YES I DO.

Perspectives of young people and health workers on sexual and reproductive health and its services in Bahir Dar, Amhara region, Ethiopia.

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Definition of key concepts

Adolescent or teenager	An individual in the 10-19 years age group (1).
Attitudes	Organization of beliefs, feelings and behavioural tendencies that is expressed by evaluating a particular entity (an object, person or act) with a degree of favour or disfavour (2).
Beliefs	Generalizing judgements or assumptions about ourselves and the world around us that we hold to be true based on our own experiences, which determine our attitude and opinions (3)(4).
Norms	A way of behaving that is considered normal in a particular society (5).
Sexual and reproductive health-care services	The constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. This includes services such as family planning counselling, prenatal and postnatal care and delivery, termination of pregnancy, post-abortion care, treatment and prevention of sexually transmitted infections including HIV and information and counselling services regarding human sexuality (6).
Unmet need for family planning	The percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception (7).
Values	Abstract concepts or principles that describe what we desire to achieve, therefore helping us decide what is right or wrong and how to act in a variety of situations (8)(9).
Violence Against Women and Girls	Violence directed only against women and girls. Violence against women and girls is characterised by the use and abuse of power and control in public and private spheres, and is intrinsically linked with gender stereotypes that underlie and perpetuate such violence, as well as other factors that can increase women's and girls' vulnerability to such violence. ... 'violence against women and girls' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (50)
Youth Friendly Services	Health services that are specifically designed to cater for young people
Young person or youth (or young girls and boys)	An individual in the 10-24 years age group (10).

Abbreviations

DHS	Ethiopian Demographic Health Survey of 2016 (11)
HDA	Health Development Army
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
VAWG	Violence Against Women and Girls
YFS	Youth Friendly Health Services

Summary

Many young people in Ethiopia face sexual and reproductive health (SRH) issues including teenage pregnancy, gender-based violence, unsafe abortion, and HIV. To address these problems, the access of young people to SRH services should be optimized. This means SRH services must respond to the needs of youth by offering private, confidential, culturally attentive, supportive and non-judgemental SRH care based on modern scientific standards. Health workers' technical competencies and their attitudes towards SRH of youth are at the core of quality youth-responsive care and largely contribute to SRH care delivery and youth SRH care-seeking behaviour.

The goal of this qualitative study was to gain insight into the access to SRH services for young people and how access and service delivery can be improved in Bahir Dar Zuria *woreda* (North-West Ethiopia), according to young people and health workers. To achieve this, two primary research fieldwork trips were carried out in 2019. The **first fieldwork was focused on health workers' perspectives**. Primary data was collected between June and July 2019. Ten health workers at eight health facilities were interviewed using semi-structured questions. It explored their belief and attitudes on SRH as well as the health-care environment-related factors that influence a responsive service provision. To be able to observe closer health workers within their environment, participant observations were carried out at all health facilities, including three health worker's consultations with youth on SRH. Moreover, health facility client exit interviews with five young people on access to SRH care were conducted. To substantiate and expand on this, additional fieldwork in the same area with primary data collection took place in November 2019. **The second fieldwork focused on youth perspectives and experiences**. Six focus group discussions (FGDs) were held with girls and boys separately. It explored young people's views, beliefs, attitudes, knowledge, and experiences of their access to SRH care, including barriers to seeking SRH care. By obtaining an insight into the obstacles youth face, the study further explored, from the youth perspective, how these obstacles can be addressed to improve access to SRH care. Subsequently, collected data was manually coded, analysed thematically, and triangulated during analysis so as to present the results from both perspectives in an integrated manner in this report.

The main results show young people mostly acquire SRH care at health facilities, and young boys at the pharmacy to purchase emergency contraceptive pills for their partners. Results also showed the most used type of SRH services were family planning for girls, contraceptive methods for boys, and some also mentioned induced abortion. The most frequently mentioned reason for making use of SRH services was the fear of out-of-wedlock pregnancy or rape. This coincides with the greatest barriers young people face when seeking SRH care: an accumulation of shame, guilt, low-self-esteem and social gossips. One great challenge for seeking SRH care lies with girls' confidence to withstand (perceived) social judgment, family ridicule and socio-cultural norms, especially among unmarried and out-of-school girls. Whereas, health workers expressed great barriers in providing SRH care as shortage of medication, equipment, materials and continuous skill trainings, which in turn affect their motivation. Moreover, it was found that health workers are subjected to the socio-cultural norms of the community and their own limiting cultural beliefs and biases that, sometimes unconsciously, influence their counselling techniques and attitude towards young people seeking SRH care. On the other hand, health workers expressed efforts to promote youth SRH and offer SRH services regardless of age, marital or educational status or sexually risky behaviour. Both health workers and young people mentioned that lack of privacy and confidentiality also affects young people's SRH service uptake.

Recommendations to improve access to SRH for young people include the following:

- **Catalyse social change:** educating communities to stimulate a positive attitude to cultivate greater space for young people to freely access SRH care – regardless of their age, marital or educational status and without social judgment, shame and gossips. Interventions targeting changing the mindset and beliefs of the community should be implemented, as a sustainable change in community beliefs regarding SRH would positively impact youth care-seeking behaviour.
- **Ensure gender equity** in SRH education and SRH promotions: further incorporating SRH into the formal education can also go a long way to increasing the uptake of services and towards changing social norms and beliefs in the long run.

- **Empower girls and engage young people directly:** improved self-esteem and confidence can help young people, and in particular girls, to find the courage to access SRH services despite socio-cultural norms on their community. Young people should be involved in feedback mechanisms to health services, to ensure the services meet young people's needs, and be encouraged to share their SRH knowledge with their peers.
- **Encourage health workers** towards greater non-judgemental and youth-friendly care provision: by supporting health workers with adequate training and effective feedback mechanisms to further advance their counselling techniques, knowledge, technical skills, counselling skills and ethical decision-making capacity. Also, as health workers seem motivated to improve the SRH of youth, their efforts to change the community's view of SRH of young people should be strengthened and supported, so as to contribute to making SRH care more accessible for youth in their community.
- **Expand and improve available SRH services:** This includes improving the infrastructure, medicine availability, health facility and staff capacity.
- **Safeguard the privacy and confidentiality** of young people seeking SRH care, during counselling and beyond. Adjustments should be made so SRH care for youth, especially young women, can be offered in strict privacy and practical health-care system barriers should be addressed in order to create a more conducive care environment. Youth Friendly Health Services (YFS) are good examples of this as they create an equitably safe space to increase the uptake these services by young girls.

1. Introduction

YFS are an increasingly popular strategy to improve access to SRH services for young people that are sensitive to their needs. YFS have become part of health strategies and interventions in many countries around the world, aiming to reduce SRH problems among young people. However, while the availability of youth-friendly SRH services is improving, the uptake of these services by young people is lagging behind. This is also the case in Ethiopia, where youth-friendly SRH services are part of the national health strategy, but young people do not access these services as much as expected. It is unclear why young people do not access SRH services, and therefore this report aims to increase our understanding on why young people's access to SRH services remains low, and what can be done to improve it.

This report is part of the Yes I Do operational research strategy and aims to assess how youth access to SRH care can be improved, with the aim of reducing teenage pregnancy. The Yes I Do program started in Ethiopia in 2016, as a collaborative alliance program with Amref Ethiopia in the lead, with implementing partners Plan Ethiopia, Development Expertise Centre (DEC) Ethiopia and Talent Youth Association (TaYa). KIT Royal Tropical Institute as a strategic partner provides guidance on the research conducted as part of the program. This five-year program aims to address the drivers of teenage pregnancy, including child marriage, gender inequality, poverty, inadequate education and lack of access to care (18). Yes I Do addressed youth access to SRH care in the intervention areas by providing SRH education, peer education, training health workers in youth-friendly care delivery, providing contraceptives for health facilities and providing education on harmful traditional practices to care providers and other community members (19). Nevertheless, research conducted earlier as part of the Yes I Do program called to further investigate the push- and pull factors influencing youth care-seeking behaviour and expressed the need to strengthen the vision on quality youth-friendly SRH services.

1.1 YOUTH-FRIENDLY SRH SERVICE PROVISION

Creating quality youth-friendly SRH services and an environment conducive to SRH of youth is proven to effectively decrease teenage pregnancy and other SRH related problems among youth (20)(21). Such a strategy entails that first of all young people should be able to access information and services on SRH that meet their needs. Secondly, the community should support SRH care being offered to youth so young people feel free to use these services. Thirdly, youth themselves should be able to participate in the implementation and evaluation process of the health services, to ensure their needs are met and to review whether they feel care is provided to them in an equitable, non-judgemental manner. The last important component is that the care offered should fulfil health care standards in term of provided information, diagnostics and treatment.

When one or more of the mentioned components are missing, this poses a challenge to youth access to SRH care (1)(22). In reality, interventions targeting the SRH of youth frequently lack consistent implementation of all the components needed for youth-friendly care and therefore they often fail to attain the results they set out to achieve (1)(23). So even though Ethiopian policy documents contain a strategy encompassing all the right components to improve the SRH of youth, question remains how these policies are implemented, especially in a care environment where resources are constrained (12).

Health-care providers' attitudes towards SRH of youth and their technical competence are at the core of quality youth-responsive care. When health workers themselves have negative and judgemental attitudes towards youth in need of SRH care they might treat youth consulting on this care disrespectfully, posing a psychosocial barrier to youth seeking SRH care (20)(24). Moreover, health workers often describe their experience with consulting with youth as challenging, as they feel they lack the ability to effectively communicate with them on sensitive topics, particularly when they are not trained to attend to the specific SRH needs of youth (25)(26). Finally, health professionals might be hindered in providing quality care and might become demotivated when important components in their care environment, such as needed medication or human resources, are lacking (27)(26)(28). Therefore, this study assesses three components that might affect health care workers' service provision to young people.

Firstly, the personal beliefs of the health worker play a role. For example, when a health worker has a negative view on induced abortion, he or she might treat youth in need of this service disrespectfully or even deny them access to this care (20)(32)(33) Secondly, health workers can be influenced by the community around them. When they experience social pressure to provide or not provide certain care, they might choose to change their course of action (30). Thirdly, the health-care environment, which represents mainly how actions of health workers are limited by barriers in their environment. This as health workers lacking the needed means, skills or time will be unable to deliver particular services or might choose not to when they have to make a disproportionally large effort to deliver them (31)(30)(24).

1.2 JUSTIFICATION AND RESEARCH OBJECTIVE

Research conducted earlier as part of the Yes I Do program confirmed issues mentioned in the section above, including the unsupportive attitudes of health workers hampering youth access to care in the Ethiopian communities studied. Yes I Do reports have therefore called for gaining insight in barriers to young people's SRH care seeking behaviour. This study aims to provide insights in how access to SRH services for youth in the Yes I Do program intervention area could be further improved and explores this from the perspectives of both youth and of health workers.

In order to make sure the perspective of youth themselves on access to SRH care is taken into account, this study includes young people's views on SRH services in their communities. It aims to understand the view of youth on access to SRH care, the barriers, and how they can be involved to further improve youth access to and use of SRH care. Furthermore, the study seeks in-depth understanding of health workers' beliefs and attitudes towards youth SRH and how these influence their service provision.

1.3 RESEARCH QUESTIONS, SUB-QUESTIONS AND REPORT OUTLINE

In line with the above described aim of this study, the main research question is:

What are the barriers to SRH service uptake of young people and how can SRH service uptake be improved in Bahir Dar Zuria *woreda* (Amhara Region, North-West Ethiopia), according to young people and health workers?

The specific sub-questions of the research entailed:

1. What SRH services do young people prefer to use and why?
2. What are the most important barriers youth face when seeking SRH care?
3. What improvements do youth suggest in order to increase their access to SRH care?
   a. What improvements do young people believe should be prioritized?
   b. Who is responsible for improving SRH services, according to young people?
   c. How would young people themselves like to be involved in creating such changes?
4. What are the beliefs, attitudes and experiences of health workers regarding the SRH of youth and how do these influence service provision?
5. What barriers do health workers face in their health-care environment when providing SRH services to youth?
   a. How does the socio-cultural environment affect health workers' SRH service delivery to young people?
   b. How does the health-care environment affect health workers' SRH service delivery to young people?
6. What improvements do health workers suggest to enhance their (SRH) service provision?

The next chapters will describe what methods were used to conduct this research, and the results are described in the following two chapters: youth perspectives on SRH services, followed by health workers' perspectives. The discussion and conclusion provide an analysis of the main insights of young people's and health workers' perspectives combined. The last chapter of the report presents recommendations for future researchers and for all parties involved in improving access to SRH care within the study area can be found in the last section of the report.

2. Methods

This chapter describes the methodological approach that was used to answer this study's research questions. A description of the study site is provided, as well as information how the site and health facilities were selected, the design of the study, participant selection, and data analysis approach.

2.1 GENERAL DESCRIPTION OF THE STUDY SITE

The study was conducted in the Amhara region, North-West Ethiopia, in the area called Bahir Dar Zuria *woreda*. This area surrounds the Amhara regional capital city of Bahir Dar and has a population of around 180,000. Most people living here are employed in the agriculture sector and the majority practices Christian orthodox religion. At *kebele* level (the smallest official administrative units in the decentralized Ethiopian government structure) there are rural health posts (population coverage 3,000-7,000) staffed by health extension workers, who provide primary care after they completed one year of government training. They have the responsibility to train the so-called Health Development Army (HDA), consisting of a network of volunteers trained in best practices to set an example for the families they are linked to. This way, the HDA contributes to social mobilization, community dialogue and improved health outcomes (34)(35). The health posts are linked to health centres (population coverage 15,000 – 25,000), where health officers and clinical nurses (who received at least four years of training) are employed and a broader range of primary health-care is provided. Referral systems connect the health posts, health centres and general and specialized hospitals (34).

2.2 SITES AND HEALTH FACILITIES SELECTION

Facilities located in three *kebeles* in Bahir Dar Zuria *woreda* were purposely selected where 1) they provided SRH services to young people, 2) their location was logistically convenient and 3) the research would have contact information of the employees working at the relevant facilities to inform them about the study and ask their permission to include their facility. In total, eight facilities were included in the study and visited by the researcher, including health centres and five health posts within their catchment area in five different *kebeles*. All except one facility were located within the Yes I Do intervention area. Additionally, a specialized reproductive health clinic in Bahir Dar was selected as patients from the included rural facilities were referred here for SRH care such as safe abortion. The general hospital in Bahir Dar was not included, due to constrictions posed by the ethical approval which did not target their facility specifically.

2.3 STUDY DESIGN AND DATA COLLECTION TOOLS AND PROCEDURES

This study has an explorative qualitative design and comprised of two fieldworks periods for primary data collection. The first fieldwork took place in June 201 and focused on the six selected health facilities and the health workers' perspectives. The second fieldwork took place in November 2019 and focussed on the young people's perspectives. During the first fieldwork phase, semi-structured interviews were held with health workers. Interviews were conducted using a topic guide with exploratory open-ended questions and probes. The interviews were held in a confidential setting at the health facility premises, in order to allow the health workers to speak freely and return to work after finishing the interview. Only the researcher and translator were present during the interviews. As the health workers spoke Amharic and the main researcher did not, the questions were asked in English, translated to Amharic and then the response was translated back to English. To triangulate data sources, semi-structured interviews with youth were held, as well as observations at the health facilities and of consultations with youth on SRH issues. One facility manager shared her view on the arrangement of care, the patient logs in both health centres were analysed and three consultations on SRH care with youth were observed. During the second fieldwork, FGDs were held with girls boys. FGDs were conducted in Amharic. Before starting each interview and observation, informed consent was asked using a consent form written in Amharic. Ethical clearance was provided by the Amhara National Regional State Health Bureau for all operational research within the Yes I Do program, including this study.

2.4 STUDY PARTICIPANT SELECTION

Health-care providers, including health extension workers, health officers and clinical nurses were purposely selected to participate in the study based on whether they provided SRH services to youth. These SRH services included providing contraceptives to youth, providing counselling on SRH for youth or prescribing treatment for STIs and HIV for youth. Health workers were recruited in-person by the research team and YID partners, health facility managers and the translator. In total, ten health workers were interviewed; two at each health centre and one at each health post and at the reproductive health clinic.

There were two sets of selection for youth participants: a) one was exit interviews with youth at the selected health facilities, and b) the other was focus group discussions with youth from selected *kebeles*. For the exit interviews with youth, most SRH care for rural youth was provided in the health centres. Because only a few young people were using SRH services on the days of observation, youth visiting the clinic for other purposes were selected with the help of the health workers providing them care to also share their view on access to SRH care in semi-structured interviews. Five youth (three boys and two girls) were interviewed at the health centres, of whom two came for SRH care and the rest for other health issues. For the FGDs, girls and boys were randomly selected in three *kebele* site areas. At each *kebele*, two FGDs were held, one with girls and the other with boys. Yes I Do partners gathered participants. Each FGD consisted of 6-8 young people aged 15 to 24. Care was taken to have, as much as was possible, a mix of backgrounds in one FGD with regards to educational background and marital status. None of the young people were parents.

2.5 DATA ANALYSIS AND PROCESSING

Interviews were audio-recorded and transcribed. Key themes were then identified, which were used to develop a code list. Coding was done manually, and data and quotes were categorized along the identified key themes. Interviews were analysed case by case to extract patterns. Based on this overview, an analysis of each theme was constructed. Preliminary findings were presented to the Yes I Do Alliance partners in a validation session.

3. Contextual Background

This section outlines important background information on young people's SRH in Amhara region and Ethiopia more broadly, so as to embed the study's findings in its contextual setting. The section first presents the current status of SRH of Ethiopian young people. After that, key policies, strategies, and interventions targeting young people's SRH are discussed.

3.1 THE SRH OF ETHIOPIAN YOUTH

Young people between 10-24 years old made up around 35% of the country's population in 2017, and the youth cohort is steadily increasing. Ensuring the health and well-being of youth and aiding them to reach their full potential will facilitate Ethiopia's progress towards goals set within the UN Sustainable Development Goal framework, including accomplishing universal health coverage, eliminating poverty, improving education and realizing gender equity (12) (13).

SRH and maternal health-related problems contribute substantially to the morbidity and mortality among young Ethiopians. They are vulnerable to contracting HIV and other Sexually Transmitted Infections (STIs) and girls have a high chance of teenage pregnancy, with 12% of Ethiopian women starting childbearing before the age of twenty (12) (11). Teenage pregnancy puts women at high risk of dying from complications related to pregnancy and childbirth and has negative health consequences for the babies born to these young mothers (14). This is reflected by the fact that Ethiopian girls under the age of fifteen are three times more likely to end their pregnancy in abortion than their older peers, accounting for almost 30% of all obstetric and gynaecological admission (12). Also, a high estimated percentage of unintended pregnancy among adolescents ends in unsafe abortion (36% in 2014), with limited exact data being available on this topic (15). Moreover, adolescent childbearing often limits education possibilities, employment opportunities and financial prospects of girls (14)(16). Many SRH related problems, such as early marriage, FGM/C, and teenage pregnancy, are manifestations of deeply rooted gender inequality, restrictive social norms, poverty, limited economic prospect, and inadequate access to SRH information and services. This asks for a multifaceted approach to the problem including catalysing social change and improving education. Importantly, the current Ethiopian health system does not seem to fully cater to the needs of youth, therefore contributing to teenage pregnancy and other SRH related health problems affecting young Ethiopians (16)(17).

With regards to the Amhara region specifically, the study site of this research, the region has one of the lowest median ages of marriage in Ethiopia (16.4 years of age). As most girls get pregnant after wedlock, early marriage is one of the drivers of teenage pregnancy. Fortunately, the average age of marriage has been rising and the teenage pregnancy rate declining over recent years, with now at 8.4% of girls aged fifteen to nineteen giving birth before age nineteen in the region according to the most recent Ethiopian Demographic Health Survey (DHS). The uptake of contraceptives has also been increasing, with the unmet need for family planning now at 12% among all women between the age of fifteen to forty-nine. Among youth, the unmet need for family planning is even lower, currently at 8.1%. Unmarried women in Ethiopia are found to have a higher unmet need for family planning than the married group (26% and 22%, respectively). This could point to different factors on the demand and supply side influencing care-seeking behaviour of unmarried women in comparison to their married peers. As for sexual risk behaviour, the DHS showed only 22% of Amhara women had comprehensive knowledge on HIV. Moreover, of youth aged fifteen to twenty-four who reported having intercourse with someone other than their husband or wife, only 12% of women and 45% of men reported using a condom. Finally, comprehensive knowledge on HIV and condom use among men and women is reportedly low and as mentioned earlier a relatively high number of adolescents end pregnancy with an unsafe abortion (11)(15). So in conclusion, even though positive trends are reported, interventions aiming to further decrease teenage pregnancy and child marriage, reduce the unmet need for family planning and increase knowledge and condom uptake are justified.

3.2 IMPLEMENTATION OF STRATEGIES AND PROGRAMS PROMOTING THE SRH OF ETHIOPIAN YOUTH

To address the health needs of youth, the Ethiopian Federal Ministry of Health launched its standard on youth-friendly reproductive health services in 2008. The national adolescent and youth health strategy, launched in 2017, includes attention to reproductive health. Both documents are based on international guidelines on youth-responsive services and provide comprehensive cadres for SRH services at different primary care service outlets. Hence, they set out to increase youth access to quality care (17)(12).

The national adolescent and youth health strategy has identified the following areas as priority areas for action: 1) increasing access to adolescent youth health information and age-appropriate CSE/life-skills education; 2) enhancing access youth-friendly health services; 3) strengthening strategic information and research on adolescents and youth; 4) promoting a supportive and enabling policy environment; 5) facilitating youth engagement; 6) strengthening inter-sectoral coordination, networking and partnership. Youth-friendly health services are sometimes provided as part of 'one-stop shops' for young people, where a range of essential services are offered to young people, including counselling and health services.

To expand access to essential health services into the most rural parts of the country, Ethiopia has been implementing a community health extension program (HEP) since 2003. Health extension workers receive a short training so that they can provide the most basic services at the community level. Indeed, through recruiting and training community-based health extension workers, health services have become more accessible to rural Ethiopians (53) and have helped significantly in reducing maternal mortality rates (54).

4. Young People's Perspectives and Experiences

This chapter presents an analysis of young people's experiences with and perspectives on using SRH services in their communities. The chapter first presents young people's reports on which services they use and what their preferences for SRH services are. It also highlights the differences in uptake of SRH services depending on background characteristics of young people, such as gender, age, and marital and educational status. After that, the chapter zooms in on the barriers young people experience in accessing SRH services and their views on how services can be improved for young people.

4.1 SRH SERVICES USE AND PREFERENCES

With regards to the use of SRH services, there was a consensus among all young people in the FGDs that these services were available at either the health centre or health post in their own *kebele*. Young people generally found the YFS to be youth centred and accessible. YFS are set up to offer a space where young people can attend and use the services freely. YFS include recreational services like ping-pong table in the health facility premises and a room equipped with television, board games and educational pamphlets and magazines for young people to enjoy. *"The setting of YFS is comfortable to access and its independent from the visibility of the communities looks"* (FGD Boys). Young people felt that if a girl or boy were to be caught at the YFS, the community would not assume they are sexually active or getting married – rather the YFS is seen as a safe space and not associated with uncustomary practices. Young people also found the YFS relevant to their needs. At the same time, not all health services were considered to have youth-friendly enough facilities and services and use of SRH services thus remained rather low.

USE OF FAMILY PLANNING AND CONTRACEPTION

Looking at what SRH services are delivered and used by young people, the use of SRH service was found mostly to be used for family planning and contraceptive methods. It was found that a range of modern contraceptives is available at the studied facilities. This includes injectable contraception, pills, condoms and emergency contraception pills. When discussing the use of contraception with young people in FGDs, preferred methods mentioned were 3-month injection and 3-year implant. It should be noted that young people reported implants were discouraged and not widely used as compared to injections, since implants were associated with infertility and aggressive behaviour from women. Young people said that the injection was used by the girls who have better economic status, but that girls with lower economic status take the 3-year implant. They also pointed out that some, in particular unmarried schoolgirls, use emergency contraception.

Reasons for contraceptive use were mostly related to avoiding unwanted pregnancy, because *"it [pregnancy] can be visibly by others,"* (FGD Boys) whereas they are less concerned about STIs. Some girls also pointed out that in their community, the girls use contraceptive methods in order to plan their families in accordance with their income. Condoms were the preferred method for relationships that were not long-lasting. Girls mentioned that sometimes the boys up to 19 and 20 years of age would use a condom, and *"he would push the girl to have intercourse, if she is not on any method of contraception he would use the condom."* (FGD with girls). At the same time, young people hear of others who do not like to use condoms because they believe it decreases sexual pleasure:

> *"We learn it's better to protect with condom. But I still hear boys saying they don't like to use condoms. The boys say they choose to rather be attacked by the disease [HIV] than to use condoms. So they learn the knowledge, but they don't like to use condoms.[...] They are not feeling comfortable. They complain about it, that they don't want to use [condoms] and that [it] decreases the [sexual] feeling."* (FGD Boys)

All participants mentioned they would be disrespected by the community if it would become known they are having sex before marriage or if they would end up with unintended pregnancy. Three young interviewees said they themselves found it important to abstain until marriage; reasons were related to religious values (one boy) and preventing unintended pregnancy (two girls).

Health workers observed that it is mostly the girls who would take the initiative to start contraceptives, as they feared becoming pregnant before knowing their partner well and before marriage. On the other hand, some interviewed youth using contraception (or who's partner used contraception) stated they make contraceptive decisions together with their partner. Boys also said to be open to the idea of their girlfriend using contraceptives: *"If my girlfriend uses the service and it gives us freedom to stay in a relationship until marriage then we both feel happiness"* (FGD Boys) However, according to health workers, boys are less worried about unintended pregnancy, especially when they wanted to marry a girl; in that case, pregnancy would be convenient leverage for making the girl stay with him. Similarly, several health workers said that girls are often visiting the health facility to start contraceptives before getting married because they want to be sure the husband will treat them well before becoming pregnant. At the same time, health workers noted that many girls would not want to take condoms home with them even when health workers advised them to, suggesting that girls prefer other forms of contraceptives.

Three health workers also elaborated on the decision-making on contraceptives after marriage and explained wives might have a different view on family planning compared to their husband. They said women generally see the advantage of limiting and spacing births, while men believe having more children will bring the family financial gains as their offspring can help with the work on the land. This results in some girls using family planning in secret without their husband knowing about it. When the husband finds out this can lead to domestic disputes and can result in men blaming the health worker for making their wife 'infertile'.

> *"He was sad, asking why she is taking the injection and hiding it from me. […] I explained limiting your family members helps to get better economic outcomes for your family. And he agreed. I told them for the next time to come together. He agreed."* (Health extension worker 4)

> *"Women are using systematic ways to use the family planning service in secret. They come when it gets dark, or they take the medicine on their way when they are getting water."* (Health extension worker 5)

Two health workers mentioned a situation in which they explained the benefits of family planning to the husband after having a dispute, and the husband then changing his mind and allowing his wife to use contraception.

USE OF ABORTION SERVICES

In addition to contraception and family planning services, the health centres and reproductive health clinic provide additional SRH services, such as treatment for STIs and HIV, have a consultation room where all youth between the age of 10 and 24 is counselled, and offer induced abortion services (up to twelve weeks of pregnancy) in line with national abortion law. This law states induced abortion can be performed in case of rape or incest, in case the mother is under eighteen years old when there are severe health threats to mother or baby and finally when the mother has a severe physical or mental disability (17). Induced abortion can be performed at the hospital up to twenty-four weeks. Clients can generally be referred to the hospital or specialized clinic in the city and travel there in under two hours by public transport (and in 30 minutes by ambulance when available). It was found the arrangement for induced abortion also required that a witness form be filled out prior to the procedure and that the girl (seeking to abort) must be accompanied by someone, and not permitted to come for the procedure alone.

Despite the availability of abortion services, FGDs with young people indicate that girls feel largely constrained in making use of these services. In all FGDs, young people knew about the options for abortion in health facilities, but also highlighted the barriers; there was one FGD with girls that mentioned that girls might prefer unsafe abortion with traditional methods to an abortion at a health centre, out of fear that the pregnancy is discovered in the community. Boys mentioned that girls who need to undergo an abortion would go to health facilities further away from home, particularly in Bahir Dar (the city), to avoid gossip and stigma. Participants said that because abortion at health facilities was possible, there was no need to undergo an unsafe abortion, and they are aware of the risks. In fact, they cautioned that it was far more likely to hear of a young girl taking her own life than undergoing unsafe abortion:

> *"In my area there was this girl, who was a ninth grader, she had a boyfriend it wasn't approved by parents yet. And she got pregnant, she was coming to school until October, she bought a poison that kills mice took it and ended her life"* (FGD Girls)

Both girls and boys mentioned the high risk of suicide, and listed rat poison and *khat* fertiliser as examples they had heard of for suicide attempts.

Indeed, six health workers explained that pregnant girls would be seen as sinners and one interviewed boy explained that a girl with unintended pregnancy would face the prospect of rejection and harassment by the community and therefore might choose to hide the pregnancy and commit infanticide.

> *"If the community finds out a girl had an induced abortion, she would be rejected, and nobody would want to marry her. If somebody knows they say it is rude, the community would not accept her. If she is ready for marriage and they know her background no one will marry her. In the culture it is not good to have abortion."* (Health extension worker 5)

This shows how shame and fear caused by societal norms can result in youth taking desperate measures to prevent being rejected by their community and their family.

BACKGROUND DIFFERENCES IN SRH SERVICE UPTAKE

Even though young people found YFS relevant to their needs, not all young people made equal use of SRH services. Differentiations as to who uses the SRH services mostly varied along the lines of gender, ability, age, marital and educational status.

GENDER DIFFERENCES

While the YFS generally provide comfort, its benefits are skewed towards the boys. Compared to girls, boys have an easier time accessing the YFS and its associated SRH services. The reason being boys are less judged, if not justified, in entering a YFS where the recreational activities, such as table tennis, games and TV, are perceived to be 'boys activities'. The girls, on the other hand, would not have a compelling enough reason given the gender norms – therefore their experience may not be as positive. As the boys who frequent the YFS shared:

> *"If a girl needs to get FP services from YFS, she couldn't pass through the mass community who waited for other health services. […] If a girl needs to attend training and awareness programs at YFS centre, their family do not allow them to be part of it."* (FGD Boys).

Youth Friendly Health Service - Boy Clients

At the end of the FGD in one town, participants were invited to take a group photo and choose anywhere they like to stand in the compound of the health facility. The boys hurried over to show where they play table tennis (inside the tent) and stood proudly right below the signpost as they giggled about how they frequent and enjoy the YFS (see photo). The girls, on the other hand, asked to be photographed under the big tree at the back of the compound, behind the YFS consultation rooms. When asked if they too would like to stand under the signpost for photos, they shied away and shrugged their shoulders. Their body language and reactions confirm how not connected they feel to the YSF and do not (feel encouraged to) access YSF.

DISABILITY

Access to YFS also does not extend to those that are disabled. Disabled youth do demand SRH services but are limited in their ability to access it. *"No in my present in YFS centre I have never seen person with disability for SRH service"* (FGD Boys). There are several reasons here, firstly youth who are disabled are not mobile within the community, fearing the negative looks they would receive by the public. Secondly, those disabled fear receiving different treatment.

> *"In my opinion if they came to the YFS, the health professionals will be surprised and react in a negative way. Even I myself will not have a positive reaction. Sure, they give the services as anybody else, but the reaction will be different"* (FGD Boys)

AGE DIFFERENCES

With regards to age, differences in accessing family planning services and contraception were noted. Most health workers stated that girls start using contraception around the age of eighteen or twenty. Indeed, when observing the family planning logs in the YFS room at the health centres, most girls registered were over eighteen years old. It should be noted, however, that young people reported girls to have their sexual debut at a younger age, around fifteen, and often before marriage. This could suggest an unmet need for family planning or contraceptives amongst sexually active girls, or that girls rely on their male partners to get condoms. Health workers indeed stated that only boys come and ask for condoms and girls do not, and the age of youth picking up condoms was not recorded.

MARITAL AND EDUCATIONAL STATUS

The use of health services not only differed per age but might also vary by marital and educational status. Boys reckoned that unmarried girls use contraceptives more than married girls mainly because *"unmarried girls cannot afford the humiliation of having to baby out of wedlock and know that keeping the baby will be a hurdle for her future"* (Boys FGD). At the same time, in-school unmarried girls were perceived as being more sexually active than those out of schoolgirls. Among unmarried in-school girls, the emergency contraceptive pill was the most popular and preferred option, indicating that girls indeed refrain from asking for condoms in health facilities. The contraceptive pill is widely available at any health facility or pharmacy. Young boys also considered educated girls living in urban areas to use contraceptives more often compared to non-educated girls who live in rural areas who they consider lack the knowledge of contraceptives and often have more children, sometimes they give birth to two children in less than two years. Unmarried girls are perceived as using SRH services far away from their own community, whereas married girls are seen as more comfortable to use SRH services within their own community since married girls are respected as a wife and mother.

4.3 BARRIERS TO ACCESSING SRH SERVICES

Young people were asked what their main barriers were to accessing SRH services. Their barriers concerned individual barriers such as shame and low-self-confidence, community values on young people's SRH, intergenerational differences, and supply-side barriers including the capacity of services and competencies of health workers.

PERCEIVED STIGMA, SHAME AND LOW-SELF CONFIDENCE

Not only unmarried youth, but all young people regardless of relationship status tend to be very shy and modest - having been raised in a society that is more conservative on social issues. Not only elders but also their peers can make young people feel discouraged to access SRH services: *"When I want to get a condom and if I advise my friends on how I can get it, they will laugh at me. This discourages my effort to get a condom"* (FGD Boys). Young people are shy and lack the motivation and self-confidence to ask health professionals in front of their peers. Their feelings of 'shyness' and 'shame' comes from their paralysing worry and fear of how the community may judge, gossip and stigmatize them when using SRH care. Youth do not 'own' their own sexuality, and do not have the confidence to demand services for their own bodies. They would rather send their close friends to get them condoms or pills instead of showing up in person. However, it should be noted that education seems to affect the level of shame felt for (unmarried) youth. According to a group of boys, uneducated young people would hide themselves by wearing scarves, fearing to be seen in health institutions. Yet, educated young people more often use SRH services in any health institutions without feeling ashamed, without looking over their shoulders wondering which relative or family member saw them.

PERCEIVED COMMUNITY VALUES, NORMS AND ATTITUDES

The barrier to access SRH that was discussed most relates to community values and norms around SRH for young people. Young people reported that they felt there was an overall negative attitude towards young people who seek to use SRH services. The negative attitude towards youth SRH led young people to fear making use of the available services. Due to the overall negative attitude towards SRH, young people associate SRH with 'a series of shameful acts', and refrain from seeking services or help. Furthermore, attitudes around SRH intersect with gender norms. For instance, boys explained that community members would condemn a girl if she was to be raped and blame her, saying she got raped voluntarily. This implies even stronger barriers for girls to access SRH services and help.

In line with earlier observations that unmarried youth prefer to avoid seeking SRH services, young people indeed explained that fear and judgement of the community is felt strongest by unmarried young people who live in rural areas. As one boy observes: *"Those who live in rural areas look behind to see if someone is watching them"* (FGD Boys). The freedoms of unmarried girls are particularly constrained by community perceptions of them having gone against customs and norms by engaging in sexual activity prior to marriage, thereby causing shame to her family. As one girl reports: *"Even when we come here for reasons other than SRH, people assume we are here for contraceptives"* (FGD Girls). Hence, young people tend to avoid health clinics because they think the community equates them with SRH services. Community perceptions thus demoralize unmarried girls from seeking SRH services, who depend on their close friends to get contraceptives.

Community norms that impacted the use of SRH services particularly centred around family planning and pregnancy before marriage. There norms were linked to religious values; young people reported that many senior religious fathers do not support family planning, explaining that *"interrupting pregnancy is like killing the creation of God"* (FGD Boys). The belief that family planning is going against God's word prevents girls from discussing contraceptives or seeking ways to access it. Those who end up using family planning methods, do so without the knowledge of their family members. Using contraceptives is a well-kept secret for many of these girls, fearing that their boyfriends may one day reveal their secret. However, some young people disagreed with the view that family planning is unacceptable. In fact, a group of boys stated that:

> *"It's advisable that any girl shall use family planning whether she has boyfriend or not. In cases of rape, girls can protect themselves from unplanned pregnancy even though they lost their virginity. Whereas girls who do not use family planning regret what happened to them."* (FGD Boys)

The main rationale for using family planning, according to these boys, is thus to prevent the shame of an unwanted pregnancy from both rape and romantic relationships.

Indeed, young people confirmed that pregnancy out of wedlock is extremely frowned upon, while young people using SRH services is stigmatised as well. As a consequence, young people, girls in particular, refrain from seeking contraceptives at SRH services out of fear of gossip about sexual activity or pregnancy, even if they want to make use of the service. Moreover, while abortion services are available in the health clinics, fear of community gossip and stigma is so strong that girls sometimes decide to commit suicide, instead of seeking services (see also section on the use of abortion services).

INTERGENERATIONAL DIFFERENCES

There exists a marked intergenerational conflict between youth and their parents. Youth prefer to talk to their close friends as opposed to family members. Boys noted that most of the time girls only trust and share their worries with their very close friends. She will not ask her family member, who she is often scared of. The elder generation holds on to cultural traditions and norms and youth are influenced by rapidly changing society and feel that their parents and older family members are failing to keep up with changes in society. In a society where the elder generation is to be respected, young people can thus feel isolated and unsupported in their SRH needs.

THE CAPACITY OF HEALTH SERVICES

The capacity of health facilities is an apparent issue. Available health posts do not have the capacity to serve all youth who might be in need for SRH services. Boys figured that *"it probably serves half of the service seekers,"* and it is generally not enough to meet the demands and high traffic. In particular, those living in remote areas are further disadvantaged to access health services. Youth who live in remote and distant areas where transport infrastructure is underdeveloped, and they have to travel large distances by foot, are particularly disappointed to experience health facilities that cannot serve them due to limited capacity.

UNFRIENDLY TREATMENT BY HEALTH WORKERS

SRH services are available to all young people, but one great barrier lies in how health workers treat young people. In particular, unmarried and in-school girls seeking SRH care are sometimes treated unfairly and may not receive the same advice or counselling as other girls. According to young boys, health professionals have been seen to humiliate clients and can be unprofessional. *"They come late to work and mistreat their clients by rudely brushing them off with comments like 'come back tomorrow' or 'we are very tired come later'"* (FGD Boys). The FGD described a case where a high school girl went to a health facility for a contraceptive injection but was denied that service because it was not available for students. Some young girls also shared their experience of feeling insulated and degraded – prompting them to seek care at private health facilities. *"Some young people prefer to go to Bahir Dar to get [SRH] service at the larger health facilities. Other young people who have money will prefer using private clinics to get SRH services"* (FGD Boys). Therefore, poor services can discourage young people to seek SRH care, especially those with limited economic means or means to travel.

4.4 YOUNG PEOPLE'S VIEWS ON HOW TO IMPROVE THEIR SRH

In addition to the barriers young people face in accessing SRH services, participants were also asked to give suggestions on how to improve the situation to enable them better access to SRH care and improve their own SRH. In doing so, they were asked to consider who is responsible for making these improvements, and how they would like to be involved in creating the changes they want to see.

IMPROVEMENTS TO PRIORITIZE

YFS have the potential to increase access to SRH and improve youth SRH. The reason for this is the YFS are considered 'services exclusively for youth' and young people would not need to feel ashamed, for example, to have an abortion at YFS, as the services do not cater to adults or children. However, when asked what improvement ought to be made to improve access to SRH services, young people highlighted the importance of a supportive community and family environment: *"The first thing to be done to make youth comfortable with SRH services is to change the outlook of the society"* (FGD Girls). There is a consensus that this starts with changing families outlook through the dissemination of appropriate information and social awareness. For example, *"society needs to be made aware that young girls using contraceptive is not a bad thing at all. In fact, it keeps them safe"* (Girls FGD). Creating such awareness amongst the community would *"reduce gossips, ridicule and judgments, […] remove the barriers regarding attitudinal problems […] and tendency of irritation"*(Boys FGD) and better services could be rendered for youth. But to sustain and expand this awareness, youth recognise that there needs to be *"SRH education for the community […] with continuous knowledge transfer, as trainers drop the subject after one or two day sessions"* (Girls FGD). Young people thus expected they would feel more comfortable using SRH services if community members would view them accessing the services more positively.

Many young people mentioned the feeling of shame when they need to access SRH care and they worry if someone would find out that they were looking for SRH care. Young people pointed out that SRH access can be improved if they are ensured that their privacy is respected.

> *"Young people, when they getting the service, their confidentiality should be respected. Young people when they get the SRH service, will be good if they get in a secret way, if so young people using the service with no ashamed."* (Boys FGD)

> *"My first point is to make hidden building, for example when a girl comes to get SRH services across here they will see her, she is afraid to walk into the health centre to the gate up to youth friendly service room. Also the place for condom distribution is not so secret, there should be a second gate at the backside."* (Boys FGD)

Three interviewed youth further explained that in their view, the facilities should offer more privacy, for example, by making a separate gate for youth and placing the condom distribution, which is now located in the maternity ward and youth-friendly service room, in a more secret place.

Suggested improvements also related to the price, availability, and equipment of health services. For example, boys mentioned that the price of emergency contraception should be lower as it is expensive (Boys FGD). With regards to equipment, boys mentioned the need for more health stations and medical equipment.

> *"I cannot be cured if I suffer from an accident because of limited provisions in the health centre here. For example, if someone wants blood test to know his/her HIV status, he/she needs to travel to other places get the service. So all health facilities should be well equipped."* (Boys FGD)

Young people also suggested that the number of health facilities and health professionals should be increased; one young person mentioned waiting for four hours to get the service they needed. At the same time, young people stated that health professionals should show respect to youth and stick to their working hours.

> *"Health professionals should respect their working time. Most of the time they come late, and they close the centre early. Health professionals also should correct their behaviour when they provide services to young people. They should give respect to their clients."* (Boys FGD)

It should be noted that youth participation did not come up until it was explicitly asked how young people's desires and opinions for improvement should be communicated, and to whom. Young people also needed more explanation when they were asked if they *"know how young people are involved in SRH services or in any decision-making about SRH services being provided in their community"*. One young boy, who is quite active in the community and well known, interpreted this question as asking about volunteering to make services more available "[for example] if emergency contraception is not easily accessible, youths beg of me to provide them the pill because they assume I am closer for the health centre". Similarly, another boy said, *"I know volunteers who work in the agricultural extension, but I'm not sure if there are volunteers in the SRH area"* (Boys FGD). It did not appear overall that there is this practice or procedure or process that young people were easily familiar with. However, young people did express their wish to be able to give more feedback to the available SRH services, and highlighted that, until now, the moments of feedback depended on NGO interventions or wider *woreda* expert meetings.

RESPONSIBILITIES OF KEY ACTORS

When asked who is responsible for improvement some participants pointed to the health centre and the health professionals. Other participants said that the responsibility for improvement of health services is on the government. Other participants pointed out that the government and NGOs should work together to improve the SRH care. A few young people considered the media to be more impactful than raising their questions to *kebele* officials only. However, others were more doubtful about it, stating that:

> *"Rather than the media, I think it is more feasible to address questions to the kebele officials face to face since it is possible to challenge them when the demands are not fulfilled as promised. Otherwise, what can be promised in the media could be for political consumption only."* (Boys FGD)

Many participants also pointed out that youth is responsible for improving SRH care. *"Young people themselves also should be responsible to improve the service. They can put their pressure on government to improve SRH services."* (Boys FGD) The importance of young people who have received SRH knowledge to share it with other youth was also mentioned. *"Young people also should take the responsibility, after they get training about SRH, they should also teach other young people. They should share the knowledge that they get from the training."* (Boys FGD) Young people saw trained youth as particularly resourceful if they *"avoid bashfulness and increase self-confidence."* They also said that young people could teach the community on Sunday in church.

When asked how young people could organise for improvement, young people suggested that "We youths [could] create groups like I will bring five or six youths to the centre if there is community wide programs and each individual will share the information for their nearby youths." They also mentioned punishment methods in order to make youth attend their program regularly by drawing on their current experiences, following the prohibition of traditional birth attendants, whereby the community decides a *"Sera"* [customary law] that if a mother delivers at home she will be fined. *"For example if the pregnant women do not use health service during delivery she will punish 500 birr. Hence, in this method SRH service users will be improved."* (Boys FGD)

5. Health Workers' Perspectives

This chapter presents an analysis of health workers' perspectives on the provision of SRH services to young people and the main barriers to uptake of and service provision to young people. The first section of this chapter discusses the personal beliefs and attitudes of health workers an key themes of young people's SRH, and how personal views might affect service provision. Following that is an analysis of the main barriers in providing SRH services to young people according to health workers. These include socio-cultural barriers as well as barriers from the health-care environment. Finally, the chapter presents what improvements health workers suggested to improve SRH service provision for young people.

5.1 HEALTH WORKERS' PERSONAL BELIEFS AND ATTITUDES TOWARDS YOUNG PEOPLE'S SRH

Care providers were asked about their personal views on SRH of youth and the influence of these views on SRH care provision. As described in more detail below, it became clear during the interviews that health workers seemed to share certain beliefs on pre-marital sex, induced abortion and gender roles with the community around them. However, they held a more progressive view on SRH care provision than most community members.

PRE-MARITAL SEX, MULTIPLE SEXUAL PARTNERS AND CONTRACEPTION

Health workers were asked to explain their view on pre-marital sex and to share the advice they give to unmarried youth coming to ask for contraception. Nine health workers reported they believed abstaining until marriage is the most suitable way for youth to protect themselves from disease and unintended pregnancy and also shared this advice with youth during consultations. Protecting youth from school drop-out, preventing them from switching partner often and therefore from getting STIs and preventing conflicts between boys and families were other reasons that motivated health workers to counsel on abstinence. Two health workers mentioned they only encourage abstinence when youth would be under eighteen or would 'look young'.

The second piece of advice health workers shared is that youth should limit themselves to one sexual partner to prevent HIV and STI infection; they believed it is better to abstain but if that is not possible young people should only have one boyfriend or girlfriend.

> *"I am not advising to have sex before marriage, but it is biological and because of that I cannot say it's not good, but I advise them to use protection for unwanted pregnancy and STIs and to be careful and to have only one partner. But it is better to wait."* (Health extension worker 1)

> *"The healthy choice for youth especially at school is to abstain, then they need to trust one to one partner, thirdly if not possible they have to use condom. If they have to do it they have to use condom. So we don't see STI and unwanted pregnancy and HIV. It better to abstain and use condom is my advice."* (Health officer 2)

Moreover, when asked what kind of advice they would give to a girl with multiple sexual relationships, three health workers started explaining about the guidance they would provide to a sex worker. This could indicate a bias in the sense that health workers associate girls with multiple sexual partners as sex workers. Alternatively, it could imply most girls have only one partner or might not disclose the details of their sexual activity during a consultation. Health workers said they would encourage unmarried young girls to abstain. In the event a young girl expressed she won't abstain, then health workers say they would provide contraceptive methods and encourage she only has one sexual partner.

Hence, according to health workers, options to contraceptive methods are provided regardless of the young client's age, marital status or sexual risk behaviour. The reasoning behind this as mentioned by care providers is that they want to promote the health and well-being of youth and therefore want to protect them from unintended pregnancy,

disease and school drop-out. So even though they think it is best when young people abstain, they will still provide contraceptives to youth who say they need them.

UNINTENDED PREGNANCY AND INDUCED ABORTION

Seven health workers expressed how their view on performing induced abortion influenced their counselling on this topic. They explained that during counselling on induced abortion their first priority would be to see if the woman might change her mind and continue the pregnancy. This as they saw her keeping the baby and starting a family as the best possible outcome of the situation, relating to the community belief that induced abortion should be avoided or not even offered at all. Some health workers did explain their advice to keep the pregnancy would depend on the situation. For example, sometimes they felt like married girls did not contemplate their decision and would come in after a domestic dispute, or unmarried girls would come as they feared telling their family or boyfriend about the pregnancy. Then, when the health worker would help the girls to calm down or would offer the girl to stand by her side when telling the family about the pregnancy, they would change their mind and keep the pregnancy.

A variety of views and actions were reported when further exploring health workers' views on active termination of pregnancy. Religious values were found to have an influence on safe abortion services. For example, two health workers who were licensed to perform induced abortion reported they themselves or one of their colleagues did not feel comfortable performing this procedure as they see induced abortion as murder due to their religious values. One of them explained to face an internal struggle as her religious beliefs contradicted her professional standard. Another health worker explained that at their health facility the husband would be asked for informed consent when a married woman would come in for induced abortion, and that he (the health worker) believed in the importance of this procedure even though such practice is not mandatory according to Ethiopian law.

> *"People decide for themselves. I decided because of my conscious. So doing abortion is like doing murder. Not even only abortion but also throwing out your sperm cells by masturbation is also a sin."* (Health officer 1)

> *"If a girl comes here for abortion, I would advise her to accept the pregnancy, I would try to change her mind. If she accepts this advice I will offer to follow up on the pregnancy. If she is not changing her mind I would refer to the health centre."* (Health extension worker 2)

At the same time, there were some health workers willing to perform induced abortion even when this would technically be unlawful. This could be done by for example registering the pregnancy as a result of rape while in reality the reason for the abortion would be financial constraints of the family. Girls themselves were also reported to lie and say they were raped as some know about the criteria stated in the abortion law. Health workers did not seem concerned about legal consequences, as they do not have to ask for any official prove of rape and it is not expected of them to ask for details on the situation of the girls.

Importantly, although the views of health workers on actively partaking in terminating a pregnancy differed, they all reported to arrange this procedure and keep it a secret when needed. This because they wanted to prevent conflict in the community, support the girl in continuing education and particularly do not want her to resort to unsafe abortion as this would put her life in danger.

GENDER ROLES: CONTRACEPTION FOR BOYS AND FAMILY PLANNING FOR GIRLS?

Health workers shared views related to gender roles that might impact their service delivery. Some health workers expressed themselves in a way indicating they see condoms mainly as something for boys, although all reported to encourage girls to use condoms as well. Whereas, family planning services seemed to be mostly offered to girls. This difference might relate to an explanation two health workers gave about SRH education. They said that when health workers teach about SRH, boys and girls will be educated separately and on different topics; boys will be taught about condom use and girls about family planning. This practice might partly explain why family planning is mainly seen as 'a women's affair' and men have less knowledge on the benefit of limiting and spacing births, while condom use is seen as something for boys. Moreover, two health workers explained they would not provide emergency contraception to boys coming to pick up this medication for their girlfriends, although one of them mentioned this was simply because in his experience the boys would not transfer the users instructions properly to the girls.

It is important to state that all health workers expressed they found it important to provide SRH services, despite certain beliefs on gender roles, contraception and family planning. They did not believe providing contraception, induced abortion and sex education promotes promiscuity. On the contrary; they believed that by offering these they are doing good for the community. Their priority is to promote the health and well-being of youth and they will pursue this goal by providing services in secret or even unlawfully when needed. Some literally stated they believe youth has a right to receive SRH services:

> *"I will not think twice about providing a service when I think it's important for the patient because this service is happening as a right of the patient. And I am doing good for the community. The patient has a right to get this service."* (Health extension worker 1)

5.2 BARRIERS IN PROVIDING SRH SERVICES

Health workers reflected on both the influence of their socio-cultural context as well as their health-care environment on their SRH delivery.

THE SOCIO-CULTURAL ENVIRONMENT

The socio-cultural environment of the communities health workers operated in affected the space health workers had to openly address and provide SRH services for young people. While they thought it did not have a direct influence on service delivery within consultation rooms, health workers did agree that it limited the education they could deliver outside the health facility in the community.

PRE-MARITAL SEX AND CONTRACEPTION

Almost all health workers, in line with interviewed youth, explained how community beliefs on youth SRH directly impact youth care-seeking behaviour and create a context that influences the care environment as well as health workers themselves. This because pre-marital sex is seen by the community as sinful and rude, putting youth at risk of being rejected by the community when anyone finds out they are having sex before marriage.

> *"When they [unmarried youth] start using family planning the society thinks that they become rude. The family would become disrespected. They believe that when they are not using contraceptives they are afraid of pregnancy and will therefore abstain until marriage. [...] They see them as rude because they are using the contraceptives."* (Health extension worker 4)

Other reasons mentioned by health workers and youth that explain why pre-marital sex is denounced include the belief held by most community members that sex distracts youth from their education and puts them at risk of getting STIs and unintended pregnancies. Most health workers also explained that part of the community believes offering SRH services to unmarried youth will promote promiscuity.

Six health workers did say they felt like SRH services for unmarried youth are becoming more accepted and one care provider was of the opinion that most people in the community would promote contraceptives for youth regardless of marital status. One health worker noticed socio-economic status and education might explain why only part of the community seemed receptive to more progressive messages regarding SRH of youth. People with less means and less education might not identify with the messages and the meanings behind these messages as used by educators and health workers. Thus, there exist multiple views in the community on providing SRH services to young people.

To summarise in the words of one clinical nurse:

> *"There are two views in the community. Some people say it [proving SRH care to unmarried youth] enables people to have multiple sexual partners. When we are distributing condoms at the market area and health station it is creating an opportunity to have multiple sexual partners. […] The other part of the community support us. They say the health workers are doing well because they are saving the community from STI and unwanted pregnancy."* (Clinical nurse 1)

UNINTENDED PREGNANCY AND INDUCED ABORTION

Actively ending an unintended pregnancy by undergoing induced abortion was also found to be controversial. The majority of study participants indicated that induced abortion is viewed as sinful by most community members, due to morals related to religion. For example, one health worker explained that a girl undergoing induced abortion would be disrespected and that therefore it would be better if she would choose to keep the pregnancy. At the reproductive health clinic in the city, the health worker noticed how sometimes girls waited at the clinic without obvious purpose and would only admit they were in need of abortion services when a health worker would actively come to ask what they came for. This shows how girls are afraid to openly request abortion services. It should be noted though that while community values condemn abortion, these did not seem to affect health workers in arranging the procedures for their clients. Rather, their personal views seemed to be more influential (see previous section). Services that did get affected due to community norms were information sharing and awareness raising activites on abortion; five health workers reported they would not be allowed by teachers and other community members to teach youth about safe abortion in public settings. This because people are afraid it will cause an increase in induced abortion, while they morally disapprove the procedure.

SRH AWARENESS PROMOTION

Health workers did report that community beliefs influenced their teaching on SRH of youth in public settings. In addition to abortion, explicit teaching on family planning was also not accepted. Similarly, two health workers reported that when they tried to organize a training on youth SRH for adults they were unsuccessful as no adults would want to talk about this 'rude' issue. Moreover, although teaching on contraceptives and sexual health in school is generally allowed, two health workers said they are not allowed to teach explicitly during these classes. For example, they are not allowed to hand out condoms as teachers and other community members believe this encourages young people to have pre-marital sex. Hence, they felt they were limited in teaching their community on this topic. Instead of public events in the community, health workers thus encouraged young people to come to the health posts to *"make awareness individually"* (Health extension worker 3)

Finally, when inquiring whether health workers felt their decision-making in the consultation room was impacted by the community generally not agreeing with unmarried youth receiving SRH care, they felt it did not influence their service delivery. Health workers said they felt free to still deliver services as they see fit, as the community would not find out about them providing these services and they were 'just doing the everyday job'. The main way in which their service provision was affected by the view of the community was that they were often forced to provide services in secret, for example by pretending they were treating for another disease while actually providing contraceptives or STI treatment.

THE HEALTH-CARE ENVIRONMENT

Several barriers were found in the health-care environment that affected the accessibility and quality of SRH services for young people. These relate to the availability of medication and diagnostic materials, administrative procedures, health worker competence and motivation including safeguarding confidentiality, health system, facility characteristics, and costs.

AVAILABILITY OF MEDICATION AND DIAGNOSTIC MATERIALS

Health workers employed at the health centres and one health extension worker working at a health post reported having stock-out of medication. This included injectable contraception, implanon and emergency contraception pills. One health worker explained how this sometimes forced him to convince girls to choose the available method of contraception instead of the one most fitting for them. Also, the available medication at the health centres seemed to differ, with one of the centres having treatment for medicinal abortion available while the other health centre only offered curettage.

> *"We try to advise them [youth] to use condom and pills. And otherwise we tell them not to use the injection again and again because it has its own side effects, it delays pregnancy. So we give them one but advise them not to use it again."* (Clinical nurse)

Another practical hurdle was posed by the unavailability of diagnostic methods at the included facilities. For example, patients could be treated for STIs at the health centres but could not be tested for infection at these facilities. Not being able to test for STIs and treating using a symptomatic approach can lead to under-treatment of STIs and over-use of antibiotics, as was observed when a patient with STI symptoms was automatically, seemingly without diagnosis, treated for both chlamydia and gonorrhoea. In addition, pregnancy testing was not available at health post level, forcing some girls to travel to the health centre for this test. Finally, no ultrasound was available at the health centres, resulting in girls undergoing induced abortion while the gestation age is only determined by the physical examination and the reported menstrual cycle.

> *"Sometimes when [girls] come for abortion they are already 4 months pregnant and they will say it is only 2 months. We have no ultrasound to check how many months they are pregnant. So there is a big risk to doing the abortion. If we do the abortion just by blind trust, maybe she will die during the procedure."* (Clinical nurse)

As this method is prone to miscalculation, girls run the risk of undergoing induced abortion in health-care setting while they are already in their second trimester, putting them at risk during the procedure. And some girls would sometimes hide their pregnancy and commit infanticide. Other girls might be referred to the city hospital for ultrasound, which might be inconvenient and costly for them.

AVAILABILITY OF HEALTH SERVICES AND ADMINISTRATIVE PROCEDURES

When observing care provision at the health facilities and interviewing health workers, length of time of consultations, costs, and waiting time seemed to have little influence on youth access to SRH care. This is because, almost all services are offered for free, walk-ins are acceptable or appointments can be made immediately, waiting time is usually short and only one health worker mentioned sometimes feeling rushed during consultations. Improvements could be made regarding opening hours, as when visiting the health facilities it was found they were sometimes unexpectedly closed due to personal errands of the health workers, public holidays and other issues. Also, youth-friendly consultation rooms at the health centres and all the health posts were closed during the weekends and evenings, while perhaps it would be convenient for youth to visit during these times. In addition, some referral procedures were inconsistent, with for example one health officer always referring to the city for induced abortion while his colleague employed at the same facility arranged it at the health centre when possible. Finally, the consent procedures on induced abortion differed, with one health centre asking the husband of the client for informed consent before performing the procure while the other facilities only requested consent of the girl herself.

REAL AND PERCEIVED COST AS BARRIERS

According to young boys, condom costs 5 birr whereas a contraceptive emergency pill costs 10 times that price – as sold at the pharmacy. This is a lot of money for young people who often are without formal or consistent means of income. Nevertheless, during the validation of this study, it became evident that actually young boys found this to be a greater barrier than young girls. This is because young boys are not permitted to get emergency contraceptive pill from the health facility where it is free. Evidently, health workers do not prescribe this to boys because they do not have enough faith that boys would convey the counselling that comes with it to their sexual partners as well as it is ethically important to counsel young girls on these pills (especially if sought repeatedly).

HEALTH SYSTEM BARRIERS AND POOR SERVICE PROVISION

Health facilities included in this study did not have dedicated spaces providing youth friendly services, except one. One health facility reported to have attempted to open one room of the health centre and use it as a youth focused centre giving SRH services – but this room is no longer functional. There was not enough focus placed on the value of having a dedicated free space for youth. Some *kebeles* do not have youth clubs in the community and school clubs are too weak to mobilize young people and sensitize them about SRH. One main reason found was the lack of coordination among different bodies like teachers, health professionals, schools, clubs obstructs any hope of focusing efforts into dedicated youth friendly services.

FACILITY CHARACTERISTICS CREATING INSUFFICIENT PRIVACY AND CONFIDENTIALITY

In a community where pre-marital sex and induced abortion are seen as sinful, young people are reluctant to seek SRH care when they cannot do so in strict privacy. Unfortunately, all health facilities except the reproductive health clinic in Bahir Dar do not seem to offer sufficient privacy. They are usually centrally located in the *kebele* so many people walking by can see who is visiting the facility, especially as there are no separate waiting areas for youth. Moreover, although health centres have a consultation room specifically for youth, they still share all other services (such as laboratory, pharmacy, space for gynaecological examination), with the rest of the patients. They use the same public waiting space in the health facilities and come in through the same front gate. Several health workers reported that as the range of services offered at the health posts is limited, youth would rather not go there, as when they are seen at those facilities other community members will more easily deduce they come for family planning. At the health centre youth can at least pretend to come for another health issue, although multiple health workers and youth said they are scared to go there while looking healthy and still fear being seen there by community members they know.

Several health centre employees explained this causes youth to try and find ways around being seen by for example coming at night or coming in through the back of the health centre by climbing a fence of walking through the bushes.

HEALTH WORKER COMPETENCE AND MOTIVATION

With health worker competence being an important determining factor of quality of care, health workers were asked to reflect on the training they received and requested to share the advice they give during consultations in order to gain insight in their skills and knowledge. Eight out of ten health workers reported to have received training on providing youth-friendly SRH care (either during their standard education or as part of an NGO program including Yes I Do) and three of them specifically remembered the communication aspect that was brought up during the training. The two health workers who had not received the training on youth-friendly care provision were motivated to receive this training when offered. All health workers reported to feel comfortable discussing sexuality with youth, but most health workers did say they would like to receive more training in general. Health extension workers as well as care providers employed at the health centre expressed a need for more refresher courses to update their knowledge on topics such as HIV and STI treatment and SRH of youth in general. Three health workers explained they wanted to be trained on how to counsel with youth. As for technical skills, three health extension workers mentioned they wanted to learn how to place and remove an implanon and one health officer as well as a health extension workers said they wanted to learn how to perform induced abortion. One of the main frustrations related to skills trainings mentioned by several health workers was that for government trainings on a technical skills, such as implanon placement and removal, only one health worker per *kebele* (employed either at the health centre or health post) while several health workers would want to learn this skill to provide adequate services. For example:

> *"If someone wants to get the service of implanon, there is only one of the three health workers [health extension workers] in the health post trained to do it. So if she is not there, I send the person to the health centre to get the implanon, because I am not trained."* (Health extension worker)

All health workers reported to generally let girls choose their preferred contraceptive methods after giving them the needed information, which reflects positively on their competence. However, at the same time they explained they discourage young girls from using injectable contraceptives, as after stopping this medication return of fertility is delayed. None of the health workers mentioned to first ask whether the girl would want to start childbearing soon or why she preferred this method of contraception over other options. One health worker mentioned health workers might be blamed for making girls infertile when pregnancy would be delayed after stopping the injections.

All health workers, except at the clinic in Bahir Dar city, perceived their health facility and therefore their work environment as insufficient. This was due to various reasons including lack of running water, too little space to consult in a comfortable manner, no room for proper physical examination, insufficient storage space, lack of office equipment and bird and bat nuisance. These circumstances were not only reported to deter youth from seeking care as it made the facilities unattractive, but also impacted negatively on health worker motivation as some felt uncomfortable in their work environment due to the aforementioned shortcomings.

Apart from technical skills, health workers being sensitive to youth problems and therefore providing private, supportive and non-judgemental care are a vital part of youth responsive service provision, especially in a context where SRH care for unmarried youth and induced abortion are disapproved of. In general, health workers indeed reported to try their best to make youth feel at ease during the consultations, as they understood youth might feel ashamed and scared when consulting on an SRH issue. One health worker did notice that in some cases patients would be treated for a urinary tract infection by other health professionals while they actually had an STI, indicating some patients might not feel comfortable reporting sexual risk behaviour or some health workers might not actively ask about this. This reflects poorly on health worker competence as well as sensitivity.

When asking how health workers would handle situations in which confidentiality might be compromised, care providers described to involve family or partners only with the permission of the client. Also, all health workers mentioned they generally believed privacy would be safeguarded during consultations. They cited examples of accompanying young people in youth-sensitive ways and keeping delivered services secret from family members, upon the wish of the client:

> *"They can call me and tell me what they want. For example if they come for abortion I will go with them to the health centre and I prepare their registration so they can go straight to the consultation room without anybody seeing them."* (Health extension worker 4)

> *"A pregnant girl came, and her pregnancy was unwanted, and she asked to get abortion in the health centre, and she asked me to go with her to show where to go and to walk with her, and we went together to the clinic to do the abortion. The family still does not know about the situation."* (Health extension worker 5)

However, when observing consultations it was noticed how doors would usually be open, other clients would walk in during the consultations and how in one case an STI diagnosis was discussed loudly with other clients overhearing. One of the interviewed boys also mentioned that other people walking in during the consultation compromised his privacy. Moreover, only one health worker employed at the health centre would give youth the opportunity to switch care provider when he would personally know him or her, recognizing that consulting with an acquaintance might compromise confidentiality and privacy. However, at the health post switching care provider might not be possible due to the limited number of health extension workers available. Finally, only one health worker saw the administrative procedure at his health centre as insufficiently private and acted upon this insight by trying out a different system (providing care to all youth after education and getting their health-care cards from the registration room himself all at once).

In summary, although most health workers seemed to have an understanding of problems that youth face when seeking SRH care, sensitivity to these problems and acting upon their understanding could be further improved. In this regard, health facilities did not seem to have a structured feedback mechanism in place through which youth could share how they experience seeking care at the facility to further increase sensitivity of health workers and improve care delivery.

5.3 IMPROVEMENTS SUGGESTED BY HEALTH WORKERS

While health care workers recognised the importance of SRH services to young people, they did not always succeed in providing them. From a health care worker perspective, the most important improvements that came forward were related to community awareness raising, improving the facilities, and ensuring the availability of the necessary medication, supplies, and competent staff.

With regards to community awareness, health workers recognized part of the community has become more accepting towards unmarried youth needing SRH care. Yet, further intensifying awareness-raising activities in the community is the intervention mentioned most frequently by both health workers and youth when asked how they believe access to SRH care could be further improved. Most of these health workers believed their own efforts to educate their community (by teaching the HDA, teaching patients picking up their medication and teaching youth in school and at the health centres) contributed to this gradual social change. Because public education on SRH was not always feasible, health workers recommended to encourage young people to the health post and educate them during consultations.

At facility level, health workers thought the facilities should be improved to attract young people to making use of SRH services, and to improve the quality of care delivered. SRH services for young people can be made more accessible to young people if youth-friendly consultation rooms are open on weekends and evenings. Quality of care could also be improved according to health workers by having more trained health workers available to young people so they could switch care provider if a young person would prefer that. Referral procedures and consent procedures should also be standardised between health workers to improve the quality of the services. Health workers observed that to attract youth to make use of SRH services, youth clubs should be set up in communities and schools, and coordination among different bodies such as teachers, health professionals, and other community actors improved.

Similar to young people, the majority of health workers and health extension workers also mentioned they would like to have a room with more space located in a more private area at the facility grounds. Three health workers explained they want a separate waiting area for youth to increase privacy and attract youth to their facility by games or a TV could be installed in this room. This way, youth would feel more invited to attend trainings at the health centre and they could be given information while waiting for their appointment. The reproductive health clinic in Bahir Dar already realized a service environment fostering privacy. They have a separate registration and waiting area for youth, a library, room for sports activities on the clinic grounds and consultation rooms with materials for physical and gynaecological examination. Health workers did not reflect on their own competency with regards to safeguarding confidentiality. Some did, however, reflect on their technical skills, mentioning they wanted to learn how to place and remove an implanon and others wanted to learn how to perform induced abortion.

6. Discussion

This chapter provides a brief summary of the main findings, which brings together the findings from the young people and health workers. Indeed, young people and health workers overall identified similar barriers to SRH service uptake of young people, particularly emphasising the socio-cultural environment, but also issues such as privacy and confidentiality in health care facilities, and other health-system related issues. However, there were also some differences in perceptions, such as on health workers' skills to maintain privacy and be youth sensitive.

This study sought to explore what young people's experiences are with SRH services, to identify barriers to SRH service uptake for young people, and how these can be improved according to young people and health workers. The study found that SRH services are mainly used for contraceptive services. Gender differences were found in use and uptake of contraceptive services; boys seemed more comfortable coming for condoms, while girls typically refused to take condoms and asked for other types of contraception for family planning purposes. This difference coincides with the fact that when health workers provide SRH education, they separate the girls and boys to talk about family planning and condoms respectively. As a result, boys are less likely to be able to make informed decisions on family planning and girls are at risk of contracting disease (especially as girls' sexual debut is earlier than their male counterparts and girls often feel like they lack the power to negotiate condom use) (40). Girls depending on boys to propose condom use seems particularly unfortunate as some interviewed boys and health workers report males do not like to use condoms as in the experience of some boys it decreases sexual pleasure. Boys not liking to use condoms might also explain why knowledge on the benefit of condoms seems relatively high, while condom use remains low (11)(40). Girls were also more restricted in using SRH services for contraception, and this largely depended on their marital and educational status. Girls who were married were generally considered to have more freedom to use SRH services, as they would be expected to be sexually active. The study also found worrying findings of girls avoiding to make use of safe abortion services because of fear, shame, and stigma. Several young people knew of girls who took their own lives because of their unwanted pregnancy, instead of making use of abortion services. This finding is alarming and underlines the importance of SRH services being available to young people and youth-sensitive.

Barriers to using the SRH services included a number of issues. First, restrictive social norms on young people's SRH affected both young people's sense of freedom to seek SRH care, as well as health worker's opportunities to raise awareness, deliver education, and freely provide SRH care. Indeed, restrictive community values on young people's SRH influenced health workers' abilities to teach on SRH in public settings, as health workers would not be allowed to teach on controversial topics such as induced abortion. While health workers stated community social norms did not affect their service delivery within the health centres, their personal values did. Even though all health workers reported to find it important to provide SRH care, they also shared certain beliefs with the community around them including the belief pre-marital sex should be avoided. When they share this view during consultations, youth might feel unsupported or judged, especially in a context where sex before marriage is disapproved of. Furthermore, some health workers were reluctant in providing abortion care because of their personal beliefs. Indeed, young people shared how unfriendly treatment from health workers towards young people, particularly towards unmarried girls and girls who are in school, led them to seek the service elsewhere in larger centres, in private clinics, or not seek services at all.

Second, the health-service environment posed barriers to accessing SRH care for young people. Health system related problems included inconsistency of opening hours, differing referral procedures, inadequate facility buildings. and shortage in diagnostics and medication. For instance, STI testing and ultrasound are currently not available at the health centre level and are not part of health centre protocols on treatment of STI, induced abortion and maternal care (36). Health workers capacity was also a barrier mentioned by both young people and health workers, who observed that due to limited number of trained health workers, young people sometimes had to wait long for the service or were unable to switch care provider in case of issues. Health workers also flagged they needed more technical skills on SRH services.

Third, an issue that came up strongly from young people's perspectives is the fact that they are worried about their privacy and confidentiality being respected. This related both to the facility level as well as to health worker competence. Young people were worried being seen and recognised when going to seek SRH services, which can cause them to refrain from seeking care. Indeed, health workers shared how they at times had to convince young people to come to seek care. At the same time, the delivery of the services did not always meet the standards of privacy and confidentiality, with consultation services being held with open doors, and the condom distribution area being in a busy place in the centre. Most health workers did already receive training on providing SRH services to youth, but do not seem to have the insight that some of the advice they share can be seen as unsupportive.

Community beliefs, in combination with other health-system barriers such as lack of privacy, thus negatively affected young people's care-seeking behaviour. Indeed, recommendations from young people and health workers to improve young people's uptake of SRH services related to both socio-cultural values and beliefs and health system issues. Young people suggested that awareness raising activities in the community about the importance of young people seeking SRH services would help them in accessing services with more confidence. Health workers also mentioned the need for community values on these topics to change so as to enable young people to freely seek SRH services. On the health-system side, recommendations included price, availability, and equipment of health services, number of health facilities and health professionals should be increased, and improved technical skills of health workers. Young people also voiced to wish to be able to give more feedback to SRH services so as to improve the access and quality of care, and that health workers' competence on respecting privacy and being youth-sensitive ought to be improved. With regards to privacy, health workers did recognise the facility-related issues on privacy (with no separate room or closed off area being available to young people) but did not reflect on their own skills related to this. Findings furthermore suggested that YFS have the potential to increase access to SRH and improve youth SRH, since they cater exclusively for young people, but are not immune to the mentioned socio-cultural and health-system barriers.

7. Conclusion

Community beliefs regarding SRH of youth were found to shape the context in which SRH care is provided. Pre-marital sex, induced abortion and use of SRH services before marriage is strongly condemned, causing young people to fear being rejected and shamed by their community when it becomes known they are using SRH care. Other studies conducted recently in Ethiopia found similar factors, including restrictive cultural norms and lack of privacy, deterring youth from SRH service use and limiting teaching on topics such as safe abortion (39)(40). As long as these community norms regarding youth SRH persist, youth access to SRH care is limited, health workers are forced to provide care in secret and SRH education will be restricted. Changing community norms obviously takes time. It is therefore fitting that most health workers and youth say they believe efforts to educate the community should be strengthened and continued. The Ethiopian government also recognizes the society's knowledge on SRH of youth is inadequate and should be improved, but does not provide a detailed action plan on how to achieve such a change, although they do mention health workers should be involved in this endeavour (17)

Secondly, it is essential to create a care environment that allows youth to seek SRH services regardless of their age, marital status or of the type of service they need. To achieve this goal, youth and health workers would be advised to make a collaborative effort to design and implement strategies contributing to a more private care setting. In an environment where pre-marital sex and induced abortion are disapproved of, it is vital that counselling on these issues is done in a non-judgemental way. However, care providers currently share advice that could be seen as unsupportive, such as the advice to abstain from sex until marriage. They should therefore be further sensitized to the effect their counselling might have on the SRH of youth. Furthermore, they should be trained in ethical decision making in order for them to have the right skills and knowledge to adequately determine their course of action when their own beliefs conflict with their professional code of conduct. Finally, health workers do not have the needed medication, equipment and facility buildings at their disposal at this moment. These materials should be made available for health professionals in the study area to enable them to provide quality care.

To conclude, the study thus identified that there remain strong barriers for young people to make use of SRH services. These barriers relate to young people's own feelings of shame and low self-confidence, which reinforced by their community's restrictive values on youth SRH. Barriers also related to the health system; health workers were challenged in providing SRH information due to restrictive norms in the community, health workers' personal values influenced service delivery, and there was a lack of adequate facilities and training in guaranteeing privacy.

At the same time, it should be acknowledged that the landscape for young people's SRH is shifting. For instance, thanks to the interactions of young people at YFS, boys seemed more open to having discussions with their girlfriends about what type of contraception to use, willingness to accompany her get an abortion or buy her emergency contraceptive pills at the pharmacy and teaching her what they learnt at the YFS. Another noticeable shift was a relaxation of abortion services; government health facilities having these facilities for youth and the law on abortion being relaxed means that girls do not necessarily need to undergo unsafe abortion. However, barriers to accessing safe abortion services remain. Abortion was mentioned as the most sensitive service to make use of and young people shared that, even though the service is available, girls refrain from using them and still undergo for traditional abortion or even commit suicide. Furthermore, the rule about girls who wish to abort have to bring an adult witness to give consent and sign forms serves as an additional barrier. At the same time, due to the strong prejudices about pregnancy among unmarried girls, some girls do decide to have an abortion, not because they do not want the baby, but to save the reputation of the family and to avoid a future where she and her family would be constantly shamed and judged by her community. A positive change is indeed that more girls become aware of the negative consequences of traditional abortion and access to service abortion has improved, so they go to health institutions for an abortion. Also, young girls use contraceptives in order to avoid unwanted pregnancies, and boys are increasingly involved in contraceptive decisions when they are in a stable relationship. There is thus increased awareness and effort among both young people and health workers to provide SRH services to young people. Continued efforts should ensure that the remaining barriers, particularly community misperceptions and judgments related to SRH, are addressed and that young people are involved in decision-making about health services that affect them.

8. Recommendations

A broad range of SRH services is available at the studied facilities, but further improvements are needed to ensure access to SRH services for all youth. Based on the findings of the study, a range of recommendations came forward that might improve the uptake of SRH services among young people. They are discussed in terms of recommendations for policy and practice, and recommendations for further research.

8.1 RECOMMENDATIONS FOR POLICY AND PRACTICE

Future interventions should include educating young people, families, and communities about the importance of young people's SRH, while focusing on creating sustainable change beyond program targets (44)(45)(46). Other strategies to increase community support for youth SRH could include promoting education in general, and realizing efforts to increase knowledge of the community on the importance of access to SRH services for youth (44). Education needs to be initiated and supported by the government, to create legitimacy amongst the community. Furthermore, parents and caretakers or guardians of young people should be included, since focusing on them gives young people, and girls in particular, more flexibility and confidence to access SRH services. SRH education should include both sexes, to enable couples to make informed decision together about contraceptives and family planning. Building women's confidence to initiate condom use and enhancing women empowerment in general should also be part of this approach (49). Importantly, education should include attention to safe abortion, and challenge stigma around pregnancy out of wedlock that currently keep girls away from safe abortion services with severe consequences or opting suicide.

To ensure young people's participation, a feedback mechanism should be created through which young people can comment on SRH service provision, so as to improve the services to meet their needs. Other forms of youth participatory approaches to improving accessibility of SRH services should also be explored and implemented. Young people should be encouraged to share their experiences and knowledge on SRH and encourage other young people to make use of the services. These youth participatory approaches should be inclusive of youth of all segments of society, including youth with disabilities, and young people who are out of school.

Creating a more private environment for care provision at health facilities would enable youth to seek SRH care in a comfortable manner. Importantly, youth should be involved to make sure the changes resonate with their needs. Improved privacy can also include changing procedures to limit the time youth spend in shared spaces with other patients, creating a second entrance at the back of the health centre and moving the condoms distribution to a more convenient place. A separate building for consultations with youth should be created including a separate waiting area fit for entertainment and education, since a youth-friendly environment and peer-led education in the waiting room was shown to dramatically increase uptake of contraceptives in studied communities in other countries (45). Ethiopian national health policy should not only aspire to eliminate social barriers to SRH care but actively pursue this goal by improving the health system and health workforce, particularly with respect to improving quality of care and privacy. At *kebele* level, cooperation should be improved between the health sector, education sector, and other sectors that can support young people in their development. Indeed, linking school educational programs with youth friendly services through an active referral system is associated with an increased uptake of contraceptives and SRH services and might therefore be of benefit to the studied community (44)(45).

Health workers seem motivated to improve the SRH of young people. At the same time, they share advice on pre-marital sex and induced abortion that is unsupportive. Health workers' training on youth SRH should thus be improved and expanded, particularly addressing misconceptions regarding contraceptive methods for girls and how to conduct youth sensitive consultations. Knowledge and skills should be further improved and consolidated by offering health workers refresher courses on SRH care for youth and by providing adequate supervision and feedback in clinical practice. Health workers should furthermore be aided in understanding the influence of their own beliefs on service provision and in making contemplated decision when their religious values or personal beliefs do not match their professional code of conduct (48).

Finally, approaches and procedures taken should be standardised to ensure all clients receive the same minimum quality of care, particularly regarding sensitive care such as abortion. This should also include relaxing the witness consent requirements, as this causes an additional barrier to make use of safe abortions services. Furthermore, a system should be implemented to ensure at least one health worker licensed to perform induced abortion is willing and trained to provide this procedure, as to prevent extra costs and inconvenience for girls in need to this care. Finally, the needed diagnostic materials should be made available to improve quality of care and prevent unnecessary referral. Care could be further improved by creating more consistency in opening hours and referral procedures, by creating an evening and weekend consultation hour.

8.2 RECOMMENDATIONS FOR FURTHER RESEARCH

In order to make sure youth is not just subject of the conversation but part of the discussion, further research should investigate the view of youth on access to SRH care in more detail. This research could include topics such as how youth experience consultations with health workers, what service outlets (public and private) they use, how they like to receive information on SRH care and how they believe uptake of services could be improved. Importantly, both in- and out-of-school youth should be included in the research to make sure the results reflect the view of both these groups.

It would be useful to find out more about the exact advice health workers give during consultations on SRH issues and how this is received by youth. Reasoning behind this is that in this research, observations formed only a small part of the data-collection, while the way in which health workers present information during consultations is an important part of service delivery and should therefore be further evaluated. Furthermore, as most health workers reported to have received training on youth responsive services but still provide unsupportive advice, the content, methods, and outcomes of these trainings should be reviewed.

Finally, since community values and norms seemed to have a serious impact on the access and delivery of SRH care for young people, future research should further scrutinise how restrictive values on SRH are maintained within communities, and how they can best be addressed. This should include an analysis of which actors are influential in maintaining and transforming values, and how to engage these actors in future initiatives addressing youth SRH. Furthermore, there are reports of health workers providing out-of-facility services for example in schools, and research should further explore how these efforts could be intensified.

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