young people made it insufficiently implemented. Consequently, there are still limitations and young people continue to face unique health problems (26).

There are differences in the extent of young people's utilization of YFSRHS across different regions and sub regions in Ethiopia. For instance, according to a study conducted at eastern Ethiopia YPFSRH service utilization was 64% while other study in western part in Nekemte town showed only 21 % (27, 28).According to a meta- analysis study in 2021 in the country using 26 relevant articles, the pooled utilization of YPFSRH service was only 42.73 %(11).

Moreover, Health services for young people are not well integrated, uneven quality ,low coverage, inequity in access , and are generally do not fully address the broader health and health-related problems faced by young people (26). For example, an assessment of youth friendly health service quality at public health facilities in Southern Ethiopia showed quality level of 54.4%,42%, and 49.1% at input, process and outcome respectively which are below the standard cut point of 75%(29).

Adolescent pregnancy is a serious public health problem since it has been linked to increased morbidity and mortality in both the mother and the child. Adolescent pregnancy has been shown to have negative societal repercussions, notably in terms of educational attainment, since women who become mothers while still in high school are more likely to drop out.(30).According to a multi-country study in sub-Saharan Africa, prevalence of adolescent pregnancy in eastern Africa was estimated to be 16.3% which was relatively lower than other regions in Africa(31). Even though Ethiopia is one of the countries in this region, a meta- analysis study in the country showed higher prevalence of pooled adolescent pregnancy(23.5%)(32). According to a WHO study conducted in a number of countries, adolescent pregnancy is linked to a higher risk of negative pregnancy outcomes. The findings revealed adolescent mothers aged 10–19 years had a higher risk of eclampsia, puerperal endometritis, systemic infections, low birthweight, premature delivery, and serious new-born disorders than women aged 20–24 years(33). Furthermore, Ethiopian Demographic Health Survey (EDHS) of 2016 also showed 13% of girls aged 15-19 in country have begun child bearing which is associated with low use of modern contraceptives and limited access to YFSRHS (30). For example ,a multilevel analysis of 2016 EDHS also showed prevalence of modern contraception use of adolescent girl and young women(AGYW) was only 34.89% in Ethiopia(34). Likewise, a study conducted in four districts in south west of Oromia regional state in Ethiopia also revealed that only 36.5% of young people utilized reproductive health services (35).

HIV is also one of the major health problem up to date in Ethiopia. According to EDHS only 24% of women age 15-24 and 39% of men 15-24 had comprehensive knowledge about HIV. Seeking HIV test for young people was seen as more difficult than for adult. As a result , only 27% and 29% of young women and men were tested for HIV respectively among those who had unsafe sex in previous 12 months(30).

Studies conducted in different sub regions of Ethiopia, found reasons for low utilization of YFSRHS include lack of knowledge about SRH, low awareness about location of YFSRHS facilities, distance from health facilities, inconvenience working hours, fear of being seen by parents, age ,reproductive health problems and negative attitude of health workers regarding use of SRH services by unmarried young people(27, 36, 37). Generally, due to prevalence , urgency and severity of health problems related to adolescent pregnancy, HIV and STI they are prioritized by this study to be emphasized by this study from other components of SRH.

2.2. Justification

There are four main reasons to carry out this study. First, studies found do not give enough attention to young people in the country . Hence, less is known regarding factors influencing low access to YFSRHS in Ethiopia (36). Second, most studies that assessed SRHS were focused on older young people (15-24) who were in-school and fail to include younger people(10-15 years)(38). Third, even though there are some scientific evidences on barriers for low access to YFSRHS , there is almost no research which identified best practices with evidence to solve those problems. Forth, as a public health professional serving in government district health offices, it is my personal and professional interest to unravel these factors and contribute towards potential solutions.

Therefore this study will review factors that influence young people's access to YFSRHS to better understand why the utilisation of these services are so low, and also identify what best practices are found improving it. Moreover, this study finding will benefit health sectors in the country to understand underlying factors for low access to Young people friendly sexual and reproductive health services for proper intervention. It may also further alert health policy makers and contribute in some policy modifications regarding young people's sexual and reproductive health.

2.3. Objectives

Overall objective**:** To explore factors influencing young people's access to youth friendly sexual and reproductive health services in Ethiopia, in order to make recommendations for relevant stakeholders on improving access to these services.

Specific objectives**:**

1. To analyse policy and organizational factors influencing young people's access to youth friendly sexual and reproductive services.

2. To analyse interpersonal and socio-cultural factors which influence young people's access youth friendly sexual and reproductive health services.
3. To describe young people's knowledge , attitude, belief ,socio-economic and demographic factors influencing access to youth friendly sexual and reproductive health services.
4. To discuss evidence based interventions from relevant Sub-Saharan settings that can inform ways to improve young people's access to youth friendly sexual and reproductive health services in Ethiopia.
5. To formulate recommendations for relevant stakeholders on improving young people's access to youth friendly sexual and reproductive health services in Ethiopia.

Chapter 3: Methodology

This chapter consisted study design and search strategy , inclusion and exclusion criteria, conceptual framework and limitation of the study design.

3.1. Study design and search strategy

This was an exploratory study based on literature review method with searches carried out between March and July 2022, mainly study references from Ethiopia were included. However, to enrich the study with important information literatures from other countries with similar settings were also used. To retrieve relevant references, appropriate combination of key words were used. In addition, Searching for factors and best practices were undergone separately. Published scientific articles were extracted through Libraries such as Vrije Universiteit (VU) library, PubMed, Guttmacher Institute, Medline and web search engines Scopus and Google Scholar. In addition, grey literature was obtained from organizational websites such as WHO, United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF) and Federal Ministry of Health of Ethiopia. More specifically, the following inclusion and exclusion criteria was used:

- Inclusion criteria: In this study published articles from January ,2012 to August,2022 which targeted either adolescent(10-19) , youth (15-24) or young people (10-24) on title of access or utilization of SRH service in Ethiopia or other Sub-Saharan countries were included. However, in case of framework, guidelines and books the reference were also include beyond the stated range. The studies which focused on specific SRH components of young people such as access to youth friendly contraception services were also included.

- Exclusion criteria: Articles which were not aimed to study access or utilization of YFSRH services were excluded . Similarly ,articles published in other language out of English were also excluded since the only scientific article the author can read is English.

Table 1: Search strategy – search terms included

Specific Objectives	**Source**		**Issue**	**Factors**	**Geographic area**
			AND		
Objective 1 Objective 2 Objective 3 Objective 5	-PubMed -Medline -Scopus -Google -Google Scholar -Guttmacher institute -VU library -WHO -FMOH -UNFPA -UNICEF	**OR**	-Youth friendly sexual and reproductive health services -sexual and reproductive health service -sexual and reproductive health and right -Adolescent -Youth -young people	-Age -sex -residence -religion -education -socio -cultural -socio-economic status -social norm -knowledge -belief -attitude -perception -availability -affordability	-Low and middle income country -Sub-Saharan Africa -Africa -East Africa -Ethiopia

				-waiting time -opening hours -provider attitude -policy -strategy -health care system	
Objective 4 Objective 5			-Best practice -Evidence based -Intervention -Effective response -Sexual and reproductive health -Adolescent/youth/young people -youth friendly service		-Low and middle income country -Sub-Saharan Africa -Africa -East Africa

3.2. Conceptual framework

To identify a framework which could guide better to analyse factors influencing access to YFSRHS in Ethiopia literature have been exhaustively searched. Particularly, Andersen behavioural model and socio-ecological model were observed. Accordingly, it was noted that Andersen and Davidson described three major components of Andersen behavioural model. It consists of predisposing, enabling factors and need factors include perceived need for health service and evaluated need(39). However, according to a systematic review of studies from 1998–2011 regarding re-revising Andersen behavioural model there were huge variations in the way these factors were categorized, especially predisposing and enabling factors among different studies and strongly suggested re-operationalization is still needed through internationally conducted primary data before using this model(40).

Socio-ecological model has four to five clearly categorized at distinct levels that made it to be selected for this study. It also adequately captures the factors intended to be explored. It recognizes and articulates the relationship between the individual and their environment covering all possible factors the author want to focus on hence fit well with specific objectives. Furthermore, the model has been also used in many studies of access and utilization of health services. Therefore, was used being adapted (see Figure 4) to fit more with the context of Ethiopia and used in this thesis.

In the adapted model socioeconomic and demographic factors were added in individual factors since they are also important in the context of the country. In addition under community factors socio-cultural factor was included since it is the focus of the objective. The place of community and organizational factor were also exchanged since in Ethiopian context, community factors and interpersonal factors have direct relation (see Figure 2).

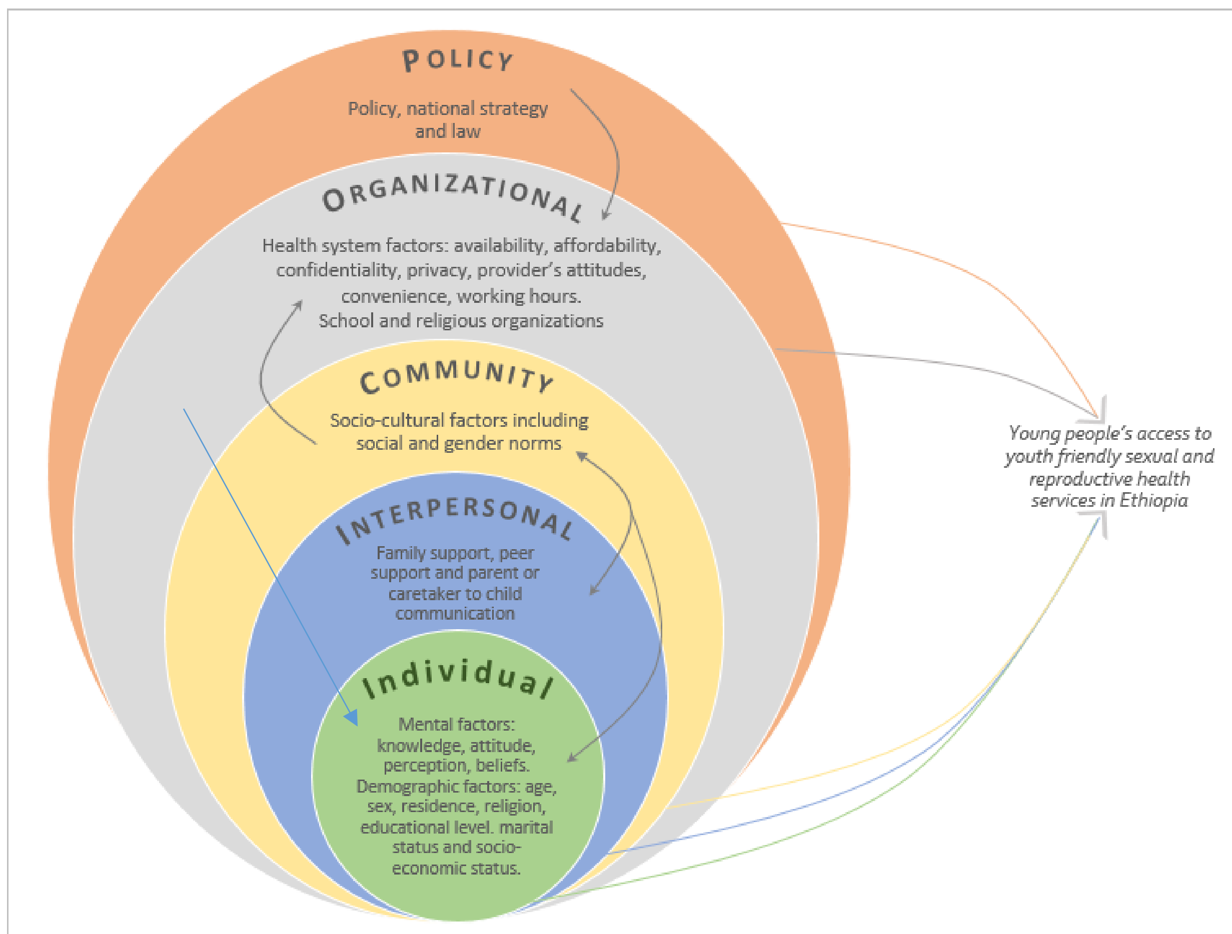

Figure 2: Adapted socio-ecological model

Methods of answering objectives or research question:

Conceptual framework was used to guide analysis of factors for the first three objectives. Therefore, Parts of conceptual frameworks were used to systematically answer objective 1,2 and 3 following the parts of the framework. One section of first objective (policy issue) was approached through analysing policy documents while the other section of first objective (organizational factors), objectives 2, 3 and 4 were answered through using published peer reviewed articles and published grey literature. The last objective (5th) was answered by consideration of all evidences obtained from all the rest objectives.

3.3. Limitation of the study design

Since literature search focused only on literatures that were published from 2012 to 2022 only; some important materials might be missed. The other main limitation was peer reviewed articles and grey materials that were written in English language only were used. Moreover, in case of shortage of articles published in Ethiopia , those published out of the country were used which might be not exactly replace the context of the country .

Chapter Four: Result

All findings of this study are organised into six sections in this Chapter. To answer the first objective, it presents an analysis of what is the policy environment of Young people's Sexual and reproductive health (section 4.1) and what organizational factors influence their access – and why (section 4.2) .Then, it also comprises what community (section 4.3) and interpersonal factors(section 4.4) influence Young people's access to SRH services to address second objective as well as what and how individual factors (section 4.5) influence access to SRH services of young people to answer the third objective being guided by socio-ecological framework to systematically address these objectives. The chapter also presents the fourth objective which is evidence based interventions (section 4.6) needed to tackle barriers identified.

4.1.Policy environment of Young people's sexual and reproductive health and rights

This section consists eight (8) subsections and presents overview of commitments of Ethiopia to international policies and analysis of health policy documents regarding how the issue of young people SRH services look like at policy level. Accordingly, this finding showed health policy of Ethiopia is promising except few limitations.

4.1.1. Commitment of Ethiopia to regional and International agreements

Ethiopia is a member of both the UN (United Nation) and the African Union (AU). As a result, the country ratified international treaties like the Convention on Rights of Children (CRC) of the UN and African charters on the rights and welfare of children. The 1994 International Conference on Population and Development (ICPD) also contributed to a greater attention on adolescent SRHR. Ethiopia signed both the African Charter on Human and Peoples' Rights and the African Charter on the Rights of Women (Maputo Protocol). Governments must "take all appropriate steps to preserve women's reproductive rights by permitting medical abortion in cases of sexual assault, rape, incest, and where the continuation of pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus," according to Maputo Protocol Article 14(2)(c)(41).

Moreover, Ethiopia's health strategy relies on primary healthcare as one of the signatories to the Alma Ata Declaration and UN political declaration on universal health coverage(42). These imply that the country accepted several international and regional agreements which are vital to promote young people's sexual and reproductive health and rights – as well as their access to SRH services to ensure this, a series of multi-sectoral policy initiatives have been introduced in Ethiopia, and one initiative most relevant for SRH was the Health Extension Program rolled out in 2003.

4.1.2. Health Extension program

The Ethiopian government launched the Health Extension Program (HEP) in the early 2000s to provide health services to the rural population. The National Adolescent and Youth Reproductive Health Strategy, which was introduced in 2007 and emphasized the need for young people to get high-quality, individualized reproductive health care, came next. These programs have recently been expanded to include adolescents in interventions for reproductive, maternal, neonatal, and child health, and the government is committed to creating YFSRHS across the country. However, implementation is the key challenge which hinder young people's access to family planning and other SRH information, care, and services(43).

Under the headings of family health, health promotion and disease prevention, hygiene, and environmental sanitation, HEP includes 18 health packages(42). The program aims to improve equitable

access to necessary preventive, promotive, and selected curative health interventions for all population segments by extending health services to communities through the deployment of 42,336 health extension workers (HEW) in agrarian, pastoralist, and urban areas. Since the country's implementation of the health extension program, there have been noticeable improvements in health outcomes(44). Because of this, it has contributed to a greater emphasis of SRH *for* young people as highlighted in the National Adolescent and Youth health Strategy established in 2016.

4.1.3. National Adolescent and youth health Strategy

The 2016 national adolescent and youth health strategy, which gave emphasis on "adolescent and youth health (AYH)" than just "SRH," is the most recent policy document specific to young people health. It was stated that AYSRH would be offered through community-based approaches and service delivery models based in healthcare facilities(health centers and hospitals). Three implementation modes were suggested for AYH as a crucial component of the HEP: individual-focused clinical services, population-focused outreach services provided by health professionals, and house-to-house services provided by health extension workers. The necessity of using schools and youth centers for comprehensive sexuality and life skills education is also described in this policy document (26). Therefore, this document comprises multi-strategies to deliver health services to young people.

In terms of quality it is observed that this policy document has some limitations . For example, it was observed by previous study which analysed this document as there was some inconsistencies between this policy document and legal document regarding age of consent to use SRH. According to a comparative policy and legal analysis of Ethiopia, Malawi and Zambia which was conducted in 2020 on SRH matters , it was stated that in legislation of Ethiopia it is prohibited to engage in sexual activity with young people before the age of 18 . Despite the fact that the age of majority is 18 years old, there is no legal consent of the age at which young people can use medical treatment without parental approval. While parental consent is indicated for HIV services, there is no information or age of consent specified in the law for contraception. Even though, Ethiopia's National Adolescent and Youth Health Strategy describes consent as " Despite the law that allows access to contraceptives without parental or guardian consent, in Ethiopia … " ,there is no such law. Therefore, such misunderstanding of the law on contraception is most certainly inaccurate and misleading(41).

4.1.4.Health sector transformation plan II

In the most recent Health Sector Transformation Plan II (HSTP II 2020–2025), adolescent and youth health programs were included in the family health component of HEP to be implemented in two ways. These strategies include community-based sexuality education and YFSRHS provided by health facilities (such as hospitals and health centers).In this document young people health was emphasized mentioning lack of knowledge about SRH in this age group and its consequences(42).

4.1.5. National Guideline for Management of Sexuality Transmitted Infections

The guideline acknowledged that young people have a higher rate of contracting a STI and established supportive conditions to treat it, paying specific attention to this age group. Adolescents, particularly younger one who are sexually active, have the highest prevalence of several STIs, because they frequently engage in unprotected sexual activity, are biologically more vulnerable to infection, and encounter numerous barriers to receiving medical care. It is also made very apparent how important it is to maintain privacy and confidentiality when working with young people. Accessibility, affordability, appropriateness, and acceptability to young people, including female sexual workers, were also incorporated into the guiding principles for services delivery.

In this same national guideline the comprehensive care packages included were listed as follows

1. Effective medical treatment,
2. Education on risk reduction,
3. HIV testing and counseling,
4. Contact tracing and management,
5. Promotion and provision of condoms,
6. Ensure follow up management,
7. Legal and emotional support (45).

4.1.6. HIV and AIDS National Strategic Plan

In this document clear goal, objective ,result expected and interventions were stated . It also included female young people as priority population to access HIV services. Accordingly, the goal intended to be achieved by 2025 is reduction of new HIV infection to less than 1 per 10,000 population. At the end of 2025, the goal is to provide combination of HIV prevention interventions to 90% of Key and Priority groups. To accomplish the objective, interventions were also generally mentioned as behavioral, biological, and structural ones. However, only 265 out of the total 1076 districts—those with an HIV incidence greater than or equal to 0.03—were planned to receive this package of interventions. The behavioral change communication (BCC) intervention, which is primarily centered on peer-facilitated small group learning, has received attention in these priority districts(11).

KEY POPULATIONS:

- Female Sex Workers (FSW) and their clients, Prisoners
- People with injecting drug use

PRIORITY POPULATIONS:

- Widowed and divorced men and women, Long distance drivers
- High risk adolescent girls and young women
- PLHIV and their partners

4.1.7. Piloting and scaling up Youth friendly health Services in Ethiopia

Pathfinder and the FMOH of Ethiopia collaborated to launch the pilot as part of Pathfinder's Reproductive Health/Family Planning initiative (RH/FP), which was supported by United States Agency for International Development (USAID). The RH/FP project institutionalized YPFSRH services in governmental policies and guidelines in order to facilitate sustainable scale-up of the program. Additionally, the FMOH worked with partners to develop national strategy and guidelines for managing YPFSRH services. The service's provider training curriculum was also developed in 2008 using Pathfinder International's training materials and curriculum. Additionally, the program's service packages were identified and started to be implemented as a trial at 20 health centers in 2005(45).

4.1.8. Education Sector Development Program 2016-2020

In this Ministry of Education(MOE) policy document comprehensive sexuality education is viewed narrowly. The document emphasis only on HIV related education in schools through school community conversation(46).

Previous study regarding adoption of CSE in Ethiopia also indicated that while FMOH gave attention to CSE through clearly including it in health policy, there was poor commitment on side of MOE to incorporate full concept of CSE in its policy to be implemented in schools. One of key informant stated the difference in commitment between these two sectors in this policy as "Sometimes it feels like we are working in two different countries. FMOH is so progressive and open about so many issues. Even in the current national adolescent and youth [health] strategy that we developed, CSE was clearly indicated that

it should be promoted among school- and out-of-school youth. But M0E is very closed about it. (International Organization, Female"(47).

4.2. Influences of the organizational level factors on access to SRH services

This section presents health system , school and religious institutions which includes finding in broader context in addition to the study setting.

4.2.1 Health system

Evidences showed health system factors such as availability, affordability, confidentiality/privacy, providers attitude and convenience working hours are among the main factors which determined young people's access to YFSRHS. A qualitative systematic review in sub-Saharan countries among young people realized that young people are motivated to use contraceptive services when confidentiality, ready availability and affordability are assured(48). The review also showed that access to YFSRH services was significantly influenced by the attitude of health professionals toward their patients. Five of the 13 studies reviewed in this study identified the negative attitudes of health professionals as a health system barrier of young people's access to contraceptives(48). These attitudes manifested as disrespect, complete denial of contraceptive services, denial of counseling about contraceptives, and discrimination. In some studies buildings were also said to be physically inaccessible because the stairs were unfavorable to young people with disabilities, which ignores their sexual and reproductive rights(48).

Type of barriers of access to young people's YFSRH services in providers perspective and view of young people themselves was usually different. For example, according a systematic review study that used 35 studies from various countries around the world , young people and health service providers often have opposing views on barriers and enablers of young people's access to YFSRH services. Young people identified attitude of providers as the main obstacle to their access and use of services, while service providers saw physical and financial constraints of service users as crucial factor. The study also indicated that certain service providers' unprofessional behavior restricts adolescents' access to SRH services(49).

Another systematic review conducted using 19 studies from low and middle income countries including Ethiopia regarding access to young people's STI services showed that the most common barrier that hinder young people to use STI service was low acceptability of the service which was in turn related to provider's behavior of being judgmental or negative attitude as described by rude, unfriendly treatment and blaming(50). Studies specific to Ethiopia also revealed that provider related barriers are common. For example, according to a cross sectional study in Ethiopia to assess willingness of Midwifes to provide safe abortion services, out of 960 respondents only half of midwifes were willing to provide the service. Surprisingly, midwives stated that their decisions regarding whether to offer the desired safe abortion care are influenced by the opinions of outside authorities, including husbands, parents, employers, and family members. Approximately 75% believed that having an abortion is a sin(51).

According to a retrospective assessment of 8 health centers in Ethiopia to scale up strengthened YPFSRH services; by including long acting reversible contraception (LARC) ,only two of the eight health centers experienced statistically significant increases in LARC uptake despite favorable policy environments, supportive stakeholders and financial support for trainings; this highlights the impact of weak health systems, as evidenced by the low quality of FP services and a lack of human resources(52).

Another study in Ethiopia also indicated that a health system related problems like shortage of fund to implement policies is more significant than policy related problems in Ethiopia. Even if fund is available YFSRHS is not usually prioritized as there are other competing programs. For example , one Key Informant

questioned whether it was reasonable to spend distinct resources to young people SRH since a lot of young people are married so that when they start having children and can thus access services for married people saying " be careful with your definitions; the majority of young Ethiopians are already married... Additionally, the health sector does offer health care to persons that fall under this category. It makes no sense to allocate resources specifically for them. They may be dealt with as adults." (53).

According to a study conducted in North West Ethiopia , Gojjam Zone in 2020 concerning quality of the service from 18 health facilities none of them achieved greater than 75% in the three components of quality measurement at input, process and outcome. Especially, privacy/confidentiality, was the most compromised one as only 56.8% of health facilities in that study had a separate room for young people. This inconvenient physical setup were reason for poor privacy which in turn decreased their satisfaction to the service so that they didn't want to visit health facility again. Furthermore, about 25% of them had no trained provider for the service and only few of them combined young people friendly service with community intervention (54).

Furthermore, inconvenient time was found to be one of barriers for young people's access to YFSRHS . For example , study conducted in Metekel Zone in Ethiopia in 2017 showed that Youth-friendly reproductive health services were 71 percent less likely to be used by youth during the typical health institution working hours compared to youth who prefer to seek treatment at times when other users are not present(55).

4.2.2. School and Religious Organizations

School teachers attitude and influence of religious leaders also found to be directly or indirectly influenced young people's access to YFSRH services. According to technical guideline of United Nations Education, Science and Cultural Organization (UNESCO) even where curricula of CSE exist usually teachers ignore to teach some topics which they are not comfortable with . In addition a qualitative study conducted in 2015 in Ethiopia also showed even though school teachers started to discuss on some sexuality issues with students , they were culturally influenced and couldn't able to discuss on broad sexual and reproductive health matter with young people(14).

Another study conducted in Nigeria on perspective of teachers on reproductive health education also showed teachers were not comfortable personally counsel students in spite of their willingness to teach in class(56). Moreover, a study conducted in one of pastoralist region in Ethiopia(in Afar) in 2016 showed, overall access to contraception services was only 8.5%. The major reason(85.3%) for not using the service was due to religious teaching by religious leaders(57).

Therefore, these findings of the first objective showed that policy environment (section 4.1) of Ethiopia is promising and so can be taken as facilitator to increase access to YFSRHS while organizational factors (section 4.2) particularly ,health system is significantly contributing to young people's low access to YFSRHS in Ethiopia. Surprisingly, the finding showed health system factors such as provider attitude can be influenced by community level socio-cultural factors.

4.3. Community level: How Socio-cultural factors are influencing access to SRH services

According to a study in low and middle income African countries in 2018 regarding social norms and young people sexual health ; although social norms are one of the most extensively studied factors influencing human behavior, there is disagreement among social norms researchers as to what they are, how they maintain behavior, and how they can be altered. However, commonly social norms were defined as

externally generated, context-dependent rules required, appropriate, and acceptable conduct that members of a certain group or community agree upon(58).

There are evidences supporting the idea that social norms have an impact on how young people behave in relation to their health. Young people place less emphasis on health risks and more on the social benefits that sex delivers to them. The majority of the research on social norms and young people SRHR focuses on sexual initiation. Despite the fact that many of these studies did not focus on measuring social norms directly, the findings suggest that these norms have an impact on how young people behave sexually. For example, after adjusting for other variables, the peers' sexual initiation ages are a reliable predictor of one's own sexual initiation ages. In addition, studies have discovered parallel relationships between peers' contraceptive use and one's own use of the method whose basic factor behind it was social norm(58).

According to a systematic review in Sub-Saharan African countries out of 19 studies reviewed 9 research highlighted societal barriers of contraception use, which included two sub-themes: social implications of contraceptive use and social norms. The stigma, being labeled as promiscuous, society's rejection of contraceptive use, societal restrictions on discussing contraception, the idea that contraception is exclusively a problem for young women, and religious bans were the specific social barriers to contraceptive use(48).

A qualitative study conducted in Ethiopia and India found that social norms and beliefs were frequently described as barriers to use of contraception in both countries. While many respondents mentioned favorable changes in societal perceptions on the average age of marriage and the first childbirth for women and girls, they also acknowledged that there are still limitations. Participants described a generally recognized social norm in which having children started soon after marriage, regardless of age or attendance at school .For example, in that study a 17 years of age girl from Ethiopia said " for it is obvious that a woman will give birth if married, she has to follow her education until grade 8 ". Despite being aware of contraceptive options, many people were discouraged from utilizing contraception by the shame attached to delayed birth. An eighteen years old married female respondent of the study in Ethiopia described this issue saying "Even when one tries to use possible means to delay birth, people in the community oppose you. According to people in the community, such attempts of delaying birth is unacceptable"(59).

Another way of impact of social norms on access of YFSRHS observed is through decreasing male support for SRH services. The USAID conducted a qualitative study in Ethiopia that revealed barriers at the socio-cultural level to be impacting male support for family planning. The study found that, among the other barriers already in place, the influence of culture and gender norms, which view family planning as a female concern, were significant roadblocks to male involvement in family planning. Thus, although they are decision makers , Ethiopian male frequently disagree with their partner's use of family planning methods and refuse to take part in it(60).

Barriers that influence access to YFSRHS at community level also reflect at interpersonal and individual level too. For example , a qualitative study on the title of "addressing SRH need of young people in Ethiopia" in 2015 indicated that the influence of culture which prevent open discussion about sexual matter was not limited at community gathering and class room places only but also at house hold level being obstacle for discussion between parents and children on sexual things openly. As one Key Informant commented: "In my view, … there is really a need for young people to be informed about sexual and reproductive health. They should know about their body… Nobody will tell them about [SRH] issues … If at all they [parents] discuss it with their children, they talk about virginity... Other issues – are taboo." .

There is signs of improvement, nevertheless, with communities start showing support young people to access SRH services and prevent childbearing so they may finish their studies(53).

The consequence of societal level factors can go beyond decreasing access to YFSRH service. For example, a qualitative research using 32 focus group discussion across four regions(Oromia, Amhara, Addis Ababa and Southern Nation and Nationality People (SNNPR), found that young, unmarried women in Ethiopia experience severe stigmatization and exclusion from society from the moment an unwanted pregnancy occurs. It was stated that stigmatizing unmarried women who become pregnant can lead to depression, homelessness, poverty, or even suicide because of the rejection from society. This kind of stigmatization can push women to seek unsafe abortions, endangering their lives(61). Therefore, these evidences revealed that one of the main reasons for low access to YFSRH services in Ethiopia is restrictive socio cultural norm.

4.4. Interpersonal level: Family and Peer influences on SRH services of Young people

This sub-chapter presents facilitators of YFSRHS which include support from family, peer and other close persons and barriers such as poor communication of unmarried young people with their parents on sexual matters, poor discussion and involvement of male partner in SRH issues of married young women and peer influences to ward risky sexual behaviour.

4.4.1. Family influence

According to a systematic review carried out focusing on studies in Sub-Saharan countries, Social support was found to be a significant driver of access to young people's contraception use. It was recognized that family support was one of the main social support which facilitate young people's use of contraceptives(48). For example, according to a quantitative cross sectional study conducted among female preparatory students at high school in Asella town ,Oromia regional state of Ethiopia in 2020,discussion about sexual and reproductive matters with parents was significantly linked to young people's access to contraception. The study showed that respondents who did not discuss sexual and reproductive issues were 60% less likely accessed contraception compared to those who have discussed with parents (AOR 0.403; 95% CI 0.205, 0.792)(62).

Similarly, a systematic review conducted in Ethiopia in 2019 revealed that adolescents who had ever discussed reproductive health issues with their family members were 3.63 times more likely to use RH services than adolescents who had never discussed such matters. The justification given by authors was that adolescents who talk about reproductive health issues with family would have higher understanding and awareness of RH services and would therefore be motivated to use the services(63).

Findings showed communication between parents and young people on SRH issues raise self-esteem and boosts their confidence to prevent risky sexual practices . Despite of this advantage, according to a meta-analysis study on adolescent-parent communication conducted in Ethiopia ,the pooled prevalence of parent-adolescent communication on SRH concerns in Ethiopia was found to be only 45.18 %. The frequency of communications between parents and adolescents varied between regions. For example, the highest level of communication between parent and young people on sexual matter was observed in Oromia , followed by SNNPR and Amhara region (64). A number of studies revealed that knowledge level of young people on SRHR, educational status of parents and young people, and belief on SRH services, social norms were associated with young people-parent communication on SRH matters(64-67).

A community based cross sectional study at Asella town in Ethiopia in 2021 also showed low level of discussion (23.%) of parents with their adolescents at least two topics of SRH matters in the last

12months. It also indicated that the most common topic of conversation between parent and adolescent when it came to discussing contraceptive options was abstinence, whereas the least common topic was condom use. Majority (77.5 %) of parents who were asked why they did not talk to their young people about reproductive health issues said that they were concerned that doing so could push them to have premarital sex(66).

According to a study conducted in East Wollega Zone, Oromia regional state in Ethiopia in 2012 ,only 21% of younger people (10 to 14 years old) reported talking to their parents, despite the fact that 42.5% of total young people (10-24) reported doing so. At the age of 15 to 19, this number rises relative to other age groups for both sex and it tends to fall at the age of 20-24(see figure below). The study also showed that males of the same age had lower discussion level than girls of the same age and discussion of same sex was noted during the study. This means, while male young people reported discussing with their fathers and sisters , female young people reported discussing with their mothers and sisters. It was also mentioned that compared to fathers and sons, mothers and daughters communicate more frequently. More surprisingly ,the study showed even the observed discussion between parent and young people were not in friendly manner, it was in form of warning and threatening(67).

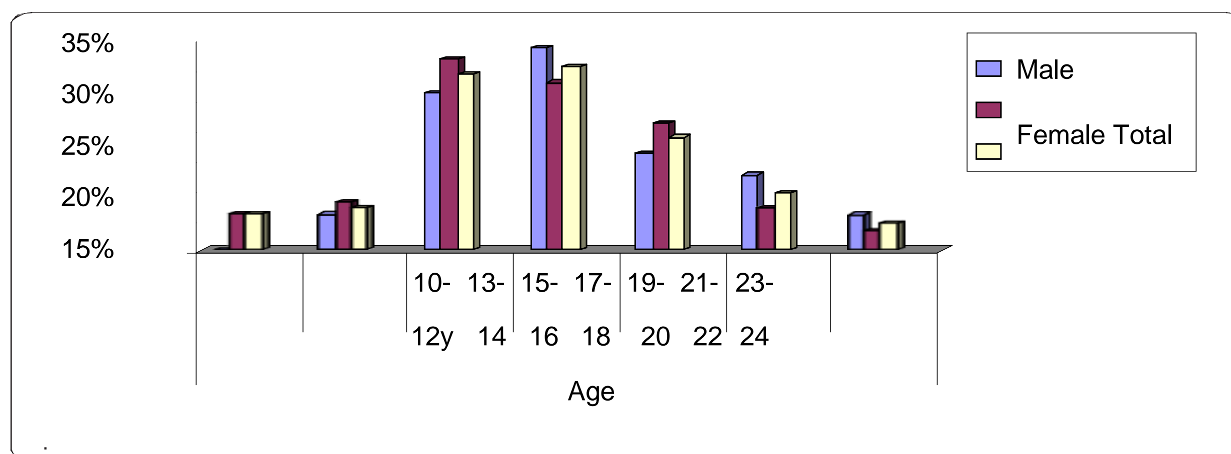

Figure 3: Parent communication about SRH by young people, Nekemte, Ethiopia,2012 (67).

4.4.2. Peer influence

In a systematic review conducted in Sub-Saharan countries one of forms of social support identified as motivator of young people's contraception use was peer acceptance and positive peer pressure which considerably encouraged young people to use contraception(48). A quantitative cross sectional study conducted among female preparatory students in Asella town ,Oromia regional state of Ethiopia in 2020, revealed while 55% of the girls had discussion on SRH issues in general most of them (60%) had discussion with peers. The study also indicated that those girls who discussed with their peer on SRH issues more likely accessed SRH Services compared to those who didn't discussed with their peers(62).

Generally, the second objective that consisted two sections (section 4.3 and 4.4) showed that social norms and gender norms are one of prominent barriers of young people's access to YFSRHS in Ethiopia. This finding showed socio-cultural norms of community level highly influenced other levels of the socio-ecological model including organizational, interpersonal and individual level factors .So that it significantly contributed to Young people's low access to YFSRHS in many pathways. It is shown that behind Individual 's choice or behavior there are underlying external factors such as how family and peers support young people and how social norm looks like as presented in these section (section 4.3 and 4.4).

4.5. What individual level factors are influencing access to YFSRHS?

In this part, most common individual factors observed to be associated with young people's access to YFSRH service is presented turn by turn which include demographic factors , mental factors and socio-economic status.

4.5.1. Demographic factors

Regarding sex of young people most of studies showed females were accessing YFSRH service more than males. For example, according to a community based cross sectional study regarding adolescent friendly reproductive health service utilization in Metekel Zone, Benishangul Gumuz, North West Ethiopia conducted in 2017 , young people's sex and access to reproductive health services were related. Female young people had 1.97 times the likelihood of using youth-friendly reproductive health services than male(55).This finding also supported by another community based study conducted in Nepal in 2020 in which female young people accessed the service five times more likely than their counter parts(40).However , institutional based study conducted in high school and preparatory school in Debra Tabor town, Northwest Ethiopia in 2020 showed higher access to YFSRH service in males than females(38).

Age and marital status of young people also found to be one of determinants of access to YPFSRH service. Studies revealed that relatively younger age accessed the service less than older young people. For example according to the finding in Metekel Zone, Youths between the ages of 15 and 17 were 10.7 times less likely to access youth reproductive health services than those between the ages of 18 and 24(55). Similarly, in Nepal a study showed adolescents from 15 to 19 were 22 times more likely to use the services than those between the ages of 10 and 14(40). A Study conducted in Nigeria in 2019 also showed likelihood of accessing YFSRHS is higher in married young people when compared with their counter parts(68).

Another demographic factor found to be associated with access to SRH services was resident of young people. A cross -sectional study on trends of adolescent contraception use in three countries in sub-Saharan Africa(Ethiopia, Burkina Faso, Nigeria) in 2015 showed that there was significant difference in utilizing modern contraception by resident in which urban adolescents used the services higher than rural adolescents(69). Similar finding was also observed in Asella preparatory female students in which those from urban used the service more likely than students from rural area (Adjusted Odds Ratio:4.60 (1.06-19.94)(70).

When education status of young people was observed, those who attended at least primary school found to be more accessed YPFSRH services than non-educated young people in many studies. A Secondary data analysis study using EDHS of 2016 showed young women of 20-24 years old who attended at least primary school found to be utilized contraception services higher than those who had no formal education(71). Similarly, different studies conducted in Ethiopia revealed that young people who attended high school and above accessed SRH services higher than those who attended only primary school(63, 69, 72).

A study which based on data of EDHS 2016 showed , in comparison to Orthodox religious members, Muslim religious followers young people were less likely to use modern contraceptives. Additionally, protestant religious members were also less likely to utilize modern contraception(71). Similarly, according to a study in three Sub-Saharan African countries it was observed that the Sahel, Nord, and Centre-Nord regions of Burkina Faso; the Afar and Somali regions of Ethiopia; and northern Nigeria—regions that are primarily Islamic—recorded the lowest percentages of young women contraception use(69). However, according to a qualitative study in Ethiopia in 2022 , both Christian and Muslim followers referenced their scripture in their religious book about the idea that God created the earth and gave humans the order to multiply and fill it in abundance,. In light of this, some people believed that family planning was sinful because it was deemed to be insulting to God(60).

4.5.2. Mental factors

A systematic review of studies from different part of the world showed that according to service provider perception one of the main factors that hinder young people to use SRH services was poor knowledge about SRH services(49).A quantitative study conducted at Mizan Tepi University , South West Ethiopia among female students also showed there was significant difference in accessing contraception services between female young students who had good knowledge regarding the service and who had poor knowledge[AOR: 3.248; 95 % CI 1.320, 7.988].This finding was also supported by other study (48, 73).

Another common barrier to young people's SRH service was about perception of young people regarding the services. For example according to a systematic review of 19 studies of sub-Saharan countries, the most frequently mentioned individual barriers to using contraceptives were myths and misconceptions. These myths and perceptions included the notion that contraception (especially condoms) are ineffective at preventing conception, that the color and size of condoms currently on the market are inappropriate, that using contraception promotes promiscuity, that using contraception lessens sexual pleasure. In addition, young people were discouraged from using contraceptives due to perceptions regarding known side effects such as weight gain, bleeding, high blood pressure, headaches, and interruption of the menstrual cycle(48).

Belief and attitude about some SRH services were another individual factors commonly became barriers to use services. For example according to a recent (2022) study in Ethiopia a belief that contraception use causes infertility was one of the main barriers observed. Accordingly, about half of the respondents (48.2%) believed that contraceptive use causes infertility. In the study male support of contraception was associated with a reduction in the odds of believing that contraception causes infertility. In addition, while visiting health centers also associated with reduction of such beliefs , home visits by Health Extension Workers (HEW) was not associated with reduction of this belief(74).

4.5.3. Socio-economic status

Several studies revealed that Young people from households of richer family had more accessed SRH services compared to the poorer families. For example, the secondary data analysis of EDHS 2016 showed young women in the middle, higher, and richest wealth quintiles in both rural and urban areas used contraception services higher than those from the lower wealth quintiles(71). Similarly, another studies in Ethiopia also showed that access to contraception services by young people increased as wealth quintiles of house hold rises(69, 72).

Generally ,this section (section 4.5) which addressed the third objective showed that young people of lower age, those who live in rural, lower educational status and unmarried are less likely accessing YFSRHS when compared with their counter parts. This finding also found that the underlying restrictive socio-cultural norms which hinder free discussion on sexual matters and the negative attitude of health providers together contributed to lack of knowledge and negative perception of young people regarding YFSRHS which in turn decreased their access to the service. However, as it was described in objective one of first section (section 4.1) there was initiatives which aimed to improve access to YFSRHS in Ethiopia through implementing interventions particularly focusing on peer education.

4.6. Evidence based Interventions to increase access to YFSRHS

This section presents interventions that were known to be effective or promising in increasing access to young people sexual and reproductive services. Based on evidences from systematic reviews of studies from low and middle income countries effective and ineffective interventions are identified and presented. In addition , experiences or 'best practices' from other countries with similar settings are included to be applied in Ethiopian context.

4.6.1. Basic evidences drawn from descriptive or systematic reviews

In 2014 , a descriptive review of the effectiveness of interventions to improve young people access to SRHS in low- and middle-income countries was conducted by three authors from university of Washington in collaboration with one from World Health Organization. The study aimed to identify how effective were the following four main types of young people's SRH interventions : facility based interventions(Hospitals and clinics), out of facility based (school based service delivery, outreach and youth centres), interventions to reach vulnerable populations and interventions to increase community acceptance. Access to SRHS as well as biological results related to sexual and reproductive health such as incidence of HIV/STI and level of unintended pregnancy(75).

According to that review, there was no evidence which support programs that only offered health staff training on how to be more adolescent-friendly. However ,the approaches using a combination of health worker training, young people friendly facility improvements, and widespread information dissemination via the community, schools, and mass media had the most data (10 initiatives demonstrating positive effects as well as one randomized controlled trial demonstrating strong positive results on some outcome measures). Except for those offered through mixed-use youth centers that showed that SRH services at these facilities were neither well used nor successful at improving SRH outcomes, they found few evidence for out-of-facility based strategies. Results from 17 of 21 initiatives evaluating activities that generate demand also showed some positive association with adolescent SRHS use. Out of 15 studies that evaluated access to SRHS and/or biologic outcomes for adolescents and asked parents and other community gatekeepers for their consent, 11 had promising findings(75).

Finally, the descriptive review concluded that implementation of packages of interventions that train health professionals, enhance facility young people friendliness (extending working hours, minimizing prices, appropriate physical lay out to increase privacy or confidentiality) and seek to increase demand through many channels were effective. Therefore, the authors classified the suggested packages of interventions as "ready" to implement according to the below box " Do not go, Steady, Ready ,Go " classifications they had adopted from WHO(75).

Box "Do not go, Steady, Ready, Go" classification

Go: Evidence threshold met Sufficient evidence to recommend large-scale implementation coupled with careful monitoring of coverage, quality and cost, and research to better understand the mechanisms of action.

Ready: Evidence threshold partially met Evidence suggests intervention effectiveness but large-scale implementation must be accompanied by further research to clarify mechanisms and impact.

Steady: Evidence threshold not met Some promising evidence, but further development, pilot-testing, and evaluation are needed.

Do not go: Strong enough evidence of lack of effectiveness or harm Do not implement.

Another review of evidences on interventions of access to young people's SRH to identify what does work and what does not work were undergone by authors being together from WHO,USAID and UNFPA in 2015.Accordingly, issues related to Youth centres, peer education, comprehensive sexuality education and Youth-Friendly Services (YFS) were presented. Peer education programs have been shown to have very little influence on encouraging healthy behaviors and enhancing health outcomes in young people, even though they result in information sharing. Additionally, the evaluation noted that peer educators themselves profited from the initiative since they received training rather than the other beneficiaries for whom the intervention was designed(76). This finding also supported by a systematic review (in 2017)

which based on 20 controlled trails in low and income countries and found that peer education didn't show any positive result regarding SRH of young people(77).

Youth centers, a non-clinical setting where SRH information and services can be offered alongside other social services, such as recreational activities or Internet cafés, were criticized for their ineffective approach because neither their use of SRH services nor any significant changes in SRH behavior were observed. First, a relatively small percentage of young people who lived nearby, predominantly male, used the youth centers. This was one of the explanations given. Second, they were significantly older than the intended target age and were most frequently visited by young males who were in school or college. Third, youth centers were mostly used for recreational activities. Fourth, the use of SRH services or contraceptive methods had no, very little, or only temporary impact. Lastly, there was a significant expense per beneficiary. However, two interventions that had been shown to improve adolescents' knowledge , attitude and behaviour were comprehensive sexuality education and appropriate SRH services(YPFSRH services)(76).A cross-sectional survey in 2017 in Mexico also support this finding in which comprehensive sexuality education shown to have significant association with improvement of SRH out comes(78).

It was also described that young people use of SRH services can be improved, when the following four approaches are implemented together:

1. Providers are trained and supported to be non-judgmental and friendly to young people,
2. Health facilities are welcoming and appealing,
3. Communication and outreach activities inform adolescents about services and encourage them to make use of services,
4. Community members are supportive of the importance of providing health services to (76).

4.6.2. Existing interventions for young people's SRH services in Ethiopia

Since 2005, Pathfinder International has been collaborating with the Ethiopian Ministry of Health to enhance adolescent and youth health. The program was launched at 20 experimental public health clinics in Ethiopia's Amhara, Oromia, Tigray, and SNNPR regions. The scaling up phase began in 2008, and by 2020, there would be 416 health facilities offering YPFSRH services. Peer education was viewed as the key component of the SRH program for young people. As a result, between 2005 and 2020, 39,000 peer educators and almost 12,000 health providers received training. The majority of YPFSRH locations have 25 peer educators working with them, with an equal number of male and female peer educators and 20% of out-of-school young people(27, 79, 80)

Through coffee ceremonies and referrals to YFS facilities, peer educators are supposed to spread health messages and offer counseling in their neighborhoods, schools, and healthcare facilities. A service package that combines demand development, referrals through peer educators, preventative and curative health treatments, including SRH services at YFS facilities was tried(79).

There are conflicting results regarding effectiveness of peer education program in Ethiopia among different studies conducted in the country. Example, according to a study which based on cross sectional and key informant interview, peer education was seen as it is effective in term of giving information for young people in Ethiopia(79). However, another study conducted in Ethiopia using experimental method showed that peer education is ineffective in changing behaviors, myths and misconceptions(81).

4.6.3. Best practices from other countries

According to a review document which presented best practices on Youth friendly HIV services in 2017 from PEPFAR(President's Emergency Plan for AIDS Relief) supported countries, successful projects were identified based on pre-set criteria of selections. These criteria were : adolescent and youth involvement,

relevance, effectiveness/impact, reach, feasibility, sustainability, replicability or transferability, ethical soundness, and efficiency. Accordingly, Seven best practices, four promising practices, and two emerging practices were identified, of which five provided strong evidence needed to recommend priorities for action(82).

Described below are three best practices of projects, mainly focused on HIV and STI prevention, found to be applicable in the Ethiopian context, and Table 2 summarizes the most relevant elements.

Table 2: Best practices on adolescent and youth friendly services from selected projects in Africa

Study Location and Program	Type	Target Population	Description(best practices)
BEST PRACTICES			
United Republic of Tanzania: MEMA kwa Vijana	Clinic-, school-, and community-based	Adolescents, ages 12–19 years, in rural areas	• Teacher-led, peer-assisted sexual health education curriculum in schools • Youth-friendly health services • Community-based condom promotion and distribution by youth • Community activities (e.g., youth health weeks)
Kenya: One2One Integrated Digital Platform (OIDP)	Mobile and web-based	Adolescents and youth, ages 10–24 years, in six counties with a high burden of HIV	• Mobile-based services for sexual and reproductive health, HIV, and gender-based violence • Provision of health information and counseling through web-based platforms • Engagement of AYLHIV and key populations in message development • Toll-free hotline
The Democratic Republic of the Congo: Supporting Youth and Motivating Positive Action (SYMPA)	Clinic-based	Youth living with HIV (YLWH), ages 15–24 years, seeking care at a clinic in Kinshasa	• Development and implementation of a curriculum on positive prevention • Monthly peer education sessions • Peer support groups

Source: selected from lists of summarized successful projects (82).

1. Mema kwa Vijana project ("Good things for young people")

This project was started in 1999 in Mwanza region of Tanzania focusing on four main components: Sexual health education ,Youth-friendly health services , Community-based condom promotion and distribution by youth and Community activities. The project's objectives included delaying early sexual initiation, lowering number of sexual partners among those who were sexually active, encouraging proper and consistent condom use among those who are sexually active, and increasing access to STI and family planning services. The project was effective for HIV-related attitudinal , behavioral and biological outcomes(82).

2. **One2One Integrated Digital Platform (OIDP), Kenya**

The project was began in 2006 with the goal of enhancing and sustaining youth health, SRH knowledge, and access to comprehensive gender based violence(GBV), HIV prevention, and treatment services in Kenya. Through the integrated digital platform in 2013–2014, information about HIV, SRH, and GBV was shared with over 2.8 million adolescents and young people. The bulk message (SMS) technology has increased awareness of HIV as well as access to HIV services. By establishing a venue for open discussion, information exchange, and guidance for young people to make informed decisions, SRH, HIV, and GBV knowledge among young people was increased(82).

3. **Supporting Youth and Motivating Positive Action (SYMPA)**

It was a project which started in April 2012 in Democratic Republic of Congo. The central purpose of the program was to ensure young people living with HIV(YPLWH) to avoid transmission of the virus to others, remained physically healthy and be on treatment as well as to ensure their engagement in HIV prevention activities. The program was analysed and reported that the intervention increased knowledge of clients to use services and it was also suitable, satisfying, and able to be implemented effectively(82).

Following these results, the next chapter interprets these findings along the research objectives.

Chapter 5: Discussion

This study is aimed at exploring factors influencing young people's access to YFSRHS in Ethiopia using socio-ecological model focusing on issues related to HIV, STI and adolescent pregnancy. This chapter includes short summary of main results, discussion on each objectives and their linkage , relevance of the analytical frame work as well as limitations and strengths of the study.

Short summary of main result

This study showed despite of its some limitations policy environment of Ethiopia is promising to increase young people's access to YFSRHS . However, implementation gaps are widely observed. The main barriers identified are providers negative attitude regarding young people's SRH service and lack of confidentiality /privacy which belong to health system factors of organizational level . Similarly, another common barriers seen are restrictive social norms and gender norms at community level. As a consequence of restrictive social norms, lack of parent-young people discussion on sexual matters are also identified at interpersonal level .Moreover , factors like sex, age, residence, educational status, marital status ,knowledge, perception and attitude as well as socio-economic status were identified as individual factors influencing young people's access to YFSRHS.

Interpreting policy environment and organizational factors (objective one)

This study revealed that Ethiopia showed commitment to international and regional agreements and developed policy documents emphasising SRH of young people . Therefore, this finding almost agree with previous studies, which concluded as : although the national policy platform has established a favorable environment for addressing young people's SRH needs, there are still difficulties in putting these policies into practice (52, 53).

Despite the fact that health policy environment is encouraging ,this finding also revealed few policy gaps. First, while it was stated that contraception can be used by young people without any preconditions like age and marital status , the national adolescent and youth health strategy was silent regarding information on consent issue of HIV and abortion services. There is also inconsistencies between legal and this policy document especially regarding rights of minors to use contraception as it was indicated by previous policy and legal analysis study in Ethiopia(41).These unclarities in the policy possibly exacerbate the barriers at organizational level , particularly health provider attitude toward contraception use of young people of less than 18 years of age. Second, even though there is a policy which adopted YFSRHS to be implemented in public health facilities (Hospital and health centers) , the strategy didn't clarify whether this service can be applied at private clinics. However, studies showed that mainstreaming of youth friendly health services to private clinics can improve young people's access to the services due to better privacy, less stigma and discrimination and more friendly .Particularly key young people such as, sex workers preferred to obtain services in private health facilities than public(83, 84).

Moreover, comprehensive sexuality education policy is still not fully adopted due to resistance on side of Ministry of Education. But, according to UNESCO, it should cover teaching about anatomy and physiology of the sexual and reproductive system, puberty and menstruation, reproduction, modern contraception, pregnancy and childbirth, STIs, HIV, sexual behavior, gender equality, non-discrimination, consent and bodily integrity, sexual abuse, and harmful customs like early marriage and female genital mutilation(5).

This study revealed that the main reason for low access to YFSRHS of young people in Ethiopia refers to weak health system. Two Studies which were conducted at Southern and North West Ethiopia showed none of health facilities scored greater than 75% of standards of quality at three domains (input, process and outcome)(29, 54). While there is some promising improvement regarding input (trained health

worker, drugs and supplies),process domains such as lack of privacy/confidentiality which related to lack of separate room is common problem identified (54). When confidentiality/privacy is compromised young people's satisfaction to the services is possibly reduced which in turn decreases acceptability of the service and then, hinder them accessing the service again as well as being obstacle of telling to their peers about need of using the service.

Similarly, the frequent health system barrier observed by this study is negative attitude of health service providers regarding young people's use of SRH service. These attitudes manifested as disrespect, complete denial of services, denial of counseling, and discrimination(48). This finding is consistent with a systematic review conducted in sub-Saharan African countries on factors influencing YFSRHS in 2021 which found that unfavorable attitudes of healthcare professionals, inconvenient hours, poor service quality, and inexperienced healthcare providers were the most frequently encountered structural(health system) factors (85).

Interpreting socio-cultural, interpersonal (2ndobjective) and individual factors (3rdobjective) and their linkages

This study also showed that community level restrictive social norm and gender norms are another main reasons for low young people's access to YFSRHS in Ethiopia. For example, the stigma, being labeled as promiscuous, society's rejection of contraceptive use, societal restrictions on discussing contraception, the idea that contraception is exclusively a problem for young women, and religious bans were the specific social barriers to contraceptive use (48).This finding is consistent with a literature review study in Asia which showed socio-cultural factors were one of the most common barriers to access to services for young people (86).

Barriers which are observed at interpersonal and individual level are mostly driven by the community level factors. For example, poor discussion between parents and young people is directly linked to restrictive socio-cultural norm(53). Similarly ,individual factors such as fear of stigma and perception (myths and misconception) of young people regarding SRH services is linked to social norm. More surprisingly, this study also revealed that organizational level factors such as health provider attitude and school teachers view on young people's SRH service are also influenced by social norm. Another surprising finding of this study is that while communication between parents and their young people is generally low in Ethiopia, even those who discussed couldn't addressed it properly. Communication about sexuality among parent and young people is usually in form of warning and focusing on abstinence only while issues of contraception and condom use are rarely discussed.

This study revealed that young people's lack of knowledge about YFSRHS is a common individual barrier to the service. This finding also in line with available evidences. For instance, a study conducted in low and middle income countries in 2014 showed only 19–26% of females aged 15–19 in South Asia and sub-Saharan Africa had comprehensive knowledge about HIV(87). This study also revealed young people of lower age , those live in rural and those who have low educational status accessed YFSRHS lower than their counter parts. This can be justified as these groups have relatively lower knowledge about importance of SRH services and have less chance of ability to afford for the services. It is line with a systematic and meta-analysis study conducted in Africa in 2018 which showed prevalence of adolescent pregnancy was higher in those who reside in rural and less educated than their counterparts as a consequence of their less access to contraception service (88).

Interpreting the evidence based interventions (4th objectives)

When it comes to intervention this study identified that despite of promising efforts to tackle barriers of access the service , interventions that are proven to be effective are less utilized in Ethiopia. According to UNESCO school based CSE is effective intervention . Its advantage includes delaying sexual relationship, reduce frequency of sexual contact , fewer partners for sexual relations, and increased condom use and contraceptives(5). However, both at policy and implementation level this intervention did not get much attention in Ethiopia in which few elements of CSE is being applied in schools which focusing on HIV and AIDS prevention only. On other hand, interventions proven to ineffective get more attention in Ethiopia and relatively applied in large dose. Example, in the project which has been led by pathfinder to scale up in Ethiopia, peer education was seen as a key strategy to create demand and enhance positive behaviour to increase access to young people's SRH services .Therefore, it gets much attention in Ethiopia where 25 peer educators are trained per young people friendly health service sites (health centers)(27, 79). However, many studies including evidences from systematic reviews conducted in low and middle countries as well as study in Ethiopia showed that peer education is not effective strategy , especially to bring behavioral change (76, 77, 81).

Among studies conducted in Ethiopia regarding effectiveness of peer education, opposing results were seen. While the study that used experimental method showed ineffectiveness of peer education(81), one which based on cross sectional and qualitative method showed effectiveness(79). The difference might be due to the difference in methodology showing most probably the latter was not strong evidence. Generally, it can be said that efforts made to improve young people's SRH and the obtained result in Ethiopia was not matched as it was observed from a meta-analysis study conducted in Ethiopia that revealed access to YFSRH service was low (11).

Therefore, this study also identified effective combination of interventions and best practices from other countries in order to apply in Ethiopia context. Accordingly, through controlled trail studies evidence based /effective strategies that able to increase access to SRH for young people is that combines young people friendly health services (focusing on both training of health workers and institutional arrangements), community based outreach services interventions , use of mass media and school based sexuality education.

Relevance of the analytical framework

When it comes to the conceptual model, the strength of the socio-ecological model used is that it possesses all concepts this paper aimed to emphasis on. In addition, the model is widely used and relatively its parts are well categorized in distinct parts without overlap when compared to other models which also works for accessibility. However, its limitations include it doesn't show interlinkages of variables clearly with in a category or between levels. Therefore, adaptation was required in this study.

Strength and limitations of the study

Finally, strength of this study is that it gave priority for systematic reviews in order to identify effective interventions to sake of quality of the finding. In addition, in case identification of factors influencing YFSRH services it focused all most all on studies in Ethiopia. Moreover, many recent literatures are used to know current status in the country. On other hand, limitation of the study is that it uses only literature review while it was important to triangulate by other methods to ensure quality of findings. In addition it is limited only on HIV,STI and adolescent pregnancy issue while other SRHR components like gender based violence, early marriage and others are also still important.

Chapter 6.Conclusion and recommendation

6.1. Conclusion

The review revealed that health policy environment of young people's SRH is promising in Ethiopia while showing implementation gap is more widely exists. Despite of encouraging efforts in accepting international agreements and developing policy documents to deliver accessible, acceptable, appropriate, effective and equitable SRH services to young people , weak health system and restrictive socio-cultural norms are found to be the main barriers of access to YFSRHS in Ethiopia.

Health system factors particularly, the unfavorable(negative) attitudes of health workers which is usually reflected in form of disrespect or complete denial of providing services to young people is among the major findings. Similarly, lack of confidence or privacy is one of the main barriers identified which is related to lack of separated physical space and inconvenience working hours . As a result of lack of welcoming health system , satisfaction and acceptability of the service by young people are found to be diminished which in turn contributed to low access to the service.

Similarly , community level factor of restrictive socio-cultural norms and gender norms are among the most frequent obstacles hindering young people's access to YFSRHS. Restrictive social norms which manifested as social stigma and discrimination attached with premarital sexual practice and utilization of contraception, taboo to discuss on sexuality issues, a perception that a women should give birth immediately after marriage are found to be prominent hindrance of young people to access the service. Similarly gender norm that hinder male involvement assuming SRH issues are female's matter a is also seen to play a role in young people's low access to YFSRHS .

This finding also showed even though initiatives to alleviate barriers in providing training for providers, fulfilling drugs and supplies as well as peer education services are in place, the combinations of interventions couldn't fully responsive .Therefore, Ethiopia could apply combination of multiple effective interventions which include facility based youth friendly sexual reproductive health services, comprehensive school based education, community based outreach activities, mass media and mobile technology to increase young people's access to YFSRHS.

6.2. Recommendation

Based on this study findings the main barriers of young people's access to YFSRH identified were weak health system ,unsupportive social norm and gender norms among others. This study findings also presented evidence based effective interventions which can be applied in Ethiopian context in order tackle these barriers. Therefore, taking these in to consideration the future intervention should include the followings which possibly work for all stake holders including government bodies at all level, donors, local non-governmental Organizations and other civil society organizations.

In order to strength health system the approach that combines and gave emphasis for multi interventions together is recommended which includes health worker trainings and educating young people, family and community at large (89, 90).

Finally, this study concludes by highlighting the most relevant recommendations for further research, programmatic and policy considerations as follows:

- Higher level government officials and partners should give emphasis for content of training manuals for health workers that should comprises on how their negative attitude will be changed in addition to knowledge and skills needed to deliver the service;

- Youth friendly facility improvement should be taken as one of main strategy through ensuring separate physical space that is appropriate and acceptable by young people so that their privacy and confidentiality is respected;

- To change social norm that restricts young people from accessing services through continuously educating communities so that their attitude and belief will gradually change;

- Give focus to gender equity through incorporating it to formal education as well as through informally educating young people, family and community at large;

- Comprehensive sexuality education should be fully adopted by policy makers and implementers (school teachers) should be motivated through on job training and supportive supervisions on how they are approaching students on SRH concerns;

- Develop a national policy which ensure intersectoral collaboration with clear role and responsibilities among ministries who deals with young people issue;

- Mainstreaming of YFSRHS in private clinics and provision of supplies to them is crucial to increase access to YFSRHS;

- Researchers should identify impacts of each interventions in order to prioritize them particularly regarding how to bring social change. In addition, research should be carried out extensively on what young people say about their SRH, barriers and how to ensure their meaningful participation.

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8. Annex

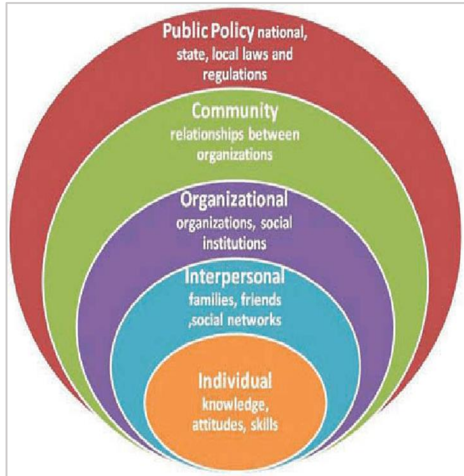

Figure 4: Original Socio-ecological model (91) .