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# Challenges Faced by Female Out-of-School Adolescents in Accessing and Utilizing Sexual and Reproductive Health Service: A Qualitative Exploratory Study in Southwest, Ethiopia

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## Abstract

**Introduction:** Due to the limited access to sexual and reproductive health service, out-of-school-adolescents become at a higher risk for early marriage, early pregnancy early parenthood, and poor health outcomes over their life course. Hence, the aim of this study was to explore the challenges faced by female out-of-school adolescents in accessing sexual and reproductive health service in Bench-Sheko zone. **Methods:** A community-based qualitative exploratory study was carried out from November 01/2020 to December 01/2020 among selected out-of-school adolescents residing in rural and urban districts of Bench-Sheko Zone, and healthcare professionals working in the local health centers. FGD participants and healthcare providers were purposely selected for this study. Eight focus group discussions and 8 in-depth interviews were conducted among female out-of-school adolescents, and health care professionals, respectively. **Result:** The study revealed that out-of-school adolescents encounter several challenges in accessing sexual reproductive health service which includes socio-cultural barriers, health system barriers, perceived legal barrier, inadequate information regarding sexual reproductive health service, and low parent-adolescent communication. **Conclusion:** The finding suggests the need to engage community influencers (religious leaders, community leaders, and elders) in overcoming the socio-cultural barriers. Program planners and policy makers have better make an effort to create adolescent friendly environments in SRH service areas. Furthermore, implementing community-based awareness raising programs, parental involvement in sexual reproductive health programs, and encouraging parent-adolescent communication on sexual reproductive health issues could improve sexual reproductive health service utilization by out-of-school adolescents in the study area.

## Keywords

sexual and reproductive health service, out-of-school, adolescents, Southwest, Ethiopia

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## Introduction

Adolescence is the process whereby a person makes the progressive movement from childhood to adulthood. It is characterized as the individual progresses from the point of the initial appearance of the secondary sexual characteristics to that of sexual maturity, the individual's psychological process and patterns of identification develop from those of a child to those of an adult, a transition is made from the state of total socioeconomic dependence to one of relative independence.[1] It is also expressed as a persons with the age group of 10 to 19 years and it is one of the most fascinating and complex life stages.[2]

This period is characterized by fast development of physical, emotional, mental and social welfare[2,3] and also a stage in life when adolescents are susceptible to many risks, particularly in relation to their sexuality; they often not have access to sufficient information, counseling, and services on issues crucial to their development needs.[3-5]

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When adolescents are not in primary or secondary education at the age of schooling in some case when adolescents in pre-primary education or non-formal education are considered as out of school.[5,6] Most of the time out-of-school adolescents have no access to health related information, counseling, legal protection, as well as health care and other social services.[7]

Now a day in the world there are around 1.2 billion adolescents from this almost 90% are found in country with lower income.[8] These young people account for 15% of the world disease and injury and from these, more than 1 million of adolescents are died annually, mainly from preventable causes.[9]

About 16 million adolescent girls are aged of 15 to 19 years and from these 2 million girls under age 15 give birth every year. One in 3 adolescent girls bearing children by the age of 18 occurs in the poorest part of the world. Adolescent girls have more risk for maternal mortality, the occurrence of pregnancy-related death for girls aged 15 to 19 years is 2 times higher and for girls aged 10 to 14 five times higher than women with the age of greater than 20s years and also they are more at risk to get unsafe abortions, from girls aged 15 to 19 about 3 million unsafe abortions occur every year.[10]

Young people who are out of school have higher risk for early marriage, early pregnancy early parenthood, and poor health outcomes over their life course.[11] School dropout makes the young people shifts from a "high human capital track" with concealed childbearing, improved health, financial freedom, to a "low human capital track" with high fertility, destitute wellbeing, financial reliance, and showed through changes in health behaviors.[12]

The study conducted in 9 sub-Saharan Africa indicates that school enrollment highly related with sexual and reproductive health service and healthcare utilization. Decreasing school dropout rate improves the sexual and reproductive health outcomes of the adolescents.[12] The study done in Uganda also revealed that out-of-school adolescents were less likely to practice safe sex and to use modern family planning methods than in-school adolescents.[13,14]

Unlike the current study, previous studies conducted in different part of the country have mainly focused on in-school-adolescents who relatively have a better access to SRH service and information when compared to out-of-school adolescents. Besides, adolescent SRH intervention programs and strategies are commonly school-based or curriculum based and the SRH needs of out-of-school adolescents are often overlooked. Hence, the aim of this study was to explore the challenges faced by female out-of-school adolescents in accessing sexual and reproductive health service in Bench-Sheko zone, Southwest, Ethiopia.

## Theoretical Framework

The social–ecological model (SEM) has been employed in several studies to comprehend the individual, social, and environmental determinants of health.[15,16] The social ecological model also delivers a conceptual framework to identify and comprehend factors that influence the reproductive health behaviors and outcomes for adolescents (Figure 1).[17] Contemporary studies have employed the SEM as a framework to comprehend in greater depths the various socio-cultural factors that determines adolescents reproductive health.[18] The SEM model has also been utilized by evidenced-based adolescent health programs to enhance impact and attain better reproductive health outcomes among adolescents.[19]

## Methods

### Study Area and Period

The study was undertaken from November 01/2020 to December 01/2020 in selected districts of Bench-Sheko zone. The Zone is found 561 km away from Addis Ababa, the capital city of Ethiopia, in Southwest direction with an estimated population of 829 493, of them 418 213 are women, 207 276 are adolescents, 129 500 are children under 5, and 26 462 are below 1 year.[20] The expected number of households in the zone is around 169 284 and the primary health service coverage of the zone is 92.6% accounting a total catchment area of 19 965.8 $km^2$ with majority 86% (1 061 120) of the inhabit in the rural areas. The zone comprises 1 city administration (Mizan-Aman), 6 Woredas (districts), 246 kebeles (smallest administrative units) (229 rural and 17 urban). Regarding health institution, the zone has 2 Hospitals, 26 health centers, and 182 health posts. There are 50 physicians' and 511 of health professionals of different ranks and 476 health extension workers.[21]

### Study Design

In this study, a qualitative approach, exploratory-descriptive design was employed. This design enables the investigator to explore the phenomena from the perspective of the participant being studied.[22]

### Population and Sampling Technique

This study was conducted among out-of-school adolescents residing in the districts of Sheko, Debub Bench, Guraferda, and Debrework and selected healthcare providers working in the specified districts. Two focus group discussions (FGD) per district, a total 8 FGDs were conducted among out-of-school adolescents; again, 2 in-depth interviews per district, a total of 8 in-depth interviews were made among healthcare providers (MCH coordinator and district health officer).

From each district 2 kebeles (1 urban Kebele and 1 rural Kebele) were randomly selected. At Kebele level, eligible adolescents for FGD discussion were identified with the help of Keble administrator, Health Extension Workers, and

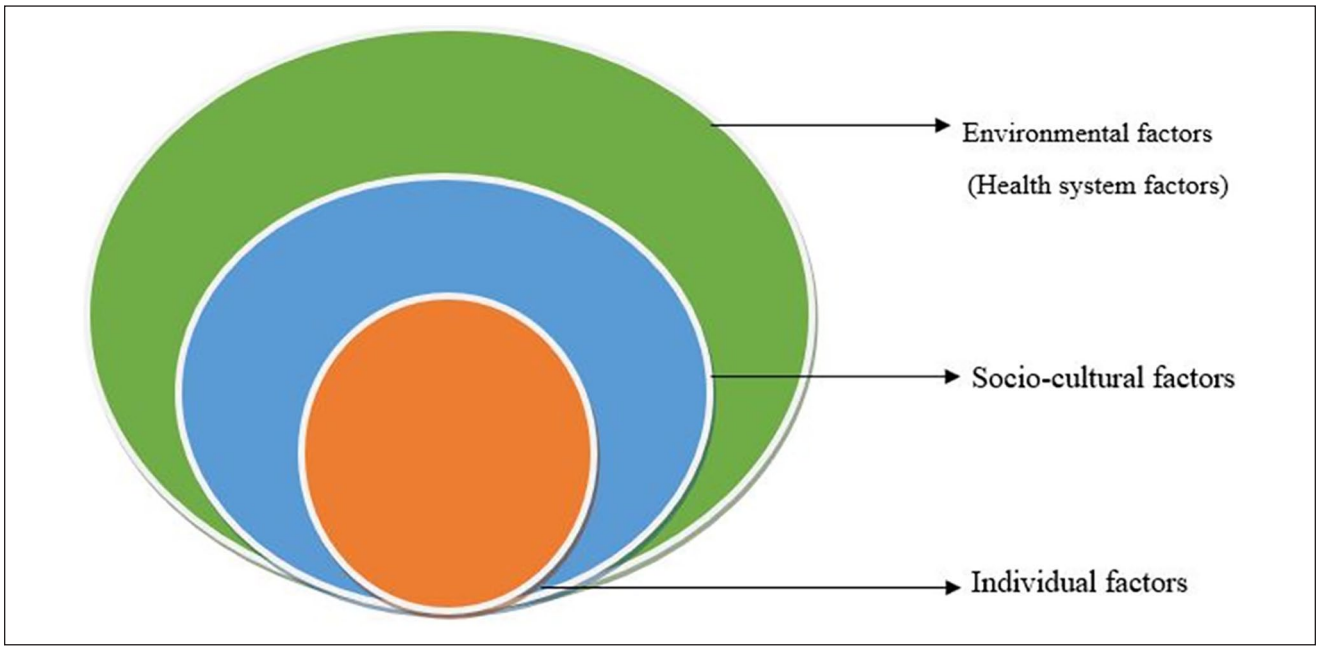


**Figure 1.** Socio-ecological model (based on the work of Stokols (1996).

Ketena (Kebele sub-administration) representative of each Keble. Then, they were screened against the inclusion criterion which includes: being female, age group 15 to 19, and residing in the area at least for 6 months. Adolescents who had active community participation such as being member youth association, engaging in HIV prevention and control program, and involving in different sexual reproductive health (SRH) activities were given priority. Upon securing consent (parental consent for adolescents age < 18), participants were informed both the time and the place where the FGD discussion was going to be held. For the in-depth interviews, district health officers and maternal and child health (MCH) coordinators were purposely selected as they were assumed to be more informative on the SRH service challenges that out-of-school adolescents are encountering.

## *Data Collection Tool and Procedure*

A self-developed FGD guide was used to conduct the FGD discussion. Before the actual data collection, the developed FGD guide was pretested in the districts that were not included in the study. Based on the pretest finding, some modifications were made accordingly. A total of 8 FGDs were conducted among out-of-school adolescents; each FGD discussion was modulated by the principal investigator and 1 public health professional who had experience in qualitative data collection technique was hired as rapporteur. Majority of the FGD discussion topic were focused on SRH service utilization experience, perceived and actual barriers to access SRH service, and SRH service preference. For instance the following question was raised: "what do you think about the challenges that out-of-school adolescents encounter when deciding to use sexual and reproductive health service?" Taking the current COVID-19 pandemic into account, the size of FGD discussants was fixed at most 8 and preventive measures such as use of personal protective materials and physical distancing were applied during the discussions. Since subject matter is sensitive for adolescents, before opening of each FGD discussions, attempts were made to build rapport among the discussants and they were insured that the information they would provide will not be disclosed. Each discussion lasted on average 80 minutes. All the discussions were tape-recorded and notes were taken to guarantee the accuracy of the data. At the end of each session, participants were briefed on the importance of SRH service utilization for adolescents. The 8 in-depth interviews were conducted among health professional working in the local health centers. A self-developed interview guide was used to conduct the interviews. The interview sessions lasted on average 35 minutes and all interview sessions were tape-recorded.

## *Data Processing and Analysis*

The audio recorded FGD discussions and in-depth interviews were transcribed verbatim. Thematic analysis was used. Two investigators (WA & MD) transcribed the audio-recorded in-depth interview data and FGD discussions independently. Then the transcribed data were translated to English by the investigators. The translated data were checked by an independent research assistant to check the quality of the translation. Inductive coding was applied

where themes were derived from the empirical evidences related with this study. Multiple consensus codding where 2 of the investigators (WA & MD) developed codes for each in-depth interview and FGD discussions. Any discrepancies between the coders were discussed until consensus meet. Those codes that could not be resolved by discussion were referred to the third member of the research team (SH) to resolve the discrepancies. Data that could not be agreed up on the consensus meeting were omitted from the analysis. Related codes were combined to form themes. Finally, in presenting the finding, participants' quotes were used to elaborate the umbrella theme being discussed.

### *Trustworthiness*

Trustworthiness of a qualitative study defines as: the extent to which the claimed meanings represent the views of the study participants correctly. The 4 criteria for warranting trustworthiness that comprises credibility, transferability, dependability, and confirmability were insured in this study. To assurance credibility, a member check was made by engaging some of the study participants to assert the correctness of transcribed data and emerging themes as accurately representing their views. A clear description of the technique for participants' selection and thorough report of the research setting was done in order to improve transferability. Method applied for data collection, analysis and interpretation is also taken within the report for dependability. An audit trail comprising of field notes, audio recordings, analysis notes, and coding details were also kept for confirmability.

## Result

### *Socio-Cultural Barriers*

FGD discussion held among rural out-of-school adolescents revealed community-stigma surrounding SRH service and community condemnation of premarital sex hinder them from seeking SRH information and service.

> *"Of course, I understand one may visit health facility for seeking SRH information, even though not anticipating to have sexual intercourse. But, you know, our community may regard you as if you have already indulged in premarital sexual activity, if someone sees you seeking the service. Note that families whose daughter engages in premarital sexual acts are disrespected by the community."* ***(Out-of-school adolescent from rural setting)***

> *"When I think of visiting health facility for SRH reasons, the thing that comes into my mind is what the community talk behind me. Thus, I usually send someone to buy emergency birth control pill from pharmacy rather than visiting health facility by myself. I chose this because once the community defames you; it is really difficult to convince people who you really are."* ***(Out-of-school adolescent from rural setting)***

Some FGD participants both from the rural and urban setting raised their concerns that religious values usually prohibit the use of modern contraceptive methods and open discussion of sexual issues that tends to hinder adolescents' access to basic reproductive health information and services.

> *"In our religion it is strictly condemned to discuss SRH issues with your family or healthcare providers."* ***(Out-of-school adolescent from urban setting)***

> *"I am orthodox Christian, according to our faith, the use of artificial birth control method is considered as transgressing the law of God."* ***(Out-of-school adolescent from rural setting)***

Other out-of-school adolescents from the rural setting complained to have encountered communication barrier between them and the healthcare provider.

> *"When visiting health facility for SRH issue, I usually find it difficult to clearly explain my sexual health matter for healthcare provider, and it would be much more difficult when the assigned healthcare provider don't listen my language."* ***(Out-of-school adolescent from urban setting)***

### *Health System Barriers*

Most adolescents from the rural setting highlighted the challenge of walking long distance on foot to access health facility mentioning that they don't afforded spending much time in accessing SRH service, given the multiple household tasks they are assigned into.

> *"Even the nearest health facility is far from my home, I found it tough to travel a longer distance and get SRH information and service. Imagine what it meant spending several hours out of home for a girl living with her distant relatives."* ***(Out-of-school adolescent from urban setting)***

Adolescents both from the rural and urban setting noted that the judgmental attitude and disappointing remarks from the healthcare provider discourage them from utilizing SRH service and information.

> *"Let me share you what my friend experienced when visiting SRH service. She went health facility to take a contraceptive; however, the healthcare provider assigned by the time was emotional even unwilling to provide the contraceptive for her, criticizing that she was too young to have sex by that time."* ***(Out-of-school adolescent from rural setting)***

> *"A friend of mine once went to health facility to obtain information regarding abortion service. The way the healthcare provider talked to her was unpleasant and she could tell from*

*his facial expression that he was completely uncomfortable with their discussion. Finally, he, impolitely, told her that the service she asked was not available" (**Out-of-school adolescent from rural setting**)*

Adolescents had sex and age preferences they preferred to be treated by female healthcare provider who is around their age. Explaining that they would be more comfortable sharing their SRH issues with young and female healthcare provider.

*"I don't feel comfortable to discuss sexual health issues with male healthcare providers. You know there are girls' things that you don't want to share with men. But, I could freely and honestly discuss all my sexual issues without any reservation with female healthcare providers." (**Out-of-school adolescent from rural setting**)*

*"How could you tell your sexual affairs to healthcare provider who is probably around your mother's or father's age? Healthcare providers by this age may consider you as a little girl who knows nothing about herself. To be frank, I'm fed-up of their long and boring advice, and the surprising thing is that they may not even give you the service you need at the end of their advice." (**Out-of-school adolescent from rural setting**)*

Some adolescents from urban setting also cited financial barrier for not utilizing SRH service from private facilities.

*"Governmental health facilities are usually overcrowded and for this reason, I prefer to see care from private clinic. But, the problem is that service cost in private clinic is too expensive, and I usually don't get the money to pay for it." (**Out-of-school adolescent from urban setting**)*

*"Apart from the high payment they request for the rendered service, private facilities are much better in terms of providing whatever SRH service you need even abortion care without further interrogation as in governmental facilities." (**Out-of-school adolescent from urban setting**)*

During an in-depth interview with district health officers, they stated that there is no targeted program for out-of-school adolescents.

*"There is no organizational support to address reproductive health needs of out-of-school adolescents. As you might have known, there are different health care program targeting in-school adolescents like immunization against cervical cancer, health information about STIs, family planning and etc. But, when we come to out-of-school adolescents there is no dedicated program for them."(**District health officer**)*

*"Through intersectoral approach we are attempting to address the health need of in-school adolescents by collaborating with educational sectors. Nevertheless, we don't have structural means to reach out-of-school adolescents." (**District health officer**)*

## Perceived Legal Barrier

FGD discussion held among rural adolescents revealed that legal restriction against some SRH service, more importantly on abortion service and long acting family planning methods imped them from utilizing the service and make them seek the service from informal institutions.

*"My neighbor once faced unwanted pregnancy that time she was unmarried and decided to terminate the pregnancy and she went for abortion service in the nearby health center. However, the healthcare provider told her that they don't provide the service, unless the pregnancy could seriously affect her wellbeing."**(Out-of-school adolescent from urban setting)***

*"I wish I could have family planning method that can protect me against pregnancy for a long period of time. Nevertheless, I don't think that this type of family planning method is legally allowed for girls in my age."*

*"After rendering abortion service, we provide a range of contraceptive options; surprisingly, some adolescents believe that it is prohibited to use longer term contraceptive by unmarried adolescents." (**Midwife, MCH coordinator**)*

## Inadequate Information Regarding SRHS

Inadequate information regarding SRHS was also identified as another most important barrier to access SRH service among rural adolescents. Adolescents had limited information on what SRH service and where these services are provided. Some rural adolescents also added that they used some SRH service from the information they gained when they were in-school.

*"I don't know which health facilities provide SRH service. No one informs us what SRH service being provided at different health facility. For instance, I want to know my HIV status. But, I don't know whether health facilities provide the service without special reason for e.g. blood transfusion or as a precondition for marriage." (**Adolescent from rural setting**)*

*"When I was in-school there were many occasions to get SRH service and information. I was a member of girls' club and had an opportunity to learn about SRH. But, this time there is no way that I could hear about these things" (**Out-of-school adolescent from rural setting**)*

*"Indeed, adolescents who don't attend school, may not have information on contraceptive. I have encountered many adolescents coming for abortion service in our health center. When I ask them why they didn't use emergency contraceptive, they often mention that they don't have any knowledge about it". (**Nurse, MCH coordinator**)*

### *Low Parent-Adolescent Communication*

Most adolescents both from rural and urban setting confirmed that there is a poor habit of communication between adolescents and their parents when it comes to sexual health matters. Thus, adolescents are ashamed and fear to ask for parental approval when intending to visit health facility for SRH purposes. Thus, adolescents usually chose to remain silent regarding their sexual health issues or discuss to close friends who themselves have limited information, rather than engaging their families because they fear of being assumed of being sexually active.

> *"My friend once experience discharge from her body and she was afraid of telling her parents; fearing that they would take her as if she had already engaged in sexual activity. That time, seeking care from health facility was impossible, as there is no place that she can go without having her parent's permission, for this reason the only thing that we could do was buying medication from the local pharmacy." (**Out-of-school adolescent from rural setting**)*

> *"My mother sometimes talks to me about menstrual hygiene; however, she has never discussed to me about birth control methods, sexual transmitted disease and other things that we are talking now, but warning me not to get involved in sexual activity." (**Out-of-school adolescent from rural setting**)*

## Discussion

The current study was intended to explore challenges encountered by female out-of-school adolescents in accessing SRH service in Bench-Sheko Zone, Ethiopia. The study employed socio-ecological model to help comprehend the diverse challenges operating at the individual, family, social, and organizational/health system level. Accordingly, the study identified various clusters of challenges which are related to socio-cultural factors, health system factors, perceived legal factors, SRH literacy, and adolescent parent communication.

The study established that rural adolescents were largely influenced by socio-cultural factors which impede adolescents' access to SRH service and information. Adolescents mentioned that they don't want to be seen utilizing SRH service, as premarital sex is deeply condemned in light of their societal perception and religious norms; and this finding of the study is supported by previous studies which suggested social stigma, fear of loss of cultural identify, and religious restriction of contraceptive usage as a major barriers to utilize SRH service by female adolescents.[23-26] This implies that adolescents' health service utilization behavior, particularly SRH service utilization behavior is heavily influenced by the cultural and religious norms of the community they live in. Thus, adolescents SRH programs and strategies need to broadly engage local community and religious leaders in the planning and implementation of programs.

The other cluster of challenge was related to the health system, where adolescents raised several health system related factors for not accessing SRH service. For instance, adolescents from rural area mentioned that the long traveling distance from home to the nearby health facility impedes them from accessing SRH service. Similarly, physical inaccessibility as a barrier to adolescents SRH service utilization was evidence by other previous studies.[1,2] On the other hand, adolescents from urban areas cited financial constrains as an excuse for not accessing SRH service in private health facilities. Studies suggest that despite the high service cost, adolescents often prefer seeking care from private health facility.[27] Given this fact, there should be strategy for extensively engage private facilities in adolescents' SRH service delivery and financial arrangement to be made for service cost exemption by the government.

Another most important health system barrier to SRH service utilizing was unfriendly approach of the healthcare provider. Adolescents both from rural and urban areas complained over the unfavorable attitude of the healthcare provider this claim was indeed substantiated by other studies, where the judgmental and unfriendly approach of the healthcare providers deter SRH service utilization.[28-31] The interesting finding of this study was that some adolescents had age and sex preference; they mentioned that they would prefer SRH service to be provided by female healthcare workers who are young (around their age). This finding is in line with other previous studies.[32] This implies that female adolescents may find it harder to share their SRH concerns to male and adult healthcare providers; hence, it is essential for SRH program planners to take the sensitivity of the matter into consideration and assign young and female healthcare providers in SRH service areas.

Although there is no any legal and policy barriers which prohibit adolescents from utilizing any SRH service other than comprehensive abortion care, some adolescents in this study perceived legal restriction against the usage of long acting contraceptive methods, when it is come to adolescents. This apprehension about being prosecuted for using long acting contraceptive was also reported by other similar studies conducted among female adolescents.[33,34]

Some adolescents from rural area admitted to have inadequate information regarding SRHS, stating that they don't even know whether these services could be provided at health center, hospital or private facilities. It is very important for adolescents to have adequate information regarding SRHS availability. Studies suggest that limited sexual and reproductive health literacy among adolescent results in poor SRHS utilization and ultimately adverse reproductive health outcome.[35]

In this study, adolescents reported to have had poor communication regarding SRH issue with their parents.

Low parental communication could be another most important factor hampering adolescents' SRHS utilization as adolescents with low parental communication may not have sufficient information regarding the SRHS availability; besides, they may not get their parental approval in seeking the service they intend. Previous studies indicate that in Sub-Saharan Africa the habit parental communication regarding SRH issue is very limited and adolescents were not informed about SRH matters, as their main source of information are friends.[36]

## Conclusion

Above all, the study revealed several challenges hampering SRHS uptake by out-of-school adolescents in Bench-Sheko Zone. Which include socio-cultural barriers, health system barriers, perceived legal barrier, inadequate information on sexual reproductive health service, and low parent-adolescent communication. These finding suggest the need to engage community influencers (religious leaders, community leaders, and elders) in overcoming the socio-cultural barriers influencing SRHS utilization by adolescents. Program planners and policy makers have better make an effort to create adolescent friendly environments in SRH service areas. Furthermore, implementing community-based awareness raising programs, parental involvement in SRH programs and encouraging parent-adolescent communication on SRH issues could improve SRHS utilization by female out-of-school adolescents in the study area.

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### Authors' Contributions

WA and SH initiated the study, developed the tool, and with MD and LG supervised the data collection process, and carried out the analysis, interpret the finding, and wrote the final paper and manuscript based on the journal criteria.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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### Ethical Consideration

Ethical clearance was obtained from the internal ethical review board of Mizan-Tepi University, reference number Ref HSE/00329/2020. Official permission letter was also obtained from Bench-Sheko Zone administration health office. After explaining the purpose of the study written consent was obtained from each of the study participant. Written parental/guardian consent was obtained from study participants that were minors. Confidentiality and anonymity had been ensured throughout the execution of the study by taking only the required information without using the name of the participants.

### Data Availability

The datasets collected and analyzed for this study is accessible from the corresponding author and can be gotten upon sensible ask.

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