

REPORT OF ADOLESCENT HEALTH SERVICES BARRIERS ASSESSMENT IN ETHIOPIA



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MINISTRY OF HEALTH - ETHIOPIA

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Report of adolescent health services barriers assessment in Ethiopia

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Table of Contents

Acknowledgements	iv
List of abbreviations	v
Executive summary	vii
Introduction	1
Methods	2
National key informant interview:	3
Literature review:	4
Quantitative data review:	4
Subnational qualitative research:	6
Ethical considerations.....	8
Findings.....	9
Availability.....	9
Accessibility.....	13
Acceptability.....	17
Utilization.....	22
Effectiveness.....	25
Summary.....	28
Limitations.....	32
References.....	34

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List of abbreviations

AHSBA	Adolescent health services barriers assessment
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
AYH	Adolescent and youth health
COVID-19	Coronavirus disease 2019
EDHS	Ethiopian demographic and health survey
FGAE	Family guidance association of Ethiopia
FGD	Focus group discussion
FMHACA	Food, Medicine and Health Care Administration and Control Authority
FMoH	Federal Ministry of Health
HTC	HIV testing and counselling
HEAT	Health equity assessment toolkit
HEW	Health extension worker
KII	Key informant interview
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
MoWCY	Ministry of Women, Children and Youth
NGO	nongovernmental organization
PMTCT	Prevention of mother-to-child transmission of HIV
PRISMA	Preferred reporting items for systematic reviews and meta-analyses

SNNPR	Southern Nations, Nationalities, and People's Region
SRH	sexual and reproductive health
STI	sexually transmitted infection
TWG	Technical working group
UHC	universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YNSD	Youth network for sustainable development

Executive summary

Globally, there are over two billion adolescents, two thirds of whom live in developing countries. Similarly, Ethiopia is a country of young people, where adolescents constitute over a quarter of the population. With the country on the brink of a youth bulge and looking to reap the benefits of the changing demographic structure, universal health coverage for adolescents is a priority. Achieving universal health coverage among adolescents entails identifying service barriers among vulnerable and disadvantaged adolescents to inform the health system, for action to be taken. This study aims to identify barriers to selected health services (sexual and reproductive health (SRH) information, family planning, HIV testing and counselling (HTC), and mental health services). The study specifically sought to: (1) identify barriers that prevent adolescents from using the defined health services; (2) define evidence that may help address the barriers so as to improve service use; and (3) facilitate evidence-based programming, targeting adolescents who are left behind, and ensuring that ongoing monitoring and evaluation captures intervention outcomes.

The assessment was undertaken using the WHO handbook for conducting an adolescent health services barriers assessment (AHSBA), which employs a mixed-method approach for identifying barriers to effective health service use. In this assessment, all modules were undertaken – a literature review, a review of the quantitative data, and qualitative research at the national and subnational levels.

The study identified adolescents who live in rural areas, in urban settings but also in the streets, sex workers, housemaid adolescents, those living with disability and those under 20 years of age working in industrial parks, as the most vulnerable with poor access to SRH information, HIV testing and counselling, contraceptives and mental health services.

Findings show that demand creation efforts and health service delivery neglected adolescents, particularly the younger 10–14-year age bracket. There is a general understanding among the public, including service providers, that these are minors. Families fail to recognize younger adolescents' need for health services. The data mining of the Ethiopian demographic and health survey (EDHS) showed that more than 95% of the respondents of the survey, in each of the survey years (2011 and 2016) reported that they did not know the source for contraceptive services and/or they had poor knowledge of, or exposure to modern contraceptive methods. Consequently, 57.5% of respondents from the 2011 survey data and 40.1% of those from that of 2016 indicated that one of the reasons for not accessing SRH services was the long distance to health facilities. The synergetic effects of deep-rooted cultural taboos, coupled with limited access to SRH information for parents prevented parents and adolescents from discussing SRH issues. Unfortunately, available communication strategies and approaches have failed to recognize local contexts, adolescent needs and specific profiles.

Similarly, the current health system setup, the level of human resource competency, as well as limited supplies and equipment did not allow for differentiation between adolescents and other population groups. The lack of awareness at the adolescent, family and stakeholder levels, evident cultural and social influence, lack of empathy of services, lack of privacy, mistrust of providers' ability to keep the confidentiality of adolescents, and lack of services at times when adolescents needed them were major barriers. Clearly, mental health remains poorly understood as a service, and potential users do not know how to make use of it.

It is therefore critical to define a policy and strategic framework to improve service availability, coordinated support (sector ministries, partners) to improve availability, accessibility, acceptability, effectiveness at schools, health centres and youth centres. Conducting advocacy and designing evidence-based and contextualized service delivery modalities

for the most disadvantaged adolescents, and considering the geographic and socioeconomic context, is both timely and vital. As mental health is the most neglected health issue of adolescents, as revealed by this assessment, policy dialogue and policy direction on mental health services will be imperative.

Introduction

Globally, the adolescent population is about two billion¹, with two out of three living in developing countries. More than 3000 adolescents die every day from largely preventable causes such as: unintentional injuries; violence and sexual and reproductive health problems, including HIV; communicable diseases such as acute respiratory infections and diarrhoea; noncommunicable diseases; poor nutrition and lack of physical activity; and mental health, substance use and suicide. An even greater number suffers from ill health due to these causes.

The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) and the Global Accelerated Action for the Health of Adolescents (AA-HA!) include a commitment that all adolescents should have a fair opportunity to attain their full health potential, without being disadvantaged from attaining that potential within the broader concept of universal health coverage. Universal health coverage means that all people, including adolescents, can use the promotive, preventive, curative, rehabilitative and palliative health services they need, while ensuring that the use of these services does not expose them to financial hardship.²

Ethiopia has a rapidly growing population, of which adolescents and youth (10–29 years) constitute the majority (42%) of the estimated total population of 94 million³. Following significant declines in mortality (particularly child mortality) and fertility rates, policy-makers in Ethiopia are positioning themselves to harness the “demographic dividend”. In other words, the dependent population is well below the working-age population, including the youth. Time is of the essence, as this phenomenon is not automatic.

¹ UNFPA (2015). Youth Supplement to UNFPA’s State of the World Population Report, New York

² World Health Organization. (2017). Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation: summary. World Health Organization. <https://apps.who.int/iris/handle/10665/255418>

³ Central Statistical Agency (CSA), <http://www.csa.gov.et/> (Accessed on 12 June 2017)

Capitalizing on the benefits of the youth is key, as once the demographic transition passes, the opportunity is lost. As the country is on the brink of a ‘youth bulge’, it is vital to ensure the health and welfare of Ethiopian adolescents and young people, so as to reap the benefits of this changing demographic structure. The data to support policies and programmes to address their needs are also critical.

A first step towards achieving universal health coverage among adolescents is to assess which adolescent subpopulations are most underserved, and the major barriers they face. Such findings can be used to improve adolescent health programming, with a focus on underserved adolescents.

Methods

The methodology employed in this assessment was adapted from the WHO handbook for conducting an adolescent health services barriers assessment with a focus on disadvantaged adolescents. The Federal Ministry of Health (FMOH) of Ethiopia, together with its partners, adapted the WHO handbook to help identify which of their adolescent subpopulations has the least access to effective health services, and what barriers those adolescents face.⁴

The national assessment team⁵ and the Ministry of Health selected four major adolescent health issues and their related health services, following a consultative meeting. These four health issues (sexual and reproductive health information, contraceptive services, HIV testing and counselling services and mental health services) were selected on the basis of prioritization. The Ethiopian health sector transformation plan and the adolescent health strategy prioritize the four health concerns. These are the

⁴ <https://apps.who.int/iris/bitstream/handle/10665/310990/9789241515078-eng.pdf?sequence=1&isAllowed=y>

⁵ The national assessment team: A small team nominated from the Adolescent and youth health technical working group (AYH TWG) to lead the assessment, the team represented from FMOH, donors and non-governmental organizations.

predominant health issues for Ethiopian adolescents, which could be considered as ‘tracer conditions’ and included in this assessment. The study method comprises national key informant interviews, literature reviews, data mining and a subnational qualitative study. The approach used is detailed below:

National key informant interview:

Key informant interviews were employed to identify: (1) inequities in adolescent health outcomes and service coverage in the country; (2) how adolescent subpopulations are underserved, and what barriers they experience in obtaining effective and sustained coverage; and (3) possible subnational sites for qualitative research.

The Director of the maternal, newborn and child health (MNCH) unit at the FMoH invited the following stakeholder organizations to nominate a senior focal point to participate in a key informant interview at the national level, as part of the AHSBA: USAID, Pathfinder, TaYA, WHO, UNFPA, UNICEF, FMoH, the Federal Ministry of Education (FMoE), the Federal Ministry of Women, Children and Youth (FMoWCY), the Food, medicine and health care administration and control authority (FMHACA), the Youth network for sustainable development (YNSD) and Packard Foundation. In addition, two adolescents (a boy and a girl) from the 10–14 and 15–19 age cohorts were interviewed. A checklist developed by WHO, which was reviewed and adapted by the assessment team members, was used to guide the interviews. Consistent with ethical approval for the assessment from the institutional review board (IRB) of the Ethiopian public health institute, all key informants were provided with information about the study and all of them completed informed consent forms. All interviews were written up individually using Template A in the AHSBA handbook. They were then collated using Template B. A thematic analysis was then undertaken by two researchers to identify subthemes under the Tanahashi framework.

Literature review:

The literature search was conducted using the four priority health issues: sexual and reproductive health information, contraceptive use, HIV testing and counselling and mental health. A review of published and grey (strategy documents, reports) literature was undertaken using PubMed, MEDLINE, Google Scholar and Google in general. Grey literature was also identified through members of the national technical working group and other organizations in Ethiopia that have data related to adolescent health. Documents produced in the last five years and before 31 December 2019 were included. The first-level search included key words related to adolescents, priority health issues and the general population. The second-level search included key words such as adolescent, youth, young, child and teen, specific to the aim of the assessment, with the four identified adolescent health problems. A total of 342 articles and reports were identified, using the above key words. Filtering was done using the PRISMA flow chart: 17 duplicate records were removed, and 210 records excluded, based on abstract screening, as those findings would be irrelevant to our study. Also, 115 of them were considered for full text assessment. From these, 34 were excluded, and 81 articles used for the final analysis.

Quantitative data review:

Data from the following surveys and service provider databases in Ethiopia were reviewed:

1. Two recent Ethiopian demographic and health surveys (EDHS 2011 and 2016).
2. District health information system from the Ministry of Health of Ethiopia (MoH, 2019).
3. Partner database from the Family guidance association of Ethiopia (FGAE, 2019), and Population Services International (PSI, 2019), which mainly emphasize the use of contraceptives and the rate of adoption of modern

contraceptive methods among adolescent females in some regions of Ethiopia.

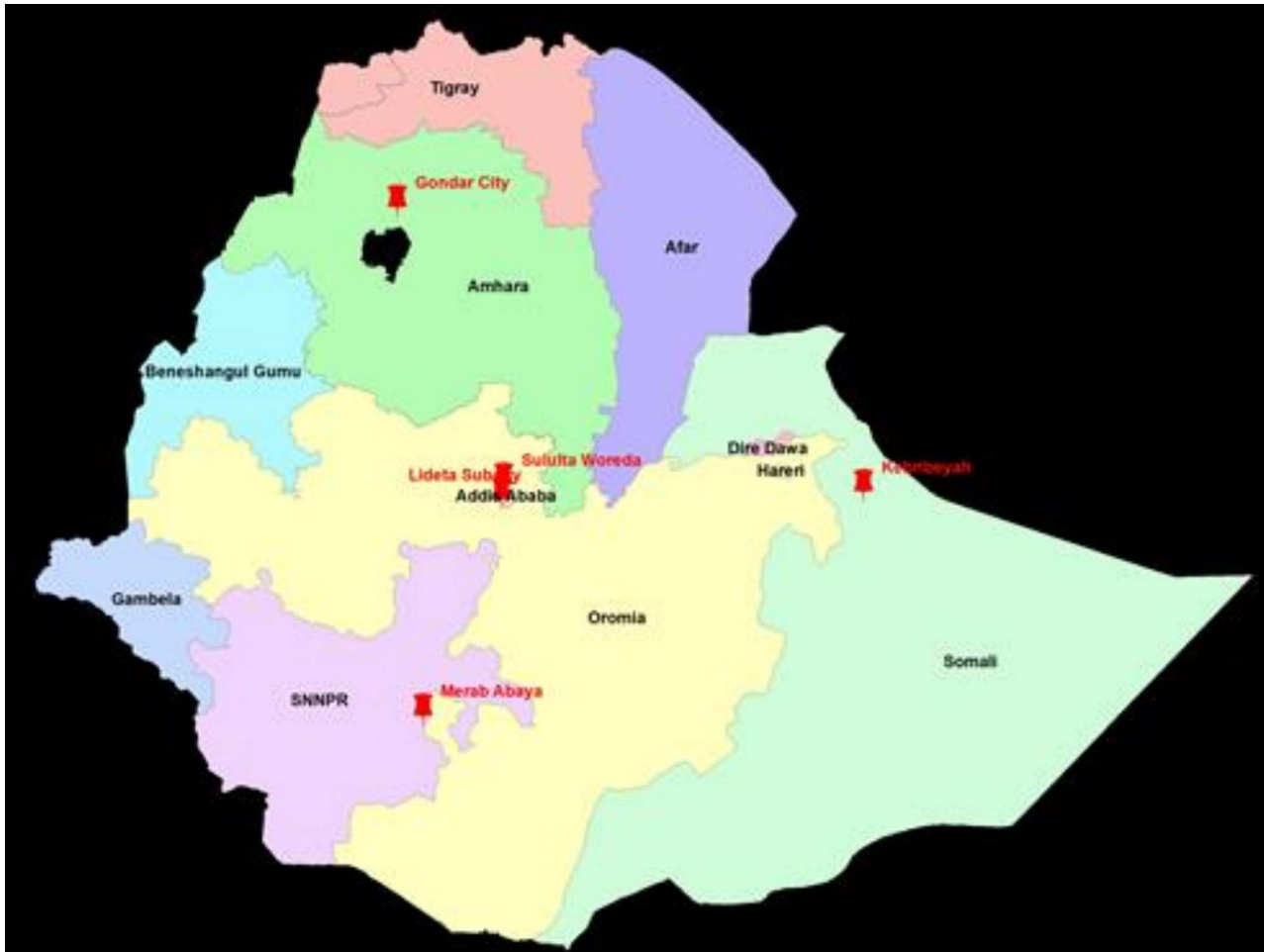
4. WHO guidelines. The assessment also made use of available data from the health equity assessment toolkit (HEAT).

Typically, the EDHS individual household member survey method collects information from individuals in the 15–49-year age range. Each dataset is then imported into the SPSS software, followed by sorting and filtering for adolescents aged 15–19. A total of 3685 15–19 year-old adolescents were registered in 2011, and 3498 in 2016. These data were further exported into the R software for secondary data analysis pertaining to the four indicators of interest, along with the corresponding measures of equity stratifiers. When information could not be fully retrieved from the EDHS dataset archives and the EDHS data did not contain adolescent-specific indicators of interest for the current research objectives, some additional subnational, regional and national datasets were retrieved from pilot studies to be included in the analysis, for the purposes of triangulation and filling of gaps. This type of dataset does not often contain adolescent-specific information, but rather, the broader 0–24-year or overlapping 10–24-year age groups. Thus, the analysis was conducted by indirectly correlating health service barriers of older age groups with that of adolescents rather than assessing equity within adolescent populations.

On the other hand, the analysis also sought to obtain data on access to mental health services for adolescents. Unfortunately, there are no such data in past and current DHS data archives, or in the databases of the Ministry of Health of Ethiopia. Although lack of evidence makes it extremely difficult to depict the real situation of adolescent mental and behavioural health barriers in Ethiopia, the team chose to focus the analysis on a more generalized inferential approach by making use of the existing limited data.

Subnational qualitative research:

1. Five subnational sites in three regions were selected, based on the findings from the other modules – the national key informant interviews, the literature review and the review of available quantitative data, in consultation with the assessment team. Somali region (Kebribeyah): The Somali region was selected to represent the pastoral setting and will provide service barriers in the context of the pastoralist community.
2. Addis Ababa: Addis Ababa was selected to represent adolescent health services barriers from the urban perspective.
3. The Southern Nations, Nationalities and People’s Region (SNNPR) (Mirab Abaya), Oromia Region (Sululta) and Amhara (Gondar) representing the major regions with a large adolescent population in semi-urban and rural settings.



Map 1: Adolescent health services barriers assessment study sites, (2019 Map)

Both key informant interviews and focus group discussions were undertaken in each of the five subnational sites as follows:

- Key informant interview: A one to two-hour key informant interview was conducted with an average of seven key informants from the health ministry, the bureau for women, children and youth, two nongovernmental organizations (NGOs) operating in the area, an adolescent health service provider at the health centre/clinic, a health extension worker (HEW) and an out-of-school youth. A total of 35 key informant interviews were conducted from the five selected subnational study sites.
- Focus group discussion: A one- to two-hour focus group discussion with eight to 10 participants from each of the following groups: (a)

underserved adolescents; and (b) adults, such as parents, social workers, community health workers and teachers who live or work with adolescents. A follow-up individual interview (15–30 minutes) with one to two focus group participants was also conducted at the end of each focus group. A total of 25 sessions of focus group discussions was completed with 214 participants from selected subnational key informants, underserved adolescents, and adults who live and work directly with underserved adolescents. Underserved adolescent group discussions were arranged for boys and girls in school and out of school, married and unmarried, with the older and younger ones grouped separately. The composition of the focus groups was homogenous, to enable participants to speak comfortably about the topic within the group.

Ethical considerations

This study employed the use of enumerators, who were trained on ethical considerations in research involving human subjects. In addition, the potential participants were informed, during the consenting process, of their rights as participants, as well as the risks and benefits involved. The study protocol was reviewed by the local institutional review board at the Ethiopian Public Health Institute and a letter of approval granted. In addition, the following ethical issues were considered during the evaluation process:

Informed consent: Informed consent was assured after information was given to participants, clearly explaining the nature and purpose of the study, the procedures it entailed, the risks and discomforts involved, the benefits of the study, confidentiality of participants' identities and responses, and their right to refuse participation at any point. To protect study participants and others, such as enumerators, against COVID-19, they were all required to wear a face mask, use hand sanitizer and keep a physical distance of at least 2 metres from each other. The enumerators obtained written consent from participants after providing them with information about the study. The

content of the informed consent form was explained in a language which the participant would understand before signing.

Findings

An analysis and triangulation of the findings from the key informant interviews at the national level, and a review of the available literature and quantitative data, as well as a subnational assessment was done by the research team, in close consultation with the technical team set up by the Federal Ministry of Health. Content analysis was done using the five domains of the Tanahashi framework (Annex 1). This synthesis enabled the identification of specific themes within these different domains. The findings are presented under each of the domains as follows:

Availability

This domain refers to evidence on availability of services, both in fixed facilities as well as through outreach, skilled human resources and appropriate supplies for the selected services (SRH information, HTC, contraception and mental health).

Data from the subnational level reveal that adolescents and other stakeholders who took part in the assessment are not fully aware of the availability of services. However, evidence from the data mining and literature review documented improved availability of trained providers at the facility level and relatively improved availability of supplies. Evidence from the national and subnational levels, however, do not corroborate such findings, but rather point to a significant shortfall of skilled providers and inputs as well as supplies at health facilities in both the rural and urban settings involved in this study. Unlike other participants in this assessment, adolescents, irrespective of age, sex, educational profile and residence reported that they were not aware of the availability of dedicated SRH information, contraceptives, HTC and mental health services at the facility level. Parents, community elders, faith-based organizations and community-

level structures all pointed out the lack of relevant information on services meant only for adolescents. Besides, they indicated that they themselves did not know much about adolescent health services.

Participants said that sexual and reproductive health information, particularly on contraceptives and HTC, is relatively more available at health facilities, particularly health centres. Nonetheless, mental health information was generally lacking for adolescents and other participants alike. While information was reported to be available at the health centres on SRH, contraceptives and HTC, these services were not considered to be of any relevance in the local context.

“Even if information is available, it is not context-friendly and developed for specific target groups. Often, such information is adapted from other countries, while Ethiopia is a multicultural nation, where what may work well in one area may not work in other areas (Key informant national level)”.

Data from the field reveal that while adolescents feel that they are well informed about SRH problems, particularly contraceptives and HTC, mental health is not included, and they are not given the complete picture of the types of services available or where to get them. One of the participants argues that:

“Adolescents, whether they are in school or out of school, do have information about HIV and AIDS and contraceptives but not about mental health. However, I don’t know which of the services are available and where. In fact, most probably, adolescents do not know if services are available for them at all” (Stakeholders, women, children and youth affairs, focus group discussion (FGD), 38, Gondar).

Contrary to adolescents in the 15–19-age bracket, younger adolescents (10–14 years of age), whether in school or out of school, in rural or urban areas,

complained that they have no dedicated message that could help them understand the problems and services relevant to them. One of the younger adolescents explained thus: “I and my peers have heard about unwanted pregnancies, contraceptives and HTC. However, we don’t know much about them or what to do if we are confronted with the issue” (Adolescent boy, FGD, 13 years old). Parents generally wonder if there is any dedicated service for adolescents. One of the parents emphasized that “I don’t know if there is a health service particularly meant for adolescents in our area. In fact, they are healthy and there are no problems encountered by adolescents in our area” (Parent, FGD, 48, Qebri Beyah).

It was found that even though adolescent health services are part of the different policies and legal frameworks of the country, their implementation is challenged because the adolescents themselves, their parents, the community and even the health providers, are unsure whether adolescents need services such as SRH information, contraceptives and HTC. The number of health professionals has increased in recent years. However, the smooth delivery of SRH information, contraceptives and HTC is hindered by lack of properly trained health professionals dedicated to adolescents at the health facility level.

In addition to the lack of awareness at the facility level, the tendency for adolescent girls, 15–19 years of age, to use contraceptive services is limited. Analysis of the Ethiopian demographic and health survey (EDHS) data from 2011 and 2016 reveals that out of the 36/1000 live births to teen mothers, only a handful (those above 17 years) were found to have sought services to delay or terminate pregnancies (fig below). This may have been compromised by poor availability of information and services to younger adolescents.

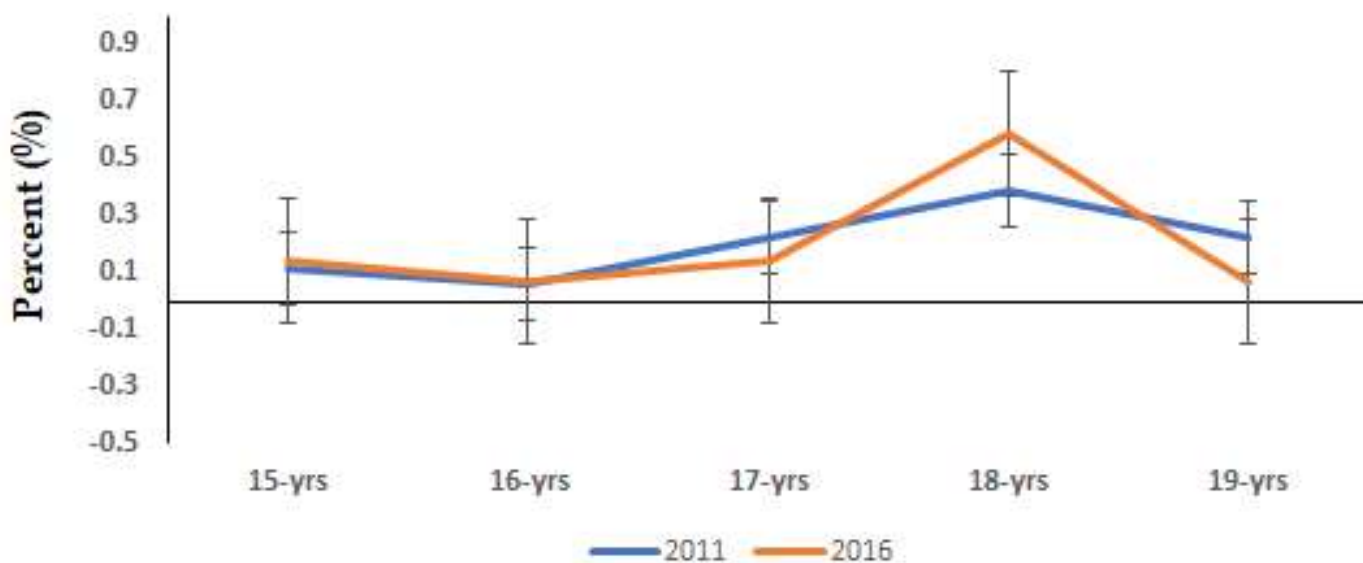


Figure 1: Adolescent girls who tried to either terminate or delay pregnancy

Even within facilities where services are reported to be available, evidence from interviews widely reveals that family planning/contraceptive commodities were not always available. This is also reported in the reviews (28)⁶. Similarly, availability of trained providers dedicated to adolescents was reported for fewer than one third of the health facilities in emerging regions such as Afar and Gambela; and for more than half of health facilities in the rest of the regions (26)⁷. Notwithstanding this finding, data from the subnational assessment revealed that health facilities do not have trained, dedicated and experienced providers. At the community level, health extension workers were reluctant to provide SRH services, including HTC, to adolescents in schools and at youth centres. Providers were found to lack skills on how to communicate with adolescents, both at the health facility and community levels, owing to limitations in their training curriculum.

⁶ Gebrecherkos K, Gebremariam B, Gebeyehu A, Siyum H, Kahsay G. Unmet need for modern contraception and associated factors among reproductive age group women in Eritrean refugee camps, Tigray, north Ethiopia: a cross-sectional study. BMC Res Notes [Internet]. 2018;1–6. Available from: <https://doi.org/10.1186/s13104-018-3956-7>

⁷ EMOH, EPHI W. Services Availability and Readiness Assessment Summary Report Ethiopia Service Availability and Readiness Assessment 2016 Summary Report 2016

Lack of contraceptive supplies as well as HIV testing and counselling were commonly cited as a barrier by all participants, including health care providers at the health facility level. One of the participants argued that “Services are not consistently available, while supplies are not replenished in time. We run out of supplies frequently and it takes time to get the supplies in place” (Health care provider, 29, key informant interview (KII), Mierab Abaya). Another participant stressed the common fact that “Health centre staff prescribe drugs that are not available in the health centre, and they advise us (adolescents) to buy these from private health facilities” (In-school boys, FGD, 16, Sululta). For providers, this does not seem to be the best option. One of the participants, who is a health provider, explained that “When we (providers) cannot offer services, which are not available in our health centre, we do not have an established referral linkage. So, the only option is for them to visit a private facility” (Service provider, KII, 35, Gondar).

Availability-related barriers had to do with the inconsistency of supplies within the facilities. SRH information, HTC and contraceptive services are not heard of at the community level. Generally, providers had limited skills. There were no differences of opinion among the different categories of participants and places.

Accessibility

Barriers, in terms of distance and transportation services, cost of services, both direct and opportunity costs, opening times and scheduled services, appropriateness of information and administrative bottlenecks, were all assessed.

The demographic and health survey reports show that distance to health facilities and cost of services compromised access to contraceptive services among adolescents 15–19 years of age. As such, the data show that in 2011, 57.5% and in 2016, 40.5% reported distance as a barrier, while 55% in 2011 and 46.5% in 2016 reported cost as barriers to accessing services. It was found that despite the availability of health centres in every village, access to

services for adolescents, irrespective of whether they are in school or out of school was not easy. Adolescents reported that services were not organized for them; and indeed, they had no money to access services.

Stakeholders from the Ministry of Education and the Ministry of Women, Children and Youth Affairs at the subnational level pointed out that as adolescents are unemployed and are under parental care, they do not have money to get to the health facility or pay for contraceptives. Although the information is patchy and not cross-cultural, distance to health facilities affects the use of services, especially among older adolescents. One of the participants underlined that:

“Access to health services is not easy. Transportation and associated costs make even closer ones seem distant. The problem is more serious in rural areas than in urban centres. Otherwise, I do not see any accessibility-related problems specific to young people” (Key informant national level).

Evidence from the quantitative data review suggests that a lower proportion of adolescents from rural areas receive HIV testing and counselling services compared to those from urban areas⁸. Furthermore, although gender analysis was not made in this assessment, available data indicated that more female adolescents underwent HIV testing and counselling services than their male counterparts. This is because adolescent girls enrol in preventing mother-to-child transmission (PMTCT) programmes.

The opening time of the services and/or lack of feasible schedules for adolescents make access difficult. First, most adolescents are in school when facilities are open for service, and second, when facilities are open, adults crowd them, denying comfort for adolescents even though they make the effort to get to the service. Service opening times are not appropriate for

⁸ Even if such services are available in local health posts, it is unlikely that adolescents would use them, as they do not trust health workers to keep their confidentiality.

adolescents. Even health posts at the community level are not readily available at a time that is suitable for adolescents.

“As adolescents, we don’t believe there are such services as SRH, contraceptive and HTC in the facilities around here. Yet, even if the service is available, the opening time of the facility is not convenient for adolescents. The service opening time is fixed and this may not be appropriate for us. Either we are in school and/or we do not feel comfortable to be seen in the health facilities by our adult community members”. (Female FGD participant 15–19 years).

Unfortunately, schools and youth centres do not have such services at a time that is appropriate for adolescents. One of the participants noted that “...just like health facilities, there is no information on sexual and reproductive health, there are no HIV/AIDS and contraceptive services for adolescents in schools and at youth centres” (Male FGD participant, 15–19). Indeed, access to services is not only about cost, time and distance, but also about whether the services are there when adolescents need them. One of the participants indicated that

“Access is not about whether the facilities are just a step away from your place. Rather, whether the facility provides services at a time when you need them, without any sense of embarrassment for finding yourself among adult men and women from the community. If the service is not organized to meet the needs of adolescents, it would be difficult to argue about service accessibility” (Key informant interview, stakeholder).

Organization of the service should clearly include flexible opening times as well as a separate section for adolescents. The quote below from a participant who is a service provider substantiates this argument: “There is no separate room and dedicated staff member within this facility for adolescents and youth. As a result, we provide the service for all without discrimination,

which is difficult for adolescents, and I understand, this is one major problem” (Stakeholders, FGD, 28, Gondar).

Figure 2 below illustrates how limited access to money, distance from a health facility and unwillingness to go unaccompanied affect adolescents' access to health services. Distance from the health facility and not wanting to go alone appears to operate as a slightly greater barrier for male adolescents than females, although the difference decreased between 2011 and 2016. However, during the same period, costs (need for money) and the need for parental permission increased, thereby becoming a potential barrier for female adolescents.

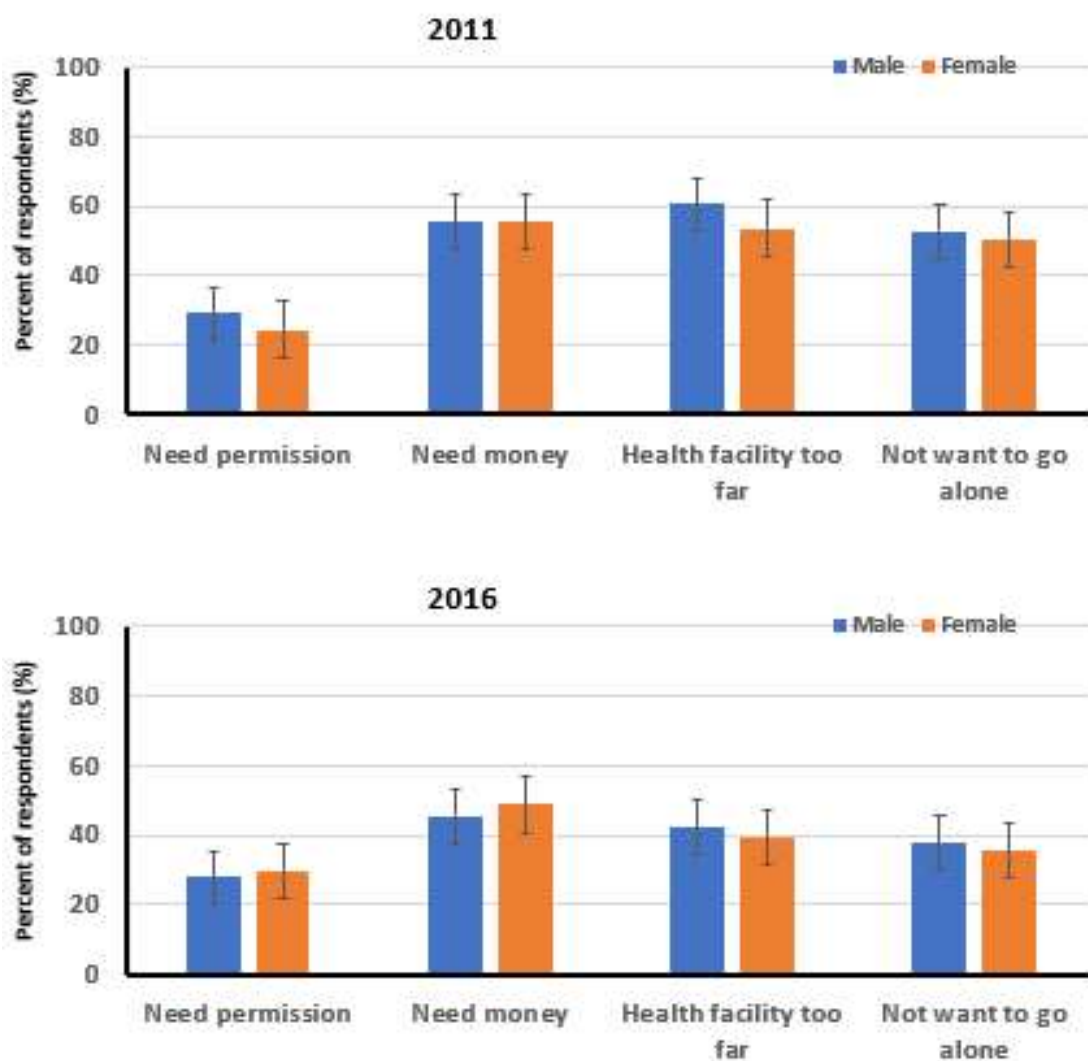


Figure-2: Factors affecting access to reproductive health services among male and female adolescents aged 15–19 years in Ethiopia

(Source: 2011 and 2016 EDHS individual household member survey).

Although data were scanty, participants, in a few cases, argued that adolescents in the rural setting who are not in school find it difficult to access sexual and reproductive health services. One of the participants underscored that:

“Access to sexual health services is not easy. Moreover, transportation and the associated costs render available services inaccessible. The problem is more serious in rural areas, and for those who are out of school, than in urban settings” (Parent, FGD, 42, Qebri Beyah).

Findings generally show that there is an overall problem in recognizing mental health as a major area of concern. Questions related to accessibility to mental health services remain vague for all participants, who do not recognize that this is indeed a problem that requires a separate service, and also, do not believe that there is such a service at the health facility level. One of the participants argued: “I don’t think we have mental health problem in our area. No one has ever seen an adolescent with a mental health problem in this area. We do not know if there are services meant for mental health at our health centre” (Adolescent boy in school, FGD, 18, Qebri Beyah).

Generally, shortage of trained health professionals who are dedicated to serving adolescents and the youth, affordability of the services, distance and transportation challenges are some of the major accessibility barriers.

Acceptability

Acceptability barriers in terms of cultural acceptance of service provision, competence and empathy of the providers depending on the age and sex of adolescents, ability to trust and confide in the providers, the perceived service quality and non-discrimination in service provision were all assessed.

Irrespective of the research settings, the findings show an overwhelming cultural resistance to sexual and reproductive health service to adolescents, while mental health is not even recognized. The literature available shows that parents do not discuss sex-related issues with their children (both boys and girls), or approve of the idea that they deserve sexual and reproductive health services (2, 8). Parents do not discuss sexual and reproductive health with their daughters and sons (12, 13). In Ethiopia, issues around adolescent sexual and reproductive health are still considered taboo. Parents who participated in the subnational assessment pointed out that:

“We as parents find it difficult to talk about sex and sex-related problems with our children be they boys or girls. This is not acceptable in our community. I do not know if urban parents have better knowledge and the skills to discuss this with their children. For us, there is no way and even if I dare to talk to my daughter, I feel she would run away because this is not normal” (Key informant interview participant).

Findings from literature indicate that adolescents prefer discussing SRH issues with their peers rather than with their parents (4, 14–16). Even those parents who overcome cultural barriers to discuss such issues with their children are challenged by their lack of knowledge of adolescent SRH and communication skills, and the concern that such discussions could encourage premarital sex (19–22).

Findings from the EDHS have documented religion as another barrier to contraceptive use. Accordingly, about 68% of pregnant teens did not accept or never used contraceptives because of religious beliefs.⁹

⁹ Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

Younger adolescents, in particular, are often invisible and excluded from sexual and reproductive and mental health information and services. They are considered minors under parental care. There is general consensus on this among participants, both at the federal and subnational levels.

“Adolescents 10–14 years old, to me, are considered as minors, still under parental care, who don’t have special needs of their own and cannot access services by themselves. Even providers would not consider them for health services without parental consent” (Key informant at national level).

The cultural limitation to adolescent SRH information, contraceptives and HTC extends beyond the family and/or community, to health facilities. Understandably, providers at the health facility are members of the community and are also part and parcel of the cultural fabric. Adolescents stated that they did not feel comfortable because they did not trust health care providers:

“Health care workers in health facilities and health extension workers all live within the community and share a common culture with us. Their views do not differ from those of our parents and the community. Indeed, they may easily divulge the information a particular girl may have shared to obtain a service. The story then becomes public and embarrassing. There is a girl who ran away from this area because of this” (In school adolescent, FGD, 19, Mierab-Abaya).

Similarly, “a boy with STI travelled to Jimma (about 100 km from his hometown) to seek treatment and the provider asked him why he didn’t get treatment from the nearby health facility. He said, my health information will reach my parents and the community at large, before I even leave the health facility compound” (Key informant at national level).

Adolescents consistently revealed their concern about trust in health care providers. Consistent with data from interviews, review of available literature shows that a significant number of adolescents find family planning and the use of contraceptives unacceptable due to stigma, privacy concerns, and poor confidentiality in clinics (28).

Health care providers do not make the time to discuss matters with adolescents and young people who seek their support. Providers maintain a negative attitude towards adolescents who come in with sexual health problems. In fact, adolescents consistently shared their lack of trust in providers, who may reveal their secret to parents (39, 40). Interviews with adolescents consistently revealed that health care providers are not supportive. “Health care providers at the facility level do not have a positive and supportive attitude in solving adolescents’ sexual health problems” (Stakeholder/NGO staff, KII, 32, Mierab Abaya). Adolescents complain that “Health staff at the health centres do not respect us. They also compel us to buy medicine from a pharmacy since they do not have it at the centre. I think it is far better to visit the pharmacy instead” (Out-of-school girl, 18, Addis Ababa). It was further explained that “A girl who may encounter a problem, including pregnancy, or requiring advice on a sex-related problem, prefers to go either to an NGO facility or a local pharmacy, which is more secure, as we feel parents or someone known from the village may not go there” (Adolescent girl, FGD, 18, Gondar). Adolescents thus have the impression that health facilities and providers do not care much about their problems. One of the participants said: “Who cares about our health condition? I don’t think we can go and visit the health facility, for they do not even recognize us” (Female adolescent FGD participant).

Findings show that health facilities are not attractive to adolescents. The unwelcoming security guards, lack of guidance and information on where to go, and poor communication skills and judgmental attitude of providers were some of the critical concerns. However, providers contend that while health facilities may not be conducive and friendly to adolescents, they are

overburdened and lack appropriate training to deal with them. Providers consistently argued that “Our services are not convenient. As professionals, we are not trained to serve their particular interest, nor do we have a convenient time and service set up for them. So, our service is not convenient”. Providers further complained that they are busy with clients coming from different areas for different problems. One such provider said:

“We are so crowded by an overwhelming number of patients on a daily basis that we don’t have the luxury to attend to these young people. I know if they come, they want to get quick service and attention, which we can’t offer. We all consider them as one of our clients which is not acceptable to them” (Provider, FGD, 27, Gondar).

As a result, health facilities are not conducive to adolescents. Similarly, health extension workers who participated in this study indicated that they are also overwhelmed with the package of services. Besides, provision of SRH information, HTC, contraceptives and mental health services has not been regular. One of the participants indicated that:

“We are overwhelmed by several health problems within the village. We are two in number, but often only one of us would be working full time, for different reasons. As a result, we don’t have time to provide services to adolescents alone. The adolescent health issue is not part of our regular job. More importantly however, we have not had relevant training on how to help them and what type of services to provide” (Stakeholder/HEW, KII, 27, Mierab Abaya).

It was argued that the curriculum for in-service training does not provide the requisite knowledge and skills in communicating, managing and caring for adolescents at the facility level by health workers and at the community level by health extension workers.

Stakeholders involved in the study have also emphasized the fact that providers lack the appropriate skills to support adolescents. “Young people are not like adults. They are restless and want to be cared for with passion when/if they have the courage to come. I do not think health workers have the required skills and competency to deal with the youth, who need a special approach” (Stakeholder/teacher, FGD, 40, Mierab Abaya).

Supplies was another major problem found in this section. Health centres are not well equipped with materials, supplies and equipment to provide contraceptive, HTC, SRH information and mental health services. This is not a problem specific to young people alone but also to the public at large.

“Public facilities lack appropriate supplies for adolescent HTC, contraceptive and mental health services. Partners provide support with supplies to a few facilities, thereby improving SRH information, contraceptive and HTC services. So, unless the Government takes over, and sends supplies to other health facilities, it would be difficult for them to receive supplies” (Stakeholders/women, children and youth office, FGD, 34, Gondar).

Apparently, the challenge with cultural taboos, the unfriendly service set up and incompetent providers has discouraged adolescents from using the services. These factors were found to affect SRH information, HTC and contraceptive supplies, with mental health remaining a grey area that fails to gain due attention.

Utilization

This section focused on actual contact between the service provider and the user, when services are available, accessible and acceptable, with focus on adolescent health literacy, i.e., adolescents not being knowledgeable about their own health, or not knowing when and where to obtain health services.

According to the findings from the literature review, adolescents demonstrated poor comprehensive knowledge about HIV/AIDS; they did not know where to go for HTC, and were not receiving adequate counselling services due to the limited competency of the providers (13, 52, 53).

Findings from data mining for married teenagers show that four in five of them had no knowledge of modern types of contraceptives, and two out of three had no knowledge of the source/location for receiving family planning services.

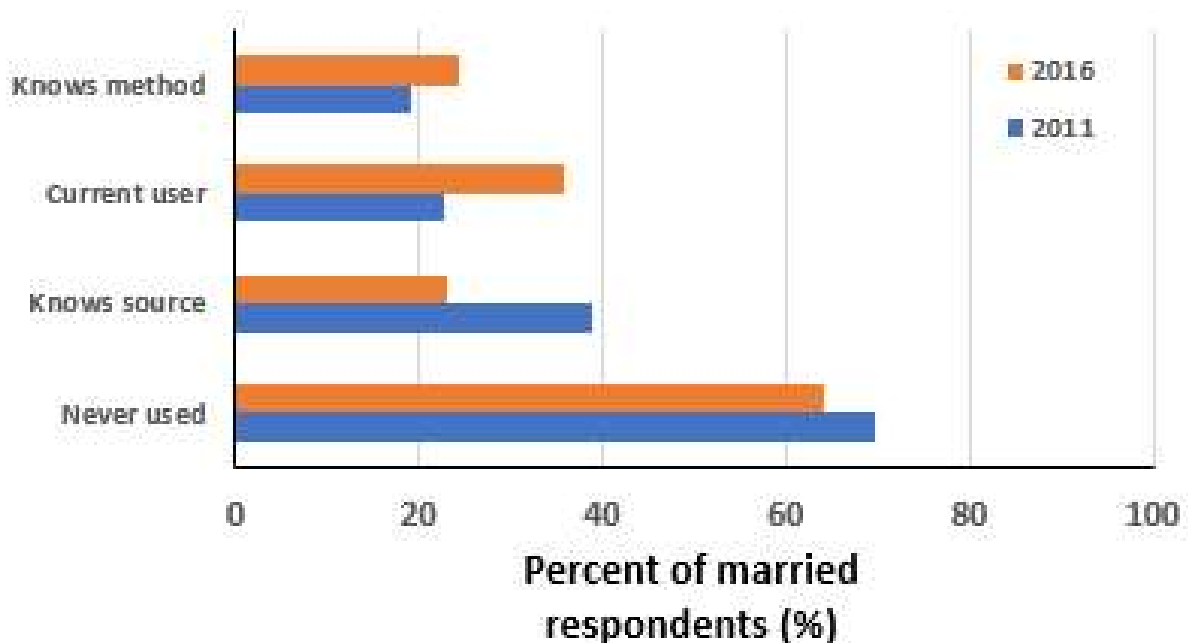


Fig 3: Adolescents' use of contraceptives and their knowledge of methods and sources of services (Source: 2011 and 2016 EDHS individual household member survey)

Similarly, findings indicate that 15, 16, and 17 are the peak ages for first sexual intercourse, first cohabitation/marriage, and first birth, respectively. This suggests that most of the earliest indicators relating to courtship, cohabitation and marriage are experienced early, due to the lack of correct and timely information.

Adolescents' awareness about available services is limited. The assessment on the use of patterns of contraceptives, the rate of unmet needs, and some of the main barriers to the use of contraceptives among adolescents aged 15–19 years showed that more than 95% of the respondents have very little knowledge about the sources and types of modern contraceptive methods. Limited knowledge/awareness of the consistent use of, and adherence to contraceptives and family planning counselling services was found to be a major problem at both the community and facility levels. Unlike urban adolescents, those in the rural areas do not have appropriate information on such services.

Misconceptions were found to be prevalent, owing to the strong role played by rumours, although their sources are not clear. As such, the use of contraceptives by younger adolescents and young adolescent girls, 10–18 years of age is considered inappropriate (22, 29). This makes adolescents, even married ones, to have doubts about the use of contraceptives. Evidently this is an indication that potential users do not recognize the value of such services.

Awareness among adolescents about SRH information, contraceptive use, HTC and mental health services is low. The study findings generally revealed that parents and community leaders share the same level of limited awareness about the service. Although the findings did not show this in clear terms, there was an indication that adolescents in the rural areas, those out of school and the younger ones were less informed about SRH, HTC, contraceptive use and mental health services.

These findings pointed to the fact that service availability, accessibility and acceptability alone does not warrant service utilization; specifically, cultural barriers, peer influence and concerns of privacy deter adolescents from using the services. Apparently, the lack of awareness about the services and their purpose has affected service utilization. In as much as adolescents lack appropriate information, so do parents and community members who could

have guided adolescents to seek services. It is not merely about lack of information per se, but also lack of information on whether such services are available, and where, and how adolescents could access them.

Generally, findings under contact/utilization reveal a gross lack of awareness among adolescents, irrespective of where they reside, whether they are in school or out of school and whether they are younger or older. Information is lacking on HIV and AIDS, contraceptives and the mental health services available, in terms of their purpose and sources of supply. As a result, utilization of those services, even when available, accessible and acceptable, will remain compromised. There is no difference in terms of the level of awareness by the type of services and the different adolescent groups, although adolescent girls aged 15–19 years in urban settings have relative awareness. Parents, community members and stakeholders also indicated that they have limited information about the services available and where to obtain them.

Effectiveness

An assessment was made, under this section, of service delivery in terms of supportive and competent providers, diagnostic support, friendly relations between adolescents and providers and adequacy of resources to maintain service delivery.

Findings from the reviews and data mining indicate that low competency in dealing with the needs of adolescents was apparent where health care providers are not well trained to communicate with, and provide services to adolescents (3). At the facility level, sexual and reproductive health education programmes are provided in a fragmented way, as health professionals do not have the necessary knowledge and skills to cater for the needs of adolescents in HTC, contraceptives and mental health. Health professionals lack the competencies to facilitate the provision of contraceptive services, prevention of HIV, ensuring adherence to antiretroviral therapy (ART),

explaining side effects, producing results from routine diagnosis, and providing mental and behavioural health-related psychological support.

Standard information and messages are not made available at the facility level for sharing with adolescents. This is the case at the community level as well, where health extension workers lack the competency to work with adolescents¹⁰. In fact, as shown above, under the acceptability section, health extension workers, who are part and parcel of the community, are influenced by the cultural context to discourage young adolescents from using SRH commodities such as condoms and other modern methods of contraception. While this may require more focused study, parents at home and teachers in school are reluctant to discuss comprehensive sexuality education with adolescents. The critical point here is that despite the cultural pressure, and unwillingness by parents and teachers to discuss sexual health issues with adolescents, they themselves do not have appropriate information to impart to adolescents (48).

As was indicated under the acceptability section above, adolescents do not trust health professionals to protect their confidentiality. That clearly depicts the poor and non-cordial relations between providers and adolescents. Providers explained the situation by citing their lack of competence in dealing with adolescents and their heavy workload at the facility level, while adolescents maintained that providers did not have a positive attitude towards them.

The service delivery setting, from the physical access to the facility, the entrance gate to the waiting areas, is evidently not friendly to adolescents. Equally important is the lack of appropriate diagnostic facilities. Participants indicate that health centres lack appropriate diagnostic facilities and medicines. There is no consistent availability of contraceptive services at the

¹⁰ FMoH. National Assessment of the Ethiopian Health Extension Programme: Final Report, Addis Ababa June 2020

facility level. Under such circumstances, adolescents are sent to private facilities and pharmacies for tests and medicines (10). Findings from the interview corroborate the fact that health facilities lack appropriate services. “I do not think the health centre has the medicines and laboratory facilities to help young people who need HTC and/or pregnancy-related services. Often, young people move from their neighbourhoods to other private health facilities in the major towns” (Adolescent girl, FGD, 18, Qebri Beyah). One of the adolescents shared a vivid experience from a friend. “Despite all her fears, my friend visited the local health centre. She said, they didn’t support her but rather advised her to go to a private clinic for testing. The health centre is not a good place to visit” (Adolescent girl, FGD, 18, Gondar).

Young people contend that the health facilities lack appropriate services, making it an unpleasant experience to visit them. One of the participants argued that:

“We can’t tell how effective the health centre service delivery is in general. However, it is evident that it is very poor for young people, as health care providers are incapable of meeting their needs due to lack of relevant resources within the facility and professional competency.”(Stakeholder/NGO, KII, 32, Mirab Abaya).

The consequence of the lack of diagnostic facilities and medicines and the limited competency of the providers is evident. About one third of married adolescents 15–19 years of age, use some method of modern contraception. This figure could be lower among unmarried adolescents. Unfortunately, health facilities were found to lack experience in auditing their successes and barriers to successful health service delivery for adolescents, who are not considered as mainstream clients (16, 44).

Effectiveness here is compromised by different factors - the unfriendly health facility environment, lack of appropriate and consistent diagnostic facilities and medicines, unfriendly approach by providers and their judgmental and

disapproving attitude, which pushes adolescents away from seeking and using HTC, contraceptive and mental health services (1, 3, 24).

Summary

Generally, the Tanahashi framework has provided useful guidance for discerning the barriers to adolescent health services. The key outcomes from this assessment are:

First, availability, accessibility, acceptability, contact/use and effectiveness all constitute barriers to SRH information, contraceptive and HTC service use in Ethiopia. The mental health component of the service is generally poorly recognized as a service.

There are glaring limitations at all levels, calling for intervention. Also, the lack of information and limited availability of the services deserve immediate attention. Structural factors in connection with acceptability-related barriers require intervention at the community level to address cultural challenges, while facility-level challenges require improved capacity-building in the form of generic and in-service training. The key barriers for the respective service areas are detailed in the table below for easy reference.

Summary of barriers

Services	Key barriers
SRH information	<ul style="list-style-type: none"> – Lack of appropriate and targeted information – Lack of information on where to get services – Non-friendly information – Limited awareness about services – Lack of clarity on what information is delivered, and by whom – Concerns of exposure to information that would encourage adolescents to engage in sexual activities – Poor discussion habits between couples – Misconceptions
Contraceptives	<ul style="list-style-type: none"> – Lack of a friendly service delivery environment and time – Limited availability of services – Cost of services – Distance to facilities – Unfriendly providers – Unsupportive cultural expectations, and social norms – Religious influence – Parent disapproval and pressure – Judgmental attitude of health care providers – Fear of side effects – Concern to be seen by family members and neighbours – Lack of trust to confide in providers
HTC	<ul style="list-style-type: none"> – Ambiguities in consenting process – Unavailability of services in accessible settings – Perceived stigma and discrimination

	<ul style="list-style-type: none"> – Cost of services – Distance to facilities – Concern to be seen by family members and neighbours – Unsupportive attitude of providers – Limited knowledge and skills of health providers – Lack of confidentiality and privacy
Mental Health	<ul style="list-style-type: none"> – Limited availability of mental health service – Inadequacy of health care providers – Poor mental health literacy – Fear of medication side-effects – Preference of traditional and religious options

Second, adolescent health in general, and the health issues targeted in this assessment in particular, require not only the health sector's attention, but also commitment from the Ministry of Women, Children and Youth Affairs. As such, providing targeted and adolescent-friendly information services both at the facility level and within the youth centres is an important intervention that may address availability- and accessibility-related barriers. Furthermore, advocacy at the level of decision-makers would help facilitate intersectoral collaboration for adolescent sexual and reproductive health and mental health services.

Third, although there were no clear-cut differences in awareness and service use among adolescents in terms of sex, place of residence and whether they are in or out of school, the younger ones, who are under parental protection, could be considered as the most disadvantaged.

Other recommendations for action are suggested per the health service coverage dimension below:

- 1. Availability:** The findings underscore the challenges faced at the health facilities, with the youth centres lacking trained and dedicated human resources, and contending with inconsistent supplies and equipment, which affect the provision of the selected services for adolescents. Providing health services at the youth centres is an important step for consideration. To this effect, the health sector, other public sectors and donors ought to focus on in-service training and continuous mentorship for providers, and ensuring consistent availability of supplies.
- 2. Accessibility:** Access to selected health services was compromised by distance, cost and inconvenient opening times of health facilities. In order to address such barriers, it is important to ensure accountability of the youth centre clinics. This will undoubtedly address distance and transportation challenges to accessing services. In addition, ensuring free access to services by adolescents requires a policy decision.
- 3. Acceptability:** The findings point to widespread cultural and religious barriers for adolescents, to using even available and accessible services. Parents, community members as well as religious leaders do not believe adolescents deserve such services. Unfortunately, this extends even to those who work in the public sector, including the health sector. As a result, adolescents find it difficult to trust and confide in the providers. With technical support from the health sector, all public sector stakeholders such as the Ministry of Women, Children and Youth Affairs should organize and run campaigns on the health rights of adolescents and their use of services. In addition, a clear strategy should be designed by the health sector to ensure the confidentiality of services provided to adolescents.
- 4. Utilization (Contact-use):** findings reveal that adolescents, parents and civil servants working in different sectors are not very knowledgeable about SRH and mental health issues and services. However, there are variations in the types of services, while the individuals themselves also differ. As such, awareness about mental health is grossly deficient, while adolescents 10–14 years old also lack awareness of the problems and

- services. This calls for immediate action to promote awareness and provide services on mental health and SRH at the primary health care unit level. Schools, youth centres, health posts, health facilities and the media are expected to play a pivotal role in advocating for and educating the public at large and adolescents in particular about SRH and mental health.
5. **Effective coverage:** Generally, the findings show that barriers are widespread across all pillars of the Tanahashi framework. Indeed, implementing the recommendations above will help improve the provider empathy, the diagnostic capacity of the facilities and centres and the consistency of resources, so as to ensure quality of services.
 6. **Lastly,** this assessment reveals significant data gaps in adolescent and youth health, specifically mental health in younger adolescents (10–14 years old). We recommend a survey at the national level to improve knowledge on the burden of adolescent health problems.

Limitations

The study has gone through lengthy pathways with the involvement of diverse entities at different levels: public, sector, civil society organizations, donors, providers, community members, including parents and adolescents of different age groups. While a very rich evidence base was generated, there was limited evidence on selected services such as mental health. In addition, data mining could access only the national report from the EDHS while the routine DHIS2 did not capture important variables on adolescents of different age groups. This has limited the efficient data mining of the report.

Interviews with adolescents 10–14 years old, were not smooth, but rather time consuming, as the data collector had to engage them differently from others in terms of the language and the manner in which they were interviewed. This was cumbersome, albeit an important learning opportunity.

The study started just before the COVID-19 outbreak was officially declared by the Ethiopian Government. This delayed the data collection process

especially at the subnational level; and after months of delay, new approaches were introduced, at additional cost, to protect study participants and researchers from potential infection.

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