

Exploring Barriers to Accessing Adolescents Sexual and Reproductive Health Services in South Ethiopia Regional State: A Phenomenological Study Using Levesque's Framework

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Introduction: Evidence suggests that adolescents face multiple barriers to accessing Sexual and Reproductive Health (SRH) services. However, there remains a notable gap in the literature regarding the nuanced interplay between supply-side and demand-side barriers. Therefore, this study aimed to examine barriers to accessing SRH services in the Gamo Zone of South Ethiopia Regional State.

Methods: A descriptive phenomenology study was conducted from September 04 to October 15, 2023. A total of seven Focus Group Discussions (FGDs), four with girls and three with boys, with a total of 75 adolescents, and ten Key informant interviews (KIIs) with healthcare providers participated in the study. A semi-structured interview guide was used to explore their lived experiences. All interviews and discussions were audio-recorded. To analyze and manage data framework analysis approach was applied using ATLAS Ti version 7 software.

Results: The major barriers preventing adolescents from accessing SRH services are related to the interplay between supply and demand-side barriers across all five domains of the Levesque framework. Despite the high need for access to health care, lack of SRH literacy, lack of outreach activities, and integration of SRH information in health facilities often hampered adolescents' healthcare need. Additionally, fear of stigma from family and community, social norms, and lack of discussion of SRH issues hindered their ability to seek health care. Shortage of supplies and healthcare providers' behaviors further hindering adolescents' ability to access health care services. Furthermore, the limited involvement of adolescents in decision-making and the lack of effective coordination further complicate the appropriateness of services for adolescents.

Conclusion: The finding of this study reveals that adolescents face multifaceted barriers. Therefore, there is a need for high-impact complex interventions, program and policy that address both supply and demand side barriers needs to give due intention to improve access to SRH services for adolescents.

Keywords: adolescent, sexual and reproductive health, access, barriers, Southern Ethiopia, levesque's framework

Introduction

Adolescents globally are a significant demographic group, estimated at 1.3 billion.¹ In Sub-Saharan Africa (SSA), adolescents make up about 25% of the population.² In Ethiopia, adolescents make up 21.6% of the total population.³ Sexual and reproductive health (SRH) related problems remain a major health concern for adolescents aged 10–19 years.⁴ Finding of studies indicates that adolescents are engaging in health -risk sexual behaviors.^{5–9} Early engagement in sexual activity has had detrimental effects on adolescent morbidity that prematurely exposing them to the inevitable consequence of: sexual transmitted infection including HIV/AIDs, unintended pregnancy, unsafe abortion and premature death.^{10–12}

Even though the comprehensive knowledge Sexual and Reproductive Health (SRH) problems is increasing around the world, many adolescents do not have the information or means to protect themselves from these problems.¹³ Many health

problems are contributed by adolescents. For example, globally each year, nearly 21 million adolescents aged 15 to 19 years become pregnant and approximately 12 million of them give birth and 5.6 million abortions undergone.¹⁴ Sub-Saharan Africa accounted for the vast majority of them.^{14,15} The latest 2023 report from UNICEF shows that in 2022 alone, 140,000 adolescents between the ages of 10 and 19 were newly infected with HIV.¹⁶ More than a quarter of girls and women in sub-Saharan Africa cannot access family planning services, fueling unplanned pregnancies and spreading HIV and other sexually transmitted diseases. Better adolescents' health is therefore a priority area.

Access to health care is the extent to which the health system adjusts, inhibits, or initiates the individual's willingness and ability to use, receive, and benefit from and achieve satisfaction with health services.¹⁷ This is getting to know, searching, entering, and traversing, as well as satisfaction with the care and benefit from the outcomes of the health service. It is not limited to consulting the healthcare provider and/or obtaining prescriptions.¹⁸ Improving access to SRH services is a key component of universal health coverage.¹⁹ It is one of the components of the Sustainable Development Goal targets (target 3.7, 3.8, and 5.6).¹⁹ It is also an essential component of the WHO adolescent-responsive health services.²⁰ To improve the adolescent overall health status and to meet the growing need of their SRH the Ministry of health in Ethiopia developed and implementing the third national adolescent and youth health strategy (2021–2025). This strategy showcases Ethiopia's dedication to improving the health and wellbeing of adolescents and youth. It emphasizes the significance of delivering high quality healthcare information and services to them through a multi-sectoral approach.²¹

Despite all these commitments, adolescents who live in Sub-Saharan Africa (SSA) struggle to access SRH services.^{4,22} Studies on barriers to adolescents' access to SRH services in Tanzania, Ghana, Kenya, Ethiopia, and Nigeria found that adolescents faced multiple barriers to accessing SRH services.^{4,23–28} However, there remains a notable gap in the literature regarding the nuanced interplay between supply-side and demand-side barriers. Few studies have comprehensively examined the synergistic effects of barriers on both sides.²⁹ Additionally, most of the existing literature often focuses on exploring supply-side barriers like lack of privacy and confidentiality, and negative attitudes of health care provider,^{23,25–27} in isolation or examining demand-side barriers like social norms about premarital sex, social stigma towards the use of contraceptives before marriage, religious norms, and a lack of awareness of about SRH services^{24,25,30–32} separately, overlooking the potential synergies and interactions between these two crucial areas.

Furthermore, existing research tends to provide a broad overview of barriers without adequately addressing the contextual and cultural factors that may shape the relationship between supply-side barriers, demand-side barriers, and access to SRH services among adolescents.^{33–35} Moreover, most previous studies identify barriers based on either adolescents' perceptions or healthcare providers' perceptions.^{28,36} There is a need for a deeper understanding of barriers from both adolescent and healthcare provider perspectives to understand the synergistic impact of these barriers on adolescents' SRH services access.^{4,29,37,38} Also, there is a need for more in-depth research that considers the socio-cultural contexts that impact adolescent SRH behaviors and decisions.

Therefore, this study aims to bridge this research gap by comprehensively exploring the interplay between supply- and demand-side barriers in adolescents' access to SRH services, incorporating a nuanced understanding of contextual factors. By understanding the complex interplay between supply- and demand-side barriers, this study aims to provide policymakers, program designers, and health professionals with new insights to develop targeted interventions, policies, and strategies to improve SRH outcomes in adolescents. Therefore, this study aimed to explore barriers to accessing SRH services from the perspective of adolescents and health care providers in South Ethiopia Regional State, using the Levesque et al framework.

Research Questions

The main research question was what the barriers to accessing sexual and reproductive health care services and how might we increase the accessibility of sexual and reproductive health services for adolescents so that they can seek out the services when they are needed?

A Conceptual Framework

We used Levesque, Harris and Russell's (2013) conceptual framework for healthcare access to guide this analysis. According to this framework access to healthcare services has been described as "the opportunity to reach and obtain appropriate healthcare services in situations of perceived need for care."¹⁷ The Levesque et al (2013) framework

acknowledges that access to healthcare is influenced by barriers from supply side and demand side. Barriers from supply side are shown in the top row and barriers from demand side are shown at the bottom row. This framework acknowledges the combination of two perspectives of healthcare access, the perspective of the consumer in terms of their “ability to perceive, ability to seek, ability to achieve, ability to pay and ability to engage” and the perspectives of healthcare professionals or health systems, reflected by the domains of “approachability, acceptability, availability and accommodation, affordability, and appropriateness”.³⁹ Approachability of SRH services refers to the extent to which people acknowledge their health needs and can recognize that a form of service exists, is accessible and has an impact on their health (Levesque et al, 2013). This framework was selected, due to its holistic future and its interpretation of access using a patient-centered approach by conceptualizing access at the interface of health systems and populations. This theoretical framework illustrates that barriers to access to healthcare are described schematically using horizontal boxes that represent the main steps related to access to healthcare. The bottom row boxes list the predisposing, enabling, and need factors related to the demand side (health care users). The boxes in the top row are supply side (healthcare providers).¹⁷ (see Figure 1). This framework has previously been used to examine healthcare providers’ and consumers’ experiences accessing healthcare across diverse groups.^{29,40,41}

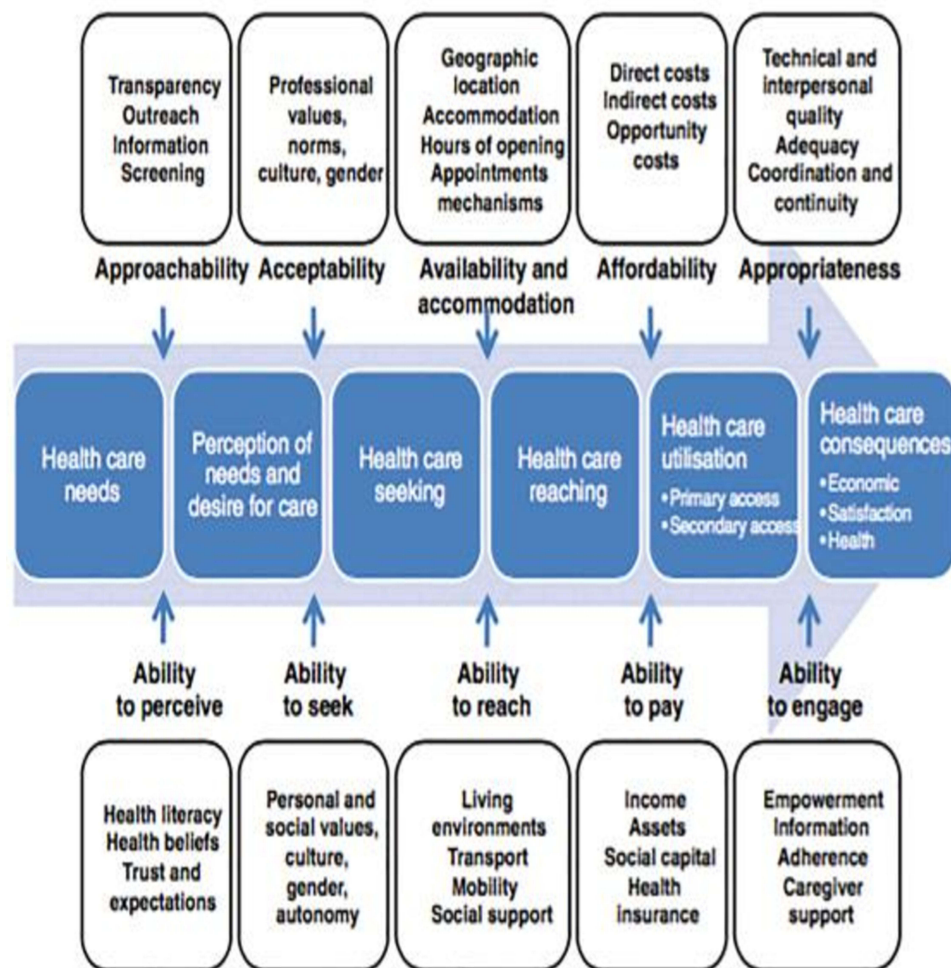


Figure 1 A conceptual framework of access to healthcare.

Note: Reprinted from Levesque JF, Harris MF, and Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health*. 2013. 12(1): 1–9. Creative Commons.¹⁷

Methods and Materials

Study Setting and Period

This study was conducted in the *Gamo zone*, which is located in the southern regional state of Ethiopia. Administratively, Ethiopia is classified into four levels: the first level (*regions*), the second (*zones*), the third (*woredas*), and the fourth level (*kebeles*). *Kebele* is the lowest administrative unit with 3000 to 5000 inhabitants.⁴² The *Gamo zone* borders the *South Omo* zone to the southwest, *Wolayta* and *Gofa* zones to the north, the *Amaro* and *Dirashe* special *woreda* to the southeast, and the *Lake Abaya* to the northeast. *Arba Minch* town is the administrative center of this Zone. This town is located 431 km from the Ethiopian capital city (*Addis Ababa*). Six town administrations and 14 rural districts with 306 *kebeles* are found in the *Gamo zone*. The total population in this zone is 1,643,205 of those 805,205 are male and 838,034 female (*Gamo Zone Health Department, Annual Performance Report, Personal Communication, July 2023*). There are currently 363 public health facilities providing preventive and curative services to the community. Of these, five are primary hospitals, one general hospital, 59 health centers and 297 health posts. In addition, there are 251 private healthcare facilities. These include one primary hospital, 190 private clinics, 56 private pharmacy, and four drug stores. According to the 2023 performance report of the Health department of *Gamo Zone*, family planning coverage was 78% of those 6.09% were adolescents aged 10 to 19 years. HIV testing coverage 75%, ANC coverage 98% and institutional delivery coverage was 73%⁴³ This study was conducted from September 04 to October 15, 2023

Study Design

A phenomenological qualitative study design was used to explore barriers access SRH services.

Target Population

All adolescents (service users) who live in the selected study area and all service providers (health care providers) working in selected health facilities during study period and fulfil the eligibility criteria were the target population.

Eligibility Criteria

All adolescents between the ages of 10 and 19 living in the chosen study area were eligible to be included as service users, regardless of their gender, schooling status, or marital status. As well as service providers who provided SRH services to adolescents in the selected public health facility during the study period.

Participants Selection

One *kebele* (lowest administrative unit in Ethiopia) and two health centers per district (town administration) were randomly selected from the target group of study participants to participate in the qualitative study. One SRH provider from each health facility was then invited to participate in the study. Adolescents were also invited to participate in each selected *kebele*. Community health extension workers facilitate the selection of adolescents from each selected *kebele*. A purposive sampling technique was used to select participants with SRH information. A total of seven FGDs, including 9–14 participants per group with adolescents. In addition, ten SRH service providers were involved in key informant interviews (KIIs). Each FGD lasted between 48 minutes and 1 hour and 15 minutes and the minimum duration was 48 minutes, while the KII lasted between 36 and 47 minutes. Data collection continued until theoretical saturation and stopped once saturation was reached.

Data Collection

Key informant interviews (KIIs) and Focus group discussions (FGDs) were used to collect the data. Semi-structured interview guides are prepared based on the concepts of Levesque et al. Access to health care framework and modified based on previously conducted similar studies.^{26,28,44–46} Before the main data collection process was started, we pilot-tested the interview guide and made refinements to make sure the guide could elicit the information we intended to capture. Based on the pilot interviews, we modified some unclear questions. Also, to get detailed information about the issues, we added more probing questions. The tool is first developed in English language and translated to the Amharic language, for data collection. The Amharic version was used during the interview. (Details of the interview guide are available in [Supplementary Tables 1–4](#))

The actual data collection started after securing written informed consent from the participants. Once their consent was obtained, the interview date and place of the interview were arranged in advance with each respondent. The FGDs were conducted in private setting where discussion could not be overheard. Adolescent groups were stratified into two homogenous categories based on their sex. Group 1: comprised of adolescent girls aged 10 to 19 years. Group 2: comprised of adolescent boys aged 10 to 19 years.

Three experienced qualitative data collectors hold Master's degrees participated in the data collection. Two days of training was given for the data collectors. The discussions of adolescents were facilitated by the same sex. The FGDs with the boys' group were facilitated by the principal investigator and two trained research assistants, while the discussion of girls was facilitated by a trained female moderator and two trained research assistants. Both facilitators were experienced qualitative researchers and were assisted by two trained research assistants who were from the same culture and facilitated the quality of data collection in a local language. Furthermore, KIIs were conducted with the SRH service providers within the selected study area. The interviews were conducted at the participants' respective workplaces to maintain privacy as well as convenience. All FGDs and KIIs were held in the Amharic language. It was recorded using a digital tape recorder with prior permission from the study participants. The note taker takes notes during discussion and interview after obtaining permission from the study participants. These field notes were used to supplement audio-recorded transcript information. At the end of each discussion and interview, the research assistants went over the main points raised and confirmed with the discussants that their points had been captured accurately before ending each interview session. Each day the principal investigator and research assistants held a debriefing session to reflect on the conducted discussions and interviews regarding the main issues as well as areas that brought challenges and insights.

Data Analysis

To analyze and manage the data, framework analysis approach, which followed seven steps was applied using ATLAS Ti version 7 software. In the first step (transcription stage), all audio-recorded KIIs and FGDs were transcribed verbatim in the Amharic language by the principal investigator (NBS) and research assistants. Then it was translated into English for analysis. All identifiers were removed from the data and the study identification number was assigned to each respondent. In the second step (familiarization phase), the transcripts were read and re-read as well audio recordings were listened to again and again to obtain a general sense of the whole content. In the third step (Coding phase), we started coding guided by Levesque's "Access to Healthcare" framework, which was produced after carefully reading the texts of the transcripts. In the fourth step (developing a working framework stage), we developed a working framework, in which we compared the labels and agreed on the set of codes to apply in the subsequent transcripts. In the fifth step (applying an analytical framework stage), we indexed the succeeding transcripts using the available codes and categories. In the sixth step (charting data into the framework matrix stage), using the spreadsheet we charted the data into the framework matrix. In the last step (interpreting the data), we organized and presented themes and subthemes and supported them with key quotes and narrations.

To Maintain the Trustworthiness of the Data

To ensure conformability, we employed data source triangulation (data was collected from service users and providers) and methodological triangulation (FGDs and KIIs). Also, the principal investigator as well as other research team members has good experience in qualitative research. This experience and specialization are important to address the research question appropriately. Besides this, we validate our findings with experienced qualitative researchers. To ensure credibility, Training was given to the data collectors, piloting the interview guide, and induction meetings were held with the research team. Each of the interviewers conducted pilot interviews. Furthermore, this helps to better understand salient characteristics of local issues, the local research assistant who knows the local language fluently was selected. After each interview, respondents were allowed to validate key findings that were said before ending each interview session. Each day after data collection, the research team held peer debriefing sessions. Data analysis was conducted simultaneously during data collection. The translation was conducted by fieldworkers to maintain prolonged engagement. The verbatim quotes were used during the reporting of the findings. Member checking was done to ensure that the data

presented in the study reflects the actual views of the participants. Moreover, we also offered transcripts to some participants to confirm their comments.

To maintain dependability, the research team reports the data analysis process. Further, a clear description of the research methods is well stated in the methodology part. During data collection, probing interview techniques were used between each question. The data collectors used a tape recorder to record the interviews and written field notes to record nonverbal information. During the analysis period, the research team reviewed the transcripts against the audio files for accuracy and clarifications provided by the transcriber. We also share the transcription and translation of the findings with study participants and the research team to get their comments and consensus on some ideas. To discuss coding the data and identification of key ideas, debrief sessions and peer reflections were conducted by the field team and authors. To ensure transferability, researchers provided thick descriptions of the findings. The team conducted an audit trail with the supervisor and co-supervisor to ensure that the analysis was grounded in the data to maintain dependability. The interview continued until data saturation.

Reflexivity

To minimize investigators' bias when collecting and interpreting the data. The principal investigator set aside their assumptions, perceptions, values, and prior knowledge during data collection, coding, and analysis. Transcription and translation of data was done by two experienced researchers. To validate the data collected, reflexive journals, investigators' field notes, memos, and as a form of triangulation. While interpreting the findings attention was taken to balance interpretation with direct quotations from the study participants. The context of this study setting is different from the setting in which principal investigators have been working and living.

Result

Participants Characteristics

Ten KIIs and seven FGDs were conducted in the South Ethiopia regional state. Four FGDs with girls and three with boys, a total of 75 adolescents were participated. In both FGDs and KIIs, a total of 85 respondents (50 female and 35 male) participated. The mean age of the FGDs was 15.61 (SD \pm 2.31) years, ranging from 11 to 19 years. Whereas the mean age of the KIIs was 34.40 (SD \pm 7.25) years, ranging from 30 to 54 years. Slightly more than half (60%) of the discussants were female. The mean year of KIIs work experience was 12 (SD \pm 7) years, ranging from 6 to 30 years. (Details on these study participants are available in [Supplementary Tables 1–4](#))

Finding

The main barriers identified in this study are grouped according to Levesques Framework of healthcare access and are described below:

Barriers to achieving healthcare needs of adolescents (Approachability)

Under this theme, adolescents' ability to perceive and desire care, as well as the accessibility of services, often hinders the achievement of the SRH needs of adolescents. Most focus group discussants explained that most adolescents refrain from seeking SRH services due to a lack of information about services and places to seek help. However, most adolescents need more information about SRH services. During the focus group discussions, most girls asked us about the right place for SRH services as most of them did not know the right place to access SRH services.

There are a lot of adolescents who do not have information about SRH services. Besides this, they [Adolescents] lack the self-confidence to access services. [11 years old female discussant]

To utilize contraceptive methods, we do not have awareness about it.....Our boyfriends also do not like to use condoms. [18 years old female discussant]

Most adolescents lack awareness about sexual and reproductive health issues. [18 years old Male discussant]

Healthcare providers also said that most adolescents do not have information about SRH services.

They [Adolescents] are not aware of these services, because there are no awareness-creation activities for adolescents to access services. [32 years old Male, Key informant]

The presence of such [SRH] services is not well known among adolescents because they lack awareness. [37 years old female, Key informant]

They (adolescents) don't know about the availability of SRH services in our institution at all. [30 years old female, Key informant]

Lack of Outreach Activities

Focus group discussants identified the lack of demand-creation activities in the school or community as the major hindering factor for adolescents' SRH care needs.

In our area, most adolescents start sexual intercourse at an early age when they are at a lower grade. It was increasing from time to time especially among school-going adolescents because nobody controlled them in school, nobody discussed unintended pregnancy, and nobody gave information about reproductive health issues in the school.... [18 years old female discussant]

Previously at school, there was awareness creation information had been provided to the students as well and there were services provision home to home, but nowadays all those activities are stopped, and nobody is concerned about it. [19 years old female discussant]

Starting from lower grades we learned about HIV, but nowadays it is being ignored. When I was in elementary school, we had an HIV/AIDS club, but when I reached high school, we did not have clubs at all. [18 years old Male discussant]

Despite this most adolescents need more information about sexual and reproductive health issues from the right sources. Adolescents said that:

In some courses, there are HIV/ADIS and SRH topics. When the teachers get to the topic, they will skip that topic by saying you have learned before. But, we want to learn that topic to know more. [16 years old Male discussant]

We get sexual and reproductive health using our mobiles, but we do not know how much of that information is true. Also, we have language barriers. [19 years old Male discussant]

Healthcare providers also confirm that there are limited school-based and community-based outreach activities related to SRH services, and information to increase adolescents' awareness and knowledge about available of services. Most respondents responded that;

There are no community-based sexual and reproductive health awareness creation activities in our area. There is no permanent program and services around the schools. [31 years old Male, Key informant]

Previously we were conveying the information to the adolescents in different ways. we teach health education to young people in schools. I think schools are best for young people to fulfill their needs. We disseminate reproductive health information to adolescents through youth centers and house-to-house. But, nowadays those all activities are stopped [30 years old Female, Key informant]

One of the ways to provide SRH information to adolescents is through adolescents seeking care during their illness. During this time, healthcare providers can typically identify potential adolescent health problems and risks in the population. Adolescents were asked what information about SRH services health workers would typically share with users and when they visited health facilities. The participants highlight that the majority of healthcare providers fail to inform adolescents about the accessibility of sexual and reproductive health services during their visits to nearby healthcare facilities.

Even when we go to the health facility, no one gives information about SRH issues. [17 years old Male discussant]

The healthcare providers neglect to provide sexual and reproductive health services for adolescents. [18 years old female discussant]

The healthcare providers explain that the current SRH services provision in most places was health facility-based and case based treatment.

.... Here in our health facility, we provide different services for adolescents such as counseling and testing for HIV, family planning, and abortion services for those who come to this facility. [37 years old female, Key informant]

Currently, there is no outreach services provision of sexual and reproductive health services. The current service provision for adolescents is case-based treatment. [31 years old female, Key informant]

Barriers to SRH Services Seeking (Acceptability)

Under this theme, we summarize barriers to seeking SRH services. The acceptability of the services that are offered and the adolescents' capacity to obtain care determine whether or not they seek out SRH services. Most focus group discussion participants described accessing SRH services as unacceptable in their community and as a sign of promiscuous behavior. Fear of stigmatization further complicates adolescents' ability to access SRH services. They describe that stigma from community and family, which is commonly manifested in shame, name-calling, embarrassment, physical punishment, fear of disclosure, and withdrawal of emotional and economic support, led many girls to seek unsafe abortions.

The society we grew up in will stigmatize! I appreciate their abstinence. Our society does not think well, they think how the girl is spoiled at this age. [18 years old Male discussant]

If we have STIs we fear going to a treatment center. Due to this most adolescents will not go for treatment. [13 years old Male discussant]

Because of fear of stigma, we will not go to buy condoms or emergency pills [19 years old Male discussant]

If I have unintended pregnancy, my family may take me to a relative's home in another area to hide me from our neighbors. [17 years old female discussant]

Healthcare providers also describe that stigma is common in their community. Due to fear of stigma adolescent cannot access services freely.

Sexually transmitted diseases, abortion, and other causes because of unsafe sexual intercourse. There are a lot of individuals who come to this health center from other areas to hide themselves from their relatives and their intimate partners. [30 years old Male, Key informant]

Most of the time adolescents cannot freely access services because sometimes they fear to ask, and they turn back. [31 years old female, Key informant]

Focus group discussant adolescent reported that most adolescents are often "forced" to switch to private facilities and use herbal medicine due to free of stigma to access SRH services.

If unintended pregnancy happens most girls will go to traditional centers to keep their secret. Traditional healers keep the information secret. [19 years old female discussant]

Focus group discussants also explain that it was generally considered less socially acceptable for unmarried adolescents to learn about and use SRH services than it was for married adults.

In our society, unmarried girls are not allowed to use contraceptives because it is said to make them infertile, and I did not use them. [18 years old female discussant]

I don't use sexual and reproductive health services for fear of what might happen to my body in the future. [16 years old female discussant]

Lack of Discussion About Sexual and Reproductive Health Issues

Discussants commonly expressed the view that discussing SRH issues with parents is hard due to societal norms and stigma within the community.

In our society, there is no free discussion about sexual and reproductive health issues in households. [15 years old Male discussant]

.... We do not have discussions about sexual and reproductive health issues in households because we fear them, also parents will not be voluntary to discuss with us about sexual and reproductive health issues. [13 years old Male discussant]

Some adolescents also said that discussing SRH issues with parents/caregivers depends on the level of their parents'/ caregivers' level of awareness about SRH issues, and family intimacy.

I think it [discussing SRH issues] depends on the parents'/ caregivers' level of awareness and acceptance. If you think your family can accept, tell them. But most families will face neighborhood and community stigma once they know about unintended pregnancy. [18 years old female discussant]

If I told my family about my love relationship when I started. I can tell them everything that happens after my love relationship. However, if I get pregnant without informing them about my relationship, they will fire me. [17 years old female discussant]

Healthcare providers also said that:

Most parents do not openly discuss SRH issues in their homes with their children. There are a lot of gaps in this regard in our community. [35 years old Male, Key informant]

The broader issue of acceptability of SRH services also influences SRH services provision for adolescents. The key informants explain that in most public health facilities abortion services were not provided for adolescents due to religion and cultural beliefs.

I don't want!!! [Abortion services training is not something I want to be trained in]. Here is my opinion: "I learned to save life, not kill it!" For instance, yesterday I experienced that. Two couples told me that she is a 12th grader and her boyfriend does not have jobs. I directed them to another health facility because, in this facility, we do not provide abortion services. [30 years old Male, Key informant]

.....in providing abortion services there is high resistance among healthcare providers. Because they relate to a religion and cultural beliefs. They don't want to take training related to abortion care. I believe it is better to provide family planning rather than abortion care. Because doing an abortion means killing a growing baby. [37 years old female, Key informant]

Most health professionals are not happy to provide abortion services. They associated it with their religion. In addition, they are not willing to go for training. The respondent also shared his experiences; he is not willing to go for abortion services training. [31 years old Male, Key informant]

No! [I do not provide abortion service] Those who volunteered to provide the service can provide the service. But I am not voluntary to do that, and I never take training. [32 years old female, Key informant]

Barriers to Healthcare Reaching (Ability to Reach, Availability and Accommodation)

Under this theme, we asked adolescents about their ability to physically go to the health facility. The focus group discussant specifically noted that most public health facilities did not offer SRH services for adolescents.

Most Participants Stated

Previously we could get condoms in our village easily, but by this time it is difficult to get condoms. [18 years old Male discussant]

Those services are not provided in most government health facilities. Besides this, the cost of services is expensive. The health providers are not volunteers to provide services. [11 years old female discussant]

Previously, we could get condoms from Kebele Health Post, but cannot get condoms now. [17 years old Male discussant]

Healthcare providers also explain that apart from saying SRH services is provided for adolescents, we actual not providing the services for the adolescents.

.... It's all about politics these days. Apart from saying that we will provide services, we are not providing services in real terms. We are living in a time where work and workers are not getting along [30 years old Male, Key informant]

It is impossible to say SRH services are provided to adolescents. [35 years old Male, Key informant]

In our area most girls when an unwanted pregnancy occurs, to get abortion services will go to traditional healers this may be due to abortion services was not given in our facilities. [31 years old female, Key informant]

There are severe supply shortages of essential goods in public health facilities, that hindering access and provision of SRH services for adolescents. The healthcare providers specifically pointed out that we can easily reach adolescents using different channels, but the main challenge is lack of supply.

To give SRH services to all adolescents, there is a shortage of supply. So, it is better if the services provision is target-based services. [35 years old Male, Key informant]

It is very difficult to say that sexual and reproductive health services are accessible because we have a shortage of supply. Since there is a shortage of condoms to provide condoms for adolescents right now. [30 years old Female, Key informant]

No! [We don't have enough supply to provide sexual and reproductive health services]. Except for some contraceptives, there is a shortage of emergency contraceptive pills and condoms. The manpower also in this area is low. It is necessary to fulfill and assign trained professionals. [37 years old female, Key informant]

We do not have enough resources for the provision of sexual and reproductive health services for adolescents. For instance, we have a shortage of trained healthcare providers right now. We have also shortage of condom. [54years old Male, Key informant]

Healthcare Providers Related

Most respondents described that the health providers in the public health facilities refused to provide their services without parental permission due to this they went back to their homes. For example, if teens ask the health provider to give them SRH services, they cannot get the services because the health provider will not provide services. In additional most providers criticize the adolescents when seeking abortion services at healthcare facilities.

When we go to our nearby health facility, they will ask us if parent or guardian consent is needed to access sexual and reproductive health services. [18 years old female discussant]

The healthcare providers neglect to provide sexual and reproductive health services for adolescents. [16 years old Male discussant]

When we seeking abortion services at public healthcare facilities the healthcare providers often tend to criticize us, relating that our pregnancy resulted from deliberate engagement in sexual intercourse. [17 years old female discussant]

When we go to health facilities, the healthcare providers will ask about our age. [18 years old female discussant]

Barriers to healthcare Utilization (Affordability and Ability to pay)

The focus group discussant describes that most adolescents are often “forced” to switch to traditional healers to get abortion services and private pharmacies to buy condoms and emergency pills. Adolescents with limited economic resources families are hit hardest by this barrier, with access to abortion services being more complicated or even impossible.

If my family has money, they could hide my pregnancy from our neighbors and they may take me to a far-away hospital to abort the pregnancy [17 years old female discussant]

Most of us shortage of money to buy a condom. [15 years old Male discussant]

We get condoms from the pharmacy but the price for condoms is expensive. [17 years old Male discussant]

No, we will buy one condom for 35 birrs! [17 years old Male discussant]

I wonder in the current situation HIV testing is free, but a condom is by fee how this did happen? [18 years old Male discussant]

I may go to the hospital, but the cost of services is expensive.” [15 years old female discussant]

Barriers to Making SRH Services Appropriateness for Adolescents

According to Levesque et al, appropriateness of services depends on engaging adolescents and healthcare providers, and lack of effective social accountability in SRH services provision makes the health system not responsive to adolescents' needs. Study participants clearly explain that the current SRH services fail to respond the need and preferences of adolescents.

Limited engagement of adolescents

The limited engagement of adolescents in decisions that directly affect them is a critical issue that affects access to SRH service. There are mechanisms in place to allow adolescents and health care providers to contribute to decisions related to their health care. However, these are not used sufficiently. This was highlighted by adolescents and healthcare providers during the discussion and feedback sessions.

We have a lot of problems. Nobody pays enough attention to adolescents, especially in terms of sexual and reproductive health. Adolescents and youths are a productive citizen, the caretaker of tomorrow's country. But nobody engage us. [16 years old male discussant]

Nowadays, the government not working on SRH issues. Especially HIV was neglected, but HIV is rising from time to time. [18 years old female discussant]

The healthcare providers also confirm that

.....most adolescents have a lot of problems not only in terms of health but also a lot of problems in their social interaction; even their interactions with their families are problematic. If the adolescents have any sexual and reproductive health problems no families want to live with them. If you openly discuss with adolescents they will speak a lot of problems, but nobody wants to hear them. I believe that there is a need for an institution like this to be opened and intermeshed intervention therapy is needed. There is no one doing this work in the city at present. [30 years old Male, Key informant]

Creating Effective Social Accountability

The lack of effective social accountability in SRH services provision makes the health system not responsive to adolescents' needs. They explain that the productive section of the community was neglected; there is no responsible body for adolescents' issues in the study. The lack of engagement will create the adolescents less social accountability in SRH services provision makes the health system not responsive to adolescents' needs. They explain that the productive section of the community was neglected; there is no responsible body for adolescents' issues in the study.

It's all about politics these days. Apart from saying that we will provide services, we will not provide services in real terms. We are living in a time where work and workers are not getting along. There are many supporting stakeholders in this city, but they are not active at the moment. [30 years old Male, Key informant]

To have better attention and better follow up adolescent and youth issues need one coordinating office that is responsible for such issues. The second and most important thing is that even if the structure is convenient and the service providers have

different attitudes, skills, and knowledge, it is necessary to reach out to the young people and deliver services that deserve to be reached by the young people. [31 years old Female, Key informant]

In your community are there no meetings organized with adolescents, sometimes we involve young people when we have public meetings in the community. [54years old Male, Key informant]

All stakeholders like healthcare providers and the heads of health facilities need to work in collaboration, but currently, nobody is paying attention to these services.[31 years old female, Key informant]

Lack of effective coordination

Lack of effective coordination significantly hampers the access to SRH services for adolescents.

There are a lot of adolescent and youth friendly centers, but due to lack of responsible bodies most of those centers are not providing services for adolescents. The respondents explain that there are youth friendly centers at *kebele*, but most youth friendly centers were not functional, there is assigned health professional for centers.

The healthcare providers said that:

Previously most adolescent sexual and reproductive health services were supported by NGOs, now those NGOs were phased out. Most youth-friendly centers are not functional right now. [54years old Male, Key informant]

Youth centers are not currently providing services. There are youth centers in each Keble, but there are no assigned health professionals. [30 years old Female, Key informant]

Regarding services provision in youth centers, there is a lot of shortage of supplies. Especially since there is a shortage of condoms and HIV kits in the center. [35 years old Male, Key informant]

Youth centers are not currently providing services. There are youth centers in each Keble, but there are no assigned health professionals. [30 years old Male, Key informant]

Some health professional also said that adolescent and youth friendly centers become the center for indecency.

There are youth centers in this town, but they are not providing services for adolescents currently. Nowadays most youth-friendly centers have become the center for Indecency. Because most of the area in the center is covered with bushes during the summer season. Nobody has been given due attention to adolescent sexual and reproductive health services, and because of this most services are not given for adolescents as their need. [31 years old female, Key informant]

Most respondent also says that due to lack of effective coordination providing responsive SRH services is difficult.

Effective provision of SRH services requires the collaboration of diverse stakeholders. Despite the increase in SRH problems in this age group, the issues of adolescents still do not get much attention. [35 years old Male, Key informant]

Now, for example, to make SRH services convenient, persuading experts to provide services, and give training for them needs to be a priority issue to make services more accessible. I think that there are many gaps in terms of facilitating access to youth centers and schools, and there is a lack of attention from higher authorities. [30 years old Female, Key informant]

Discussion

The findings of this study reveal that new insights in how adolescents in the Southern Ethiopia regional state access SRH services. The findings were summarized using the five demand side barriers and five supply side barriers. We found that supply-side barriers like a lack of outreach initiatives, physical inaccessibility of services, shortages of essential supplies, healthcare provider behavior and judgmental attitudes, and a lack of interdisciplinary coordination hindering access and provision of SRH services for adolescents. Whereas demand side barriers like a lack of SRH literacy, social norms, fear of stigma from family and community, lack of free discussion about SRH issues, and not engaged adolescents in adolescent-related issues were barriers hindering access to SRH services.

The finding of this study reveals that the nuanced interplay between lack of SRH literacy and lack of demand-creation activities in the school, community, and health facilities was the major hindering factor for adolescents to access SRH services. This finding is in line with previous study findings.^{30,47} Another study finding from Nepal also revealed that lack of outreach activities and poor SRH literacy were identified as the main barriers.²⁹ This finding highlights the need to strengthen the outreach programs for schools as well as the community. Also, there is a need to reach out to adolescents using different digital media platforms for such anonymous communication may be effective in improving adolescents' literacy.²⁹

Social norms and culture influenced participants' health-seeking behavior, making it difficult to have a free discussion about SRH issues with parents and interactions with healthcare providers, which could be seen throughout their healthcare journey. There is stigma from family and community, disapproval from the community, and being seen as a sign of promiscuous behavior was describe by most discussants. Many adolescents are frequently "forced" to keep their SRH issues hidden, some use herbal medicines if they are poor and some others will access SRH services from private facilities if they have money. The findings of a study conducted in Rwanda also show that family members and religious leaders hinder adolescents' health-seeking behavior.⁴⁸ Likewise, another study finding from Nepal also revealed stigmatization, gender norms, and lack of autonomy were identified as the main barriers for adolescents to seeking health care.²⁹ Similarly, findings from a study conducted in Rwanda show that fear of stigma from their families, peers, wider community, and service providers hinders adolescents' ability to reach healthcare because it is linked to multi-faceted stressors and social isolation.⁴⁹ The finding highlights the need to make SRH services provision socially and culturally appropriate.

Adolescents' ability to reach healthcare services was subject to the physical availability of services in those facilities. We found that most public health facilities did not provide SRH services like abortion services for adolescents. Shortages of essential goods in public health facilities and healthcare provider behavior and judgmental attitudes hinder adolescents' ability to reach healthcare. The finding of this study was supported by previous systematic review finding which shows that physical inaccessibility of SRH services, healthcare providers' behaviors, and shortage of supplies were identified as barriers hindering adolescents' ability to reach healthcare services.⁵⁰ The finding implies that the need to increase the services provision area like private clinics, pharmacies, and traditional healers with effective training about SRH services may be an alternative approach to improve the availability of SRH services.

Regarding healthcare utilization, adolescents' ability to understand SRH services, their health literacy, their beliefs, trust, and expectations (their ability to perceive), and their actual source and location of where to seek and obtain healthcare were often influenced by their ability to pay for healthcare. We found that most adolescents were willing to purchase emergency pills and condoms from private pharmacies, but the cost hindered them from purchasing them. Previous study findings conducted in Ethiopia also show that most of the adolescents expressed financial challenges as one of the factors that hinder them from using the SRH service.⁴⁷ Likewise, a study conducted in Rwanda also showed that most study participants were access SRH services from private facilities with fees; this limits most adolescents from accessing SRH services.⁴⁸ This finding highlights the need to identify cost-effective strategies for economically empowering adolescents to increase healthcare utilization and make services affordable for adolescents.

The appropriateness of services depends on the health system's ability to engage adolescents in the provision of SRH services, a lack of interdisciplinary coordination, and a well-implemented social responsibility approach. We found that adolescents were not engaged in any adolescents-related issues. Also, there is a lack of interdisciplinary coordination hindering the provision of SRH services for adolescents. Previous study findings also suggest that the lack of a well-designed and well-implemented social accountability approach makes services less appropriate for service users.⁵¹ Thus, using social accountability strategy may be a promising strategy for improving access and utilization of SRH services.^{52,53} The finding implies that there is a gap between the implementation of strategies and what is happening in practice. Thus, the responsible bodies need to close the gaps urgently.

Study strengths and limitations.

As random sampling for the interviews was used, this study included respondents from six study districts/ urban town administration. This was considered strength because it meant their individual healthcare experiences differed and so were the clinics that healthcare was accessed from. We used health extension workers to assist in the recruitment of focus

group discussants. However, health extension workers may have selected adolescents for their reasons, and this could have introduced some bias into the dataset. A further limitation of this study was the use of framework analysis, there may be significantly more data that may not be captured. Furthermore, the data collection methods that we used allowed us to collect a standardized set of qualitative data from the targeted participants. Although there was the opportunity to probe specific topics that arose during the semi-structured interviews and focus groups, and we sought to encourage an open atmosphere during the discussions, this need for standardization required us to follow a broad set of predefined topics.

Conclusion and Recommendations

Findings from both health service providers and adolescents reveal that adolescents face multifaceted barriers. From the perspective of the access to healthcare framework, supply side barriers like inadequate essential supplies and poor health system for adolescents SRH services contribute to unsupportive, judgmental, and biased SRH services. Services that fail to include counseling about SRH services in adolescent OPD services demonstrate a lack of integration in services provision. Lack of outreach activities further hampered adolescent need for SRH services. Appropriateness of SRH services further hampered by limited engagement of adolescents and healthcare providers, lack of effective social accountability, and effective coordination. Demand-side barriers such as a lack of information about SRH services, social norms, fear of stigmatization from family and community, and lack of free discussion of SRH issues with parents, and healthcare providers hinder adolescents' access to SRH services. The finding of this study indicates the importance of a multidirectional approach to address barriers to accessing SRH services. Since the demand-supply barriers to accessing SRH services are interrelated, addressing only demand-side barriers or supply-side barriers may not mean adolescents can access services.

The finding highlights the need to develop national and other regional operational plans and a monitoring and evaluation framework for SRH services provision in Ethiopia urgently needed to improve access to services. Also, strengthen school and community-based outreach activities on adolescent SRH issues and strengthen SRH information in the health facilities need to give due attention to increase adolescents' awareness and knowledge of available services. Moreover, to improve access to SRH services, there is an urgent need for full coverage of supplies and equipment, engagement of relevant stakeholders, and due consideration of adolescent health. Furthermore, to improve access to SRH services for adolescents, there is a need to develop highly effective, complex interventions aimed at strengthening SRH competence of health care providers and building the capacity of adolescents and the community.

Data Sharing Statement

All the data generated or analyzed during the study was included in this manuscript. However, the de-identified datasets used in the reported study are available upon reasonable request from the corresponding author.

Ethical Consideration

Ethical approval for this study was obtained from the Institutional Research Ethics Review Committee (IRRC) of Wolaita Sodo University on February 9, 2023 (project reference number: WSU-IRRC/004/2023). Before the fieldwork, necessary communications about the overall purpose of the study were made with the respective responsible bodies. A written permission letter was obtained from the Gamo Zone Health Department. Verbal consent from the village head/mayor is obtained before conducting community surveys. Written informed consent was obtained from all study participants after clearly describing the purpose of the study, benefits and risk of participation, being anonymity and the right to refuse at any stage of the interview. For participants under 18 years old, assent was obtained from study participants and written Informed consent was obtained from their parent and/or legal guardian. To ensure the publication of their anonymized responses, informed consent and assent were obtained from all study participants. Participation of the participants in the study was voluntary. There was an opportunity to ask questions about the study and the right to decline or cancel the interview. Privacy and confidentiality of information of the study participant was assured before obtaining data. With regard to confidentiality, respondents were given information that guaranteed them that the information they provided

during the study would be used for the research purpose and would not be disclosed to anybody outside the research team. All methods were followed according to the Helsinki Declaration.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors declare that they have no competing interests in this work.

References

1. United Nations, department of economic and social affairs, population division. Adolescents data; 2023. Available from: <https://data.unicef.org/topic/adolescents/overview/>. Accessed March 21, 2024.
2. Shinde S. Adolescent health and well-being in sub-Saharan Africa: strengthening knowledge base and research capacity through a collaborative multi-country school-based study. *Maternal and Child Nutrition*. 2002;3:e13411.
3. United Nations, Department of Economic and Social Affairs, Population Division. Estimates and Projections of Family Planning Indicators 2019. New York: United Nations; 2019. Available from: <https://www.un.org/development/desa/pd/data/family-planning-indicators>. Accessed March 21, 2024.
4. World Health Organization. Report of adolescent health services barriers assessment in Ethiopia; 2021.
5. Munea AM, Alene GD, Debelew GT. Does youth-friendly service intervention reduce risky sexual behavior in unmarried adolescents? A Comparative Study in West Gojjam Zone, Northwest Ethiopia. *Risk Manage Healthc Policy*. 2020;13:941. doi:10.2147/RMHP.S254685
6. Abrha K, Worku A, Lerebo W, et al. Sexting and high sexual risk-taking behaviours among school youth in northern Ethiopia: estimating using prevalence ratio. *BMJ Sex Reprod Health*. 2019;45(3):200–206. doi:10.1136/bmj.srh-2018-200085
7. Tolera FH, Eshetu G, Abebe M, et al. Risky sexual behaviors and associated factors among high and preparatory school youth, East Wollega, Ethiopia, 2017: a cross-sectional study design. *J Public Health Epidemiol*. 2019;11(1):1–12. doi:10.5897/JPHE2018.1077
8. Nigussie T, et al. Magnitude of risky sexual behaviors, determinants, and consequences among high school and preparatory school students in Mizan Aman Town, Ethiopia. *J Midwife Reprod Health*. 2020;8(1):2096–2104.
9. Addila AE. Premarital sexual practice and its predictors among preparatory school students living with and without parents in Hossana Town, Southern Ethiopia. *Science*. 2020;8(3):63–71.
10. Dadzie LK, Agbaglo E, Okyere J, et al. Self-reported sexually transmitted infections among adolescent girls and young women in sub-Saharan Africa. *Int Health*. 2022;14(6):545–553. doi:10.1093/inthealth/ihab088
11. Abdul R, Gerritsen AAM, Mwangome M, et al. Prevalence of self-reported symptoms of sexually transmitted infections, knowledge and sexual behaviour among youth in semi-rural Tanzania in the period of adolescent friendly health services strategy implementation. *BMC Infect Dis*. 2018;18(1):1–10. doi:10.1186/s12879-018-3138-1
12. Muchiri BW, Dos Santos MM. Family management risk and protective factors for adolescent substance use in South Africa. *Subst Abuse Treat Prev Policy*. 2018;13(1):1–10. doi:10.1186/s13011-018-0163-4
13. Chandra-Mouli V, Akwara E. Improving access to and use of contraception by adolescents: what progress has been made, what lessons have been learnt, and what are the implications for action? *Best Pract Res Clin Obstet Gynaecol*. 2020;66:107–118. doi:10.1016/j.bpobgyn.2020.04.003
14. World Health Organization. Adolescent pregnancy; 2023; 2020. Available from: <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>. Accessed March 21, 2024.

15. Kananura RM, Waiswa P, Melesse DY, et al. Examining the recent trends in adolescent sexual and reproductive health in five countries of sub-Saharan Africa based on PMA and DHS household surveys. *Reprod Health*. 2021;18(Suppl S1):121. doi:10.1186/s12978-021-01111-0
16. Abdurahman C, Oljira L, Hailu S, et al. Sexual and reproductive health services utilization and associated factors among adolescents attending secondary schools. *Reproductive Health*. 2022;19(1):161. doi:10.1186/s12978-022-01468-w
17. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equ Health*. 2013;12(1):1–9. doi:10.1186/1475-9276-12-18
18. Yakob B, Ncama BP. A socio-ecological perspective of access to and acceptability of HIV/AIDS treatment and care services: a qualitative case study research. *BMC Public Health*. 2016;16(1):1–15. doi:10.1186/s12889-016-2830-6
19. World Health Organization. *World Health Statistics 2023: Monitoring Health for the Sdgs, Sustainable Development Goals* Licence: CC BY-NC-SA 3.0 IGO. Geneva: World Health Organization; 2023.
20. Envaladu EA, Massar K, de Wit J. Healthcare workers' delivery of adolescent responsive sexual and reproductive healthcare services: an assessment in Plateau state, Nigeria. *BMC Women's Health*. 2023;23(1):132. doi:10.1186/s12905-023-02288-1
21. Federal Democratic Republic of Ethiopia, Ministry of Health. National Adolescents And Youth Health Strategy (2021-2025); 2021. Available from: <https://www.moh.gov.et/site/sites/default/files/2023/08/Ethiopia-National-Reproductive-Health-Strategy-2021-2025.pdf>. Accessed March 21, 2024.
22. World Health Organization. Handbook for conducting an adolescent health services barriers assessment (AHSBA) with a focus on disadvantaged adolescents: knowing which adolescents are being left behind on the path to universal health coverage, and why; 2019.
23. Mbeba RM. Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study. *Pan Afr Med J*. 2012;13(Suppl 1):1.
24. Abuosi AA, Anaba EA. Barriers on access to and use of adolescent health services in Ghana. *J Health Res*. 2019;33(3):197–207. doi:10.1108/JHR-10-2018-0119
25. Onasoga OA. Challenges and barriers to adolescents' post-abortion care services: implications for reproductive health policy in Nigeria; 2017.
26. Ezenwaka U, Mbachu C, Ezumah N, et al. Exploring factors constraining utilization of contraceptive services among adolescents in Southeast Nigeria: an application of the socio-ecological model. *BMC Public Health*. 2020;20(1):1–11. doi:10.1186/s12889-020-09276-2
27. Manguro G, Mwaisaka J, Okoro D, et al. Failing the rights: sexual vulnerability, access to services and barriers to contraceptives among adolescents in Narok County, Kenya. *Int J Hu Rights Healthc*. 2021;14(4):374–386. doi:10.1108/IJHRH-11-2020-0099
28. Hailemariam S, Gutema L, Agegnehu W, et al. Challenges faced by female out-of-school adolescents in accessing and utilizing sexual and reproductive health service: a qualitative exploratory Study in Southwest, Ethiopia. *J Prim Care Commu Health*. 2021;12:21501327211018936. doi:10.1177/21501327211018936
29. Shrestha S, Wærdahl R. Girls' access to adolescent friendly sexual and reproductive health services in Kaski, Nepal. *Asia Pac Policy Stud*. 2020;7(3):278–292. doi:10.1002/app5.305
30. Mohamed S, Nmadu AG, Usman NO. Barriers to adolescents' access and utilisation of reproductive health services in a community in north-western Nigeria: a qualitative exploratory study in primary care. *African J Primary Health Care Family Med*. 2020;12(1):1–8.
31. Ndayishimiye P. Perceptions and barriers toward sexual reproductive health services accessibility, availability and quality among adolescents in selected cities of Rwanda; 2020.
32. Thongmixay S, Essink DR, Greeuw TD, et al. Perceived barriers in accessing sexual and reproductive health services for youth in Lao People's Democratic Republic. *PLoS One*. 2019;14(10):e0218296. doi:10.1371/journal.pone.0218296
33. Chimphamba Gombachika B. A social ecological approach to exploring barriers to accessing sexual and reproductive health services among couples living with HIV in southern Malawi. *Int Scholarly Res Notices*. 2012;2012:2.
34. Cohen N, Mendy FT, Wesson J, et al. Behavioral barriers to the use of modern methods of contraception among unmarried youth and adolescents in eastern Senegal: a qualitative study. *BMC Public Health*. 2020;20(1):1–9. doi:10.1186/s12889-020-09131-4
35. Geary RS, Gómez-Olivé FX, Kahn K, et al. Barriers to and facilitators of the provision of a youth-friendly health services programme in rural South Africa. *BMC Health Serv Res*. 2014;14(1):1–8. doi:10.1186/1472-6963-14-259
36. Ooms GI, van Oirschot J, Okemo D, et al. Healthcare workers' perspectives on access to sexual and reproductive health services in the public, private and private not-for-profit sectors: insights from Kenya, Tanzania, Uganda and Zambia. *BMC Health Serv Res*. 2022;22(1):873. doi:10.1186/s12913-022-08249-y
37. World Health Organization. WHO recommendations on adolescent sexual and reproductive health and rights; 2018.
38. Wado YD, Bangha M, Kabiru CW, et al. Nature of, and responses to key sexual and reproductive health challenges for adolescents in urban slums in sub-Saharan Africa: a scoping review. *Reproductive Health*. 2020;17(1):1–14. doi:10.1186/s12978-020-00998-5
39. Haggerty JL, Roberge D, Lévesque J-F, et al. An exploration of rural–urban differences in healthcare-seeking trajectories: implications for measures of accessibility. *Health Place*. 2014;28:92–98. doi:10.1016/j.healthplace.2014.03.005
40. Voorhees J, Bailey S, Waterman H, et al. Advancing an understanding of access as 'human fit': a qualitative participatory case study in general practice. *Br J Gen Pract*. 2022;72(718):e342–e350. doi:10.3399/BJGP.2021.0375
41. Vergunst R, Swartz L, Hem K-G, et al. Access to health care for persons with disabilities in rural South Africa. *BMC Health Serv Res*. 2017;17(1):1–8. doi:10.1186/s12913-017-2674-5
42. Wubneh M. Ethnic identity politics and the restructuring of administrative units in Ethiopia. *Int J Ethiopian Stud*. 2017;11(1–2):105–138.
43. Gamo Zone Health Department. The 2022/23 fiscal year annual performance report of Gamo Zone Health Department, Arba Minch, Ethiopia 2023.
44. Habtu Y, Kaba M, Mekonnen H. What do service providers in Southern Ethiopia say about barriers to using youth-friendly sexual and reproductive health services for adolescents?: qualitative study. *Reproductive Health*. 2021;18(1):1–15. doi:10.1186/s12978-021-01092-0
45. Challa S, Manu A, Morhe E, et al. Multiple levels of social influence on adolescent sexual and reproductive health decision-making and behaviors in Ghana. *Women Health*. 2018;58(4):434–450. doi:10.1080/03630242.2017.1306607
46. Silumbwe A, Nkole T, Munakampe MN, et al. Community and health systems barriers and enablers to family planning and contraceptive services provision and use in Kabwe District, Zambia. *BMC Health Serv Res*. 2018;18(1):1–11. doi:10.1186/s12913-018-3136-4
47. Wakjira DB, Habedi D. Barriers to access and utilisation of sexual and reproductive health services among adolescents in Ethiopia: a sequential mixed-methods study. *BMJ Open*. 2022;12(11):e063294. doi:10.1136/bmjopen-2022-063294

48. Ndayishimiye P, Uwase R, Kubwimana I, et al. Availability, accessibility, and quality of adolescent Sexual and Reproductive Health (SRH) services in urban health facilities of Rwanda: a survey among social and healthcare providers. *BMC Health Serv Res.* 2020;20(1):697. doi:10.1186/s12913-020-05556-0
49. Coast E, Mwali MM, Isimbi R, et al. 'If she's pregnant, then that means that her dreams fade away': exploring experiences of adolescent pregnancy and motherhood in Rwanda. *Euro J Develop Res.* 2021;33(5):1274–1302. doi:10.1057/s41287-021-00438-5
50. Sidamo NB, Kerbo AA, Gidebo KD, et al. Socio-ecological analysis of barriers to access and utilization of adolescent sexual and reproductive health services in sub-saharan africa: a qualitative systematic review. *Open Access J Contrace.* 2023;Volume 14:103–118. doi:10.2147/OAJC.S411924
51. Panthi GP. Social Accountability for Adolescent Sexual and Reproductive Health. *Himalayan J Soc Anthropol.* 2016;7:13–39. doi:10.3126/hjsa.v7i0.17149
52. Usaid Momentum. *The Role of Social Accountability in Improving Respectful Care.* Washington, DC: Usaid Momentum; 2022.
53. Schaaf M, Arnott G, Chilufya KM, et al. Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations. *Int J Equ Health.* 2022;21(Suppl 1):19. doi:10.1186/s12939-021-01597-x

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