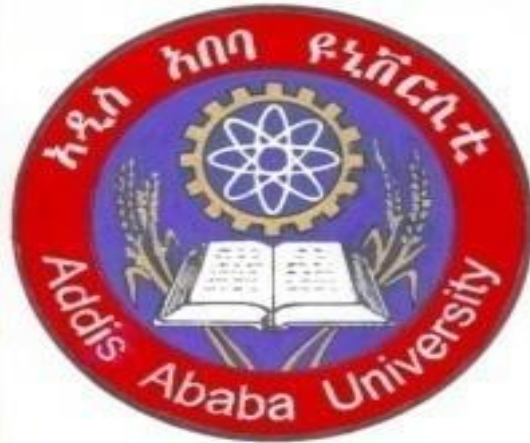


**ADDIS ABABA UNIVERSITY COLLEGE
OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH**



**Barriers to Meaningful Adolescent Engagement in Sexual and Reproductive
Health Programs in North Shoa Zone, Amhara Region, Ethiopia:
the Application of Socio-Ecological Model**

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DECLARATION

I the undersigned, declare that this thesis is my original work, has never been presented in this or any other university, and that all the resources and materials used for the thesis development are recognized and cited, and people who involved in are acknowledged.

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Abbreviation and acronyms

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
DFID's	Department for International Development
EASE	Engaging Adolescents in Sexual Health Service in Ethiopia
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
ICPD	International Conference on Population and Development
MAYE	Meaningful Adolescent and Youth Engagement
MAE	Meaningful adolescents' engagement
NGO's	Non-Governmental Organizations
PAR	Participatory Action Research
SGD	Sustainable Goal Development
SRHR	Sexual and Reproductive Health and Right
SRH	Sexual and Reproductive Health
TYPE	Typology of Youth Participation and Empowerment Pyramid
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
YPAR	Youth Participatory Action Research

Abstract

Introduction: - Adolescents are at a critical age, for sexual and reproductive health, since they are undergoing physical, social, and biological changes that may increase their vulnerability to sexual and reproductive health problems. Because of the sexual and reproductive health burdens in this age group, their engagement in their own needs and programs was advised to reduce this burden. However, despite the presence of guidelines in front, meaningful involvement of adolescents has not been observed. This necessitates further research to understand the hurdles impeding adolescents' engagement in sexual and reproductive health programs.

Objective: - The general objective of this study is to explore barriers to meaningful adolescent engagement in sexual and reproductive health programs at different levels from individual to institutional level by applying a socio-ecological model.

Methods: - The study was conducted at North Shoa Zone Amhara region in Kewet woreda and Shewarobit town. The study used a qualitative method. A total of 16 FGDs with participants (24 at Yellen, 20 at Abay Atir, 44 at Shewarobit with repeated five consecutive days, and 4 FGDs at Shewarobit for repeated two consecutive days) were conducted with both in-school and out-of-school adolescents, 27 key informant interviews were conducted with adolescents, parents, teachers, youth club leaders, and health officials, and SRH program administrators. Interview guides were used for data collection. The socio-ecological model was used to identify the barriers at individual, family, community, and institutional levels. Data were analyzed abductively using framework analysis and Atlas Ti version 9 soft wares was used for analysis.

Result: - The finding of this study showed that adolescents' engagement in SRH programs is inadequate merely with the focus on the implementation of a program. It was noted that there was gender variation in their engagement, as well as a mismatch between what is taught and what is found at the practical level. Also, the engagement status of out-of-school adolescents was found to be more than that of in-school. This paper further explores barriers that inhibit meaningful adolescent engagement at multiple levels. Lack of awareness, lack of skill on how to engage, belief about sexual, and reproductive health issues, and individual behavior were identified as individual-level barriers. Lack of

support, discouraging environment, and poor awareness were articulated as family, and peer-related barriers, norms of viewing sexual and reproductive health issues as taboo and young people as unequal to adults were mentioned as community-level barriers, and institutional-level barriers were related to lack of manuals, structures, inadequate financial support, and Tokenism.

Conclusion and recommendation; Barriers to meaningful adolescent engagement in sexual and reproductive health problems have occurred at multiple levels. Therefore, the barriers that have been explored at each level in this study shall be emphasized to develop and implement meaningful engagement of adolescents in sexual and reproductive health. Aside from adolescents, considering the family to institutions is vital because adolescents' decisions are mostly influenced by the environment in which they live, such as their parents, community, and institutions. Institutions have to build institutional support for meaningful adolescent involvement, including capacity building for adolescent participants. Young individuals (adolescents) should be assigned a certain number of posts, and protocols should clearly outline their tasks, expectations, and performance metrics. Capacity building at each level shall be in place.

Keywords: Adolescents, SRH program, Barriers, meaningful engagement

1. Introduction

1.1 Background

The World Health Organization (WHO) defines adolescents as periods of specific health and developmental needs and rights when transition from childhood to adulthood occurs, from age 10–19-year-olds which is a critical age for life-altering decisions (1,2). Globally, this age group makes up 1.3 billion people of the world population and most of all the 2021 World Population Prospect states that 23% of sub-Saharan African countries are 10-19 years old (3,4). In Ethiopia, young people 10-24 are considered the single largest section of the population accounting for 33% of the total population ("Adolescents aged between 10 and 19 years old are also included in the largest section.") (5).

The WHO reports that adolescents in this age group (10–19-year-old) face numerous sexual and reproductive health issues, such as early and unwanted pregnancy, sexual coercion, intimate partner violence, lack of education and information, lack of access to health services, gender inequalities, and harmful traditional practices (e.g. FGM, child marriage), STIs, including HIV (6). Available evidence shows such SRH problems widely prevail in SSA (7–9). To address these problems, the Nairobi Summit on International Conference on Population and Development (2019) reinforced adolescents' participation in matters that affect them to meet their educational and health services needs, to enable them to deal positively and responsibly with their sexuality, and also the global strategy for children, women, and adolescents (2016-2030) suggests that recognizing adolescent rights, potential, and involvement can help achieve sustainable development goals (10,11).

In 2018, Global consensus was made in the presence of more than 170 organizations worldwide on meaningful engagement where agreed to be considered as “An inclusive, intentional, mutually respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people’s ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and world.”(12).

In this regard, Ethiopia has developed the Adolescents and Youth Health Strategy (2016) which aims to involve adolescents in health programs to play an active role in decision-making regarding their issues (13). As a result, the strategy promoting adolescents and youth participation in key decision-making around policy, advocacy, budgeting, planning, research, and implementation process as high impact intervention for improving adolescents and youth health. Similarly, the 2021-2025 Adolescent and Youth Health Strategic Plan was launched and implemented with key recommendations to boost adolescent engagement and integration in Ethiopian SRH services (14).

In 2018, the Federal Ministry of Health (FMOH) and partners developed national implementation guidelines to meaningfully involve adolescents in SRH (15). This guideline provides evidence on adolescent and youth engagement as well as strategies that guide FMOH and its stakeholders on the engagement of adolescents in the implementation of national and youth health strategies. The approaches for engagement included in the guideline enable adolescents and young people to actively contribute to their health. Since the development of the guideline, local and international NGOs have provided space for adolescents and young people to engage in programs to improve and maintain their health (16).

As a result, meaningfully engaging adolescents in their decision-making enables understanding the needs of adolescents and developing program and policies which is more effective and allow efficient use of resources. Most of all, especially in countries such as Ethiopia which have a high demographical population of adolescents, their engagement is beneficial for them as well as for the community because adolescents are in better positions to represent their peers due to shared experiences, language, and perspectives and more importantly they are more primed for engagement beyond their family which could be more protective for their self (17). On the other hand, their disengagement may increase their vulnerability to high-risk behaviors such as violent behaviors, physical harm, substance abuse, and risky sexual behaviors that can affect their well-being as well as the community (18).

This study was carried out to provide new policy-relevant knowledge that can help in understanding the barriers to meaningful engagement of adolescents in SRH programs which can help to improve and develop strategies considering the barriers. It presents the findings on adolescents' engagement in SRH programs from the perspective of adolescents as well as adults that influence the decision of SRH programs of adolescents (parents, community, teachers, government officials as well as programmers) while examining the areas of variation in gender, age, schooling and setting through applying the socio-ecological model.

1.2 Statement of the problem

For a program involving adolescents in SRH to be successful and responsive, it is essential to actively involve them in the development, implementation, monitoring, and evaluation of the SRH program (18). Not only does this facilitate the success of youth-oriented policies and programs, but it also gives young people an opportunity to cultivate leadership abilities that can build their self-confidence and sense of capability (19).

Adolescents and youth engagement in the SRH program is widely recognized by adolescents and youth engagement guidelines as a useful measure for improved outcomes of the Government and NGO programs in adolescents and youth health (15). Even though there have been several adolescent and youth sexual and reproductive health programs implemented in Ethiopia, the engagement of adolescents in these programs has been limited and token (20). Studies from eastern African countries revealed that adolescents' involvement in sexual and reproductive health and rights programs remains only as a beneficiary rather than stakeholders and lack of practical implementation strategy has been complained (21,22).

A study conducted in Ethiopia to assess adolescent and youth sexual reproductive health needs revealed that young people are less likely to contribute to their well-being and development due to inadequate government commitment and implementation of national youth engagement strategies (23).

To understand the reason why adolescent engagement has not been prominent, the need for further research was recommended. Therefore, this study aimed to explore barriers that affect meaningful adolescent engagement in their sexual and reproductive health problems, and services (24).

To describe the barriers at different levels, a socio-ecological model has been used. Through this model, social determinants are well understood on how an intersecting web of factors increases the likelihood of having a powerful and equity lens and it is vital to have a more holistic understanding of how identity, system, and power influence outcome or engagement (25).

1.3 Significance of the study

The findings from this study will primarily be used as input for policymakers in various sectors including local and international non-governmental organizations (NGOs) working on adolescents, to work on how to address the barriers to meaningful engagement of adolescents in SRH programs.

It will also serve as a starting point for understanding the current environment in the area regarding engagement that can meet the needs of adolescents and the effectiveness of programs. Furthermore, the findings of this study will help programmers, decision-makers, and academia to use evidence-based approaches. Additionally, this can help adolescents understand the barriers to their engagement and how to best position themselves for success in various contexts. Finally, it will serve as a basis for further study in the area of meaningful engagement.

2. Literature Review

2.1 SRH Program

The SRH Programme ranged from providing adolescents with education and awareness on health, sexuality, gender norms, and HIV to youth governance and organizing, as well as youth participatory research and evaluation. Information, education, and communication/behavior change communication (IEC/BCC); peers; youth centers; plays; theater; and community involvement of parents and religious leaders were all popular communication/outreach aspects (27). The late-aged teenagers (15-19 years old) were primarily targeted in SRH programs. Adolescents from 10 to 14 were less frequently targeted. All SRH programs have stages which include planning, implementation, monitoring, and evaluation (26).

2.2 Meaningful adolescent engagement

It has been three decades since a UN agreement acknowledged children's right to maturity-based participation in all choices that affect them (28). After a few years, in 1994, the International Conference on Population and Development (ICPD) specifically recognized young people's right to participate in programs that promote sexual and reproductive health (29). This contributed to the development of several definitions of youth participation. The concept of "meaningful" participation—defined as young people actively taking part in all stages of the design, implementation, and evaluation of laws, programs, and services that affect their lives—has received a great deal of attention (27). Further, it includes a long-term, active, and empowered partnership with youths as stakeholders, problem solvers, and change agents in any programs that actively focus on others (30).

In the same way as the national adolescents and youth health strategy, adolescent and youth engagement in health is defined as the “active participation of young people on equal terms with adults in designing, planning, implementing, monitoring and evaluating of health programs, policies, and interventions” which is used for this study (13).

2.3 Adolescent Engagement Models

Adolescents should be engaged in different phases of a program from designing to implementation and also monitoring and evaluation. Since adolescent engagement is dynamic different levels or types of engagement might appear depending on the program or intervention, policy, and social, cultural, and political contexts (31,32). Different levels and types were developed as Hart's Ladder of Youth Participation(33), Wong's TYPE Pyramid (34), flower of Participation (35), and DFID's Three Lens Approach (36) to Youth Participation and Engagement. All emphasis is on sharing power with youths in decision-making by avoiding tokenism to reach the level of youth engagement. Hart's Ladder of Participation (1992) has eight ladders of participating young people and depicts participation as a continuum, from manipulation and tokenism the first three rules (which do not constitute meaningful engagement), to higher levels of participation of the rest five rules where young people initiate, lead and share the decision with older people is where engagement can be achieved (32,33). Wong's TYPE (Typology of youth participation and empowerment) pyramid is depicted as a "V" with greater adult participation and lower youth control on the left and less adult participation and greater youth control on the right, with shared "pluralistic" adult-youth control centered at the apex of the pyramid. Wong's model argues with Harts's model in that Hart stated that the appropriate rung of the ladder depends on the age, abilities, preferences, and tasks of the youth; however, shared power is ideal for youth empowerment and development regardless of the condition due to Wong's model which also stated by DFID (2007), taking youths as beneficiaries, partners, and leaders where it considers youths as a targeted group and adequately formed as a beneficiary despite a series of aspects (34).

Therefore, this study considers the 'flower of participation' model which is also adopted in the national adolescents and youth engagement guideline as it is a technical guideline for youth engagement developed by Choice for youth and sexual behavior. This model directly adopts Treseder's five types of participation as five 'petals' and reintroduces Hart's three forms of non-participation which are manipulation, decoration, and tokenism as 'leaves'.

Likewise, it is usually useful in evaluating an organization's level of youth engagement and serving young people to understand their position and potential roles in engagement (35).

2.4 Rationale for Meaningful Adolescent Engagement

Adolescents have fundamental rights to engage in sexual and reproductive health programs as international conferences in population and development (29). Therefore, adolescents have the right to be engaged in SRH programs which in case related to them. Besides being the right of adolescents, the WHO guidelines emphasize that achieving the ambitious SDG is not possible without the meaningful engagement of adolescents which needs their need to be reflected and recommended for the success of a program in their policy briefs (37). In addition, engaging adolescents benefits not only adolescents but also has unrealized benefits of socioeconomic growth and health that can bring positive results for adolescents themselves, for adults, organizations program objectives, social change, and development (38,39). Operational research on youth participation conducted in Ethiopia by the ASK program revealed that adolescents who participated in peer educators in SRH programs gained confidence, allowing them to speak in public places and discuss SRH issues with their parents, thereby helping young people realize their full potential for health, wellbeing, and their right to health (36). In addition, a formative study conducted in Zambia showed that engaging young people in the design of interventions found important in tailoring user needs which can be acceptable to adolescent youth populations and feasible to implement (40). Thus, all of the benefits of adolescent and youth engagement can be proved in HIV programs that meaningfully engage adolescents by using three lens approaches (beneficiary, partner, and leaders) which are used to improve the efficacy of the effort for service demand including testing, adherence and involving HIV prevention services (41).

In conclusion, despite the recognition of these benefits, adolescents and youth participation in SRH programs should be encouraged to bring a better understanding of their needs and provide a better outcome in adolescents' sexual and reproductive health.

2.5 Current practice in the engagement of adolescents in SRH programs

Meaningful engagement of adolescents in SRH programs can improve the quality and effectiveness of the program which can in turn lead to improvement in the development outcomes. In 2018, nearly 250 organizations pledged and endorsed implementation in alignment with accountability and monitoring agreements for meaningful adolescence and youth engagement (42). Based on the 2021 meaningful adolescent and youth engagement accountability report there is no adequate guidance on how to accompany MAYE principles, Thus, youths are emerging both as participants and leaders in adolescents' youth sexual and reproductive health all around the world (43). However, based on the 2018 global online survey which was conducted to present the current state of evidence and experience of youth participation approaches in HIV and sexual and reproductive health decision-making, policies and programs mentioned that there is improved outreach participation and representation of affected communities by young peoples, but reflected concerns issues related to age discrimination, tokenism or failed spaces for participation as possible reasons (44,41).

In Sub-Saharan Africa, youth networks have been mentioned as leading HIV/AIDS response policy and program initiatives. The youth network also contributed to the development of the Global Strategies for Women's, Children's, and Adolescent Health 2010-2015 and 2016-2030, as well as the 2020 HIV Prevention Roadmap (45). A study conducted in Malawi reported that there are various forms of adolescent engagements such as youth clubs in school, communities, or donor projects which enable adolescents to participate in sexual and reproductive health activities but their engagement is more often token (46). Nerveless, female adolescents, people with limited formal education, and those living in rural areas are not getting equal access to engaging in SRH programs due to the absence of a favorable environment (46,47). A study conducted in 7 African countries (Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda) under Access Service and Knowledge showed that the extent of adolescent engagement in adolescent sexual and reproductive health programs is limited (22). Which, Ethiopia is one of the countries where FMOH of the country made policy commitments to support and facilitate youth engagement and ownership in health planning and programming at all levels but many adolescents are unaware that this policy even exists (46).

In conclusion, there is some engagement of adolescents and young people in program planning, implementation monitoring, and evaluation, but this is not fully meaningful which is more often token and limited. But in the case of engagement, once adolescents are given a platform to exercise their participation in decision-making, they have the power to shape themselves as well as their community.

2.6 Barriers to meaningful engagement of adolescents in SRH programs

There are a few research examining the factors that contribute to barriers to the engagement of adolescents in SRH programs worldwide, but to the researcher's knowledge, there is no study conducted in Ethiopia. Identifying the barriers to the engagement of adolescents in SRH programs can provide a clear insight into how programs should be designed, implemented, and monitored (22).

A study conducted in Kenya on late-age adolescents (15-19 years old) aims to explore factors affecting meaningful youth participation in SRHR programs where a mismatch between the aspirations of young people to be active decision-making agents and the actual roles and responsibilities assigned to them find to be different and the factors differ from individual to community level (21). The individual barriers are found to be related to lack of knowledge and ignorance by adolescents, low educational attainment, lack of skill or technical knowhow, feeling of inferiority, undiscipline, and prone to substance abuse which all render them unfit to perform their roles which is assigned/given to them. In the same way, findings from the youth engagement networks environmental scan study stated that adults don't see adolescents' contributions as valuable adults don't consider them as capable of leadership or don't have the skills to effectively undertake assigned tasks (26).

In 2021, an environmental scan study of youth engagement networks was conducted with a review of various literature and found that families' attitudes towards the program were one factor that could prevent adolescents from participating in sexual and reproductive health programs. It was also stated that "Additional education and empathy are needed to help families feel comfortable with young people's involvement" and that parents should have a positive attitude towards the program (26). Furthermore, because families have a strong influence on adolescents' sexual and reproductive health decisions, their decision to participate in SRH would be influenced (44).

The findings from the youth engagement network environmental scan, religious teachings, the taboo of adolescents discussing SRH issues, and interclan supremacy/nepotism were a factor that are preventing adolescents from engaging in sexual and reproductive health programs (26). This finding was also supported by a study from Malawi on adolescents' participation, girls who are actively involved in SRH issues are often considered or labeled as 'prostitutes' by the community members (49).

The other factors were organizational such as lack of guidelines and structures on how to engage adolescents at different levels, lack of resources, and political interference which makes it difficult to recruit adolescents who can represent the diversity of racial, ethnic, and socioeconomic backgrounds presented in the studies conducted in Kenya as well as in the report of an accountability survey of the global consensus statement on meaningful adolescents and youth engagement (21,26,49).

The study findings on barriers to adolescents' participation described above primarily focus on late-aged adolescents (15-19 years) and do not examine variance in barriers to adolescent engagement by educational status, age, or gender. Focus on the viewpoints of adolescents and experts rather than both adolescents and adults, who impact adolescents' decision roles at different levels such as peers, teachers, and families.

2.7 Socio-ecological model

The SEM was developed by a number of prominent researchers such as Urie Bronfenbrenner's ecological system theory (1979) which mainly focuses on the relationship between the individual and environment as well as other scholars focusing on the level of influence on health behaviors (50). The model helps to understand and address health and social issues by examining how these various levels of influence shape individuals' behaviors and opportunities. The individual level focuses on personal characteristics, knowledge, attitudes, and behaviors that impact health and well-being. It recognizes the influence of individual factors such as age, gender, education, and genetics (51).

The interpersonal level examines the relationships and interactions individuals have with their immediate social networks, including family, friends, peers, and coworkers. Interpersonal factors such as social support, communication, and social norms significantly impact individual behavior. The community level considers the broader community and the physical and social environments in which individuals live, work, and socialize. The institutional/organizational level looks at the institutions and organizations that individuals interact with, such as schools, workplaces, faith-based organizations, and community-based organizations. Organizational policies, practices, and resources can influence individual behaviors and create supportive environments (50).

By considering the multiple levels of influence, the socio-ecological model provides a holistic approach to addressing health and social issues. It highlights the need for interventions and policies that target multiple levels simultaneously, recognizing that changes at one level can have cascading effects across other levels of influence. Therefore, socioecological models have been developed to consider influences of individual factors such as knowledge, and one recent study looked at how SEM could be used to study the behavioral influence on community engagement in a community health program which showed the importance of the socio-cultural environment on community engagement. This study considers the impact of economic, technological, political, physical, and individual factors to see their influences on community engagement activities (51). To the best of the researcher's knowledge, there has been no exploration to date of socioecological influences on barriers to meaningful adolescent engagement in the SRH program.

This thesis therefore addresses the barriers to the engagement of adolescents in SRH programs in Ethiopia. It also addresses the gap in the current knowledge by developing a socio-ecological model of adolescents' engagement in SRH programs to identify barriers to such engagement. Such an understanding holds the potential to look beyond individualized conceptualizations of behavior and consider a multitude of social and cultural influences. This knowledge can then be used to develop multi-faceted and multi-layered solutions to tackle the barriers to adolescents' engagement in SRH programs. Therefore, The work of different scholars has been used, modified, and evolved with revision on the levels and for this study, SEM was used through modifying the SEM developed by the Center for Disease

Control and Prevention (CDC) which recognizes that individual behavior and choices are influenced by multiple levels of influence, including interpersonal relationships, community factors, societal norms, and institutional contexts.

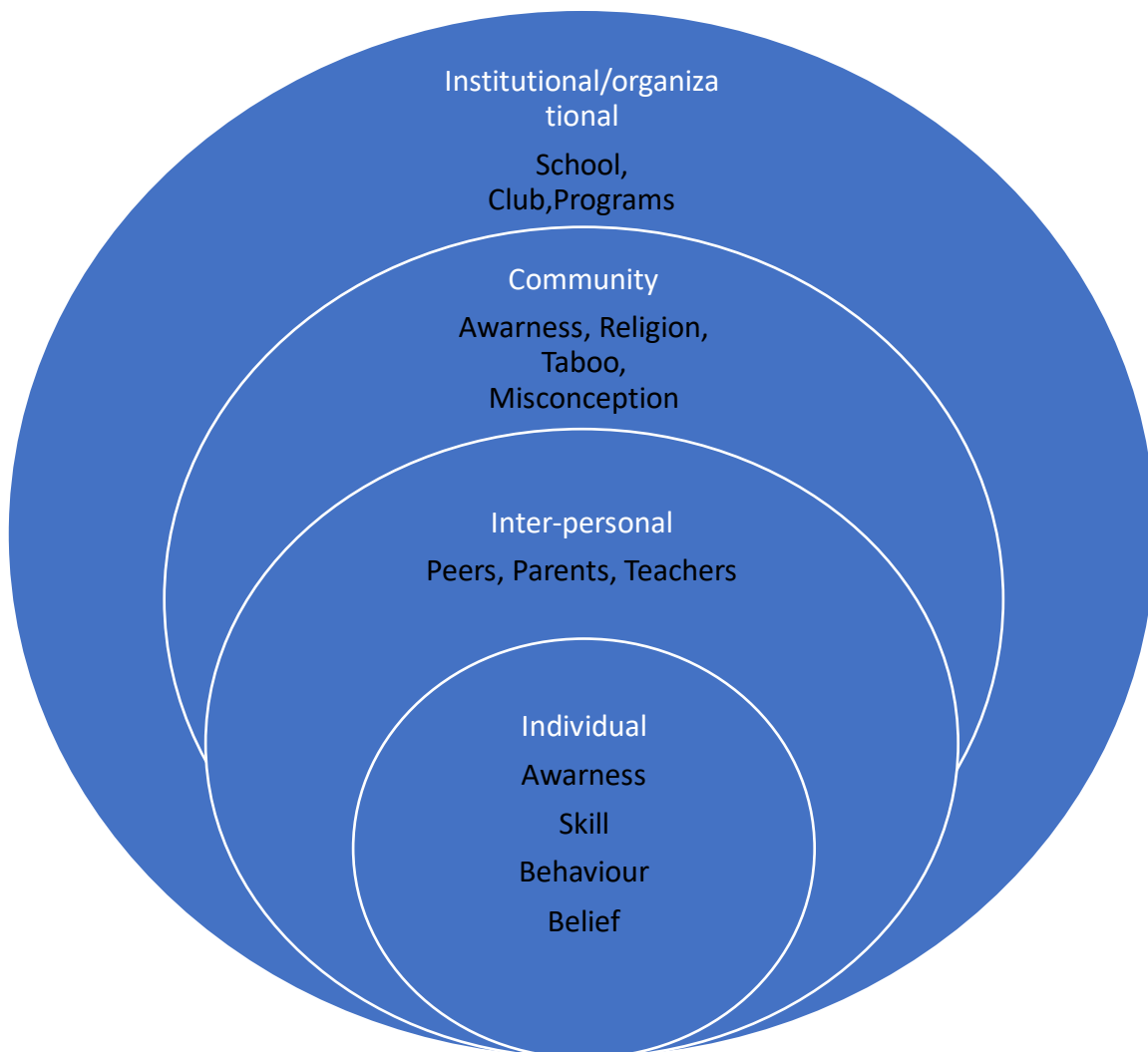


Figure 1. Socio-ecological model for adolescents' engagement in the sexual and reproductive health program. (Conceptual framework Adopted and modified from CDC)(50)

3. Objective

3.1 General Objective

- To explore barriers to meaningful engagement of adolescents in sexual and reproductive health programs in the North Shoa zone, Amhara region, Ethiopia.

3.2 Specific Objectives

- a) Explore individual-level barriers to meaningful adolescent engagement in SRH programs in Kewet woreda, North Shoa, Amhara region, Ethiopia.
- b) Explore Interpersonal level barriers for meaningful adolescent engagement in SRH programs in Kewet woreda, North Shoa, Amhara region, Ethiopia.
- c) Explore Community-level barriers to meaningful adolescent engagement in SRH programs in Kewet woreda, North Shoa, Amhara region, Ethiopia.
- d) Explore Institutional-level barriers to meaningful adolescent engagement in SRH programs in Kewet woreda, North Shoa, Amhara region, Ethiopia.

4. Method

4.1 Study area and period

The study was conducted in Shewarobit town and Kewet woreda of North Shoa zone, Amhara region, Ethiopia from February to June 2023. North Shoa is one of 12 zones of the Amhara region bordered by the Oromia region in the south and west, south Wollo in the north, and the Afar region in the east. According to the Ethiopian Statistical Service 2022 report, the estimated total population in the North Shoa zone was 2,100,331 where 1,046,706 (50%) of female. The largest ethnic group is Amhara with orthodox predominance followed by Muslims (52). There are six hospitals and ninety-two health centers in the area. Its largest population centers are Debre Brehan, Ankober, and Shewarobit.

For this study, Shewarobit town and Kewet woreda were selected from North Shoa because of representation with various socio-cultural characteristics, where we get the urban characteristics from Shewarobit town, rural from Yellen and pastoral characteristics from Abay Atir (which are located 27km and 16.4km from Shewarobit town, respectively). The study area's economy is mostly based on rain-fed agriculture. The northern display zone climate ranges from desert lowlands in the south, west, and east to cold high mountain regions in the center, with dramatic temperature and rainfall ranges (53). The total estimated population of adolescents in Shewarobit town is 8,119 (10-14 years of age) and 7,977(15-19 years of age) also in Kewet Woreda, it is estimated to be 14,192 (10–14 years) and 10,070. (15-19 years) (Based on the 2021 North Shao administrative annual report).

Kewet Woreda has 34 different levels of health facilities with three youth-friendly health services in Abay Atir, Tere, and Yellen health centers, while Shewarobit town has eighteen health facilities in total, one health center with one youth-friendly service in the health center. There are also 50 schools in Kewet and 22 schools in Shewarobit town. Two primary schools from Yelen and Abay Atir, one secondary school in Shewarobit, and two and four youth clubs in each area of Shewarobit town and Kewet Woreda were identified respectively. There is one Health office, adolescent and youth office, youth and sports office, and women's and children's office in each wet woreda and shewarobit town. (From Shewarobit and Kewet woreda administration office).

An International Non-Governmental organization called Amref Health Africa has been actively working on the adolescent and youth sexual and reproductive health in the North Shoa Zone for almost a decade and currently implementing a project called "Power to Youth" as part of the North Shoa project, along with other projects in the area. The "Power to Youth" program is funded by the Dutch government which is led by Amref Health Africa with three local civic partners Youth Network for Sustained Development (YNSD), Hiwot Ethiopia, and Fana Addis Tiwulid Ethiopia. The Power to Youth program is a five-year initiative that aims to ensure that young people are meaningfully included in discussions and decisions, particularly those concerning adolescent girls and young women's sexual and reproductive health and rights. The program aims to improve youth-led and focused advocacy and accountability in relation to unintended pregnancy, sexual and gender-based violence, and harmful practices such as child marriage and female genital mutilation/cutting by increasing the participation of young people from a variety of backgrounds and groups in political and civic space (20).

There is an active research project in Kewet Woreda and Shewarobit town called Engagement of Adolescents in Sexual and Reproductive Health (EASE) implemented by Addis Ababa University joint with Trinity College Dublin, Ireland. The EASE project aims to advance the current understanding of meaningful adolescent participation' within sexual and reproductive services in the North Shoa Zone, Amhara region of Ethiopia. As a result, the findings of this study will be used as input for the project to develop a model of best practice for engaging adolescents in sexual and reproductive health considering the barriers (54). Similarly, the study includes youth clubs which are the focal points of power to youth projects, allowing the study to explore program characteristics of barriers to adolescent engagement.

4.2 Study design (approach)

A qualitative study with an abductive approach and framework analysis was conducted. This method allowed the researcher to gather detailed information and insights from participants, enabling a deeper exploration of the topic. According to Nichola et.al Framework analysis was selected for this study because it can be used to manage large data sets while obtaining a holistic descriptive overview of the entire data set. It also enables constant comparative techniques through the review of data in different groups. The study approach enabled the researcher to gain an understanding of the research topic and draw meaningful conclusions (55).

4.3 Selection of study participants

The study involved adolescents aged 10-to-14 years and 15-to-19 years, as well as key members of various youth and adolescent stakeholder groups such as parents, teachers, community leaders, woreda-level health officials, youth club leaders, and SRH program administrators. These participants hailed from Shewarobit town and Kewet Woreda, North Shoa zone. The researcher selected both in-school and out-of-school adolescents to gain a deeper understanding of both environments and achieve the research objectives. Additionally, 12 parents (Four individuals were selected from each site, ensuring maximum variation in terms of educational status and income), 6 teachers (Two individuals from each site were selected based on their role in fostering adolescents' engagement in the school), 4 youth club leaders (Individuals who have sufficient experience and knowledge of youth clubs were identified.), 2 community leaders (Individuals who were identified as influencers in the community.), 3 health officers (Individuals from each site who were responsible for SRH programs), and 2 program administrators (Individuals who carry out a program within a specific geographical region.) were planned to be included as key stakeholders who contribute to adolescent engagement.

To recruit participants, the principal investigator took several steps. Firstly, school directors and youth club coordinators were contacted to explain the purpose and process of the study. During these discussions, the investigator gathered information about teachers, youth club leaders, and SRH programs currently active in schools and youth clubs. Then, in collaboration with school directors and youth club leaders, adolescents were selected

from two primary schools, one high school, and four youth clubs. The participants were allocated based on age, sex, and schooling type, with male and female participants from both early (10-14) and late (15-19) age groups in each sex and age group. Additionally, participants were allocated based on their schooling type, with some being in-school (enrolled in Yellen and Abay Atir primary schools, Shewarobit High School, and Charie Elementary School) and others being out-of-school (members of youth clubs in Shewarobit town and Kewet Woreda), with one youth club from Abay Atir, one from Yellen, and two from Shewarobit being included based on program implementation areas which was the suggestions of the school directors and youth club leaders.

Initially, 120 adolescents were planned to participate in FGDs, while 29 participants were planned to participate in KII. Nonetheless, after the FGDs began to be conducted, the attrition rate was 9.1%, with adolescents missing some FGDs from the consecutive five weeks of FGD conducting days, where for the FGD to take place, these adolescents were replaced with other participants using an appropriate procedure that was purposefully selected in discussion with teachers and youth club leaders but some of them returned in some FGDs. In addition, two groups of adolescents (elementary (10-14) year old adolescents) were added from the findings of Shewarobit, to obtain detailed information on the findings reflected from late adolescents which increased the number to 150. The following table shows the total number of FGD and KII.

Table 1- Number of FGD and KIIs conducted in the respective study area, North Shoa zone, Amhara region, Ethiopia, 2023.

Name of School/youth club	FGD	KII	No male participant	No female participant
1, Yellen	24	9	24	31
2, Shewarobit	44	11	38	37
3, Abay Atir	20	7	27	20
4, Total	90	27	89	88

For the key informant interview, a maximum variation purposive selection method was used to select parents based on their educational and wealth status. This was done by selecting parents who had formal education versus those who didn't, as well as parents who had higher income versus lower income because it was believed that this would provide different inputs to the research's objectives. The school teachers and youth club leaders were selected based on the gradual sampling method, as they were believed to play an important role in engaging adolescents in SRH programs, such as teachers who coordinate different clubs. Eight participants were selected at the school level, two from each site, and three youth health officers and two program managers were selected using the gradual purposive sampling method, based on adolescents who were mentioned to have a role in adolescents' engagement in the FGDs. Additionally, two adolescents and two youths were chosen through a gradual sampling method after the consecutive FGDs were conducted. These individuals were believed to have a comprehensive understanding of adolescent engagement in youth club activities. Besides this, a health official was selected for an interview due to their knowledge of the adolescents' participation in programs as the coordinator of the youth clubs at the woreda level. While initially planning to interview four parents at each site, the information saturation level was reached after interviewing nine parents. As a result, the total number of study participants was limited to nine parents based on the repeated information seen when the number of study participants was around seven.

4.4 Inclusion and exclusion criteria

4.4.1 Inclusion criteria

For the study, all adolescent residents of the study area at the time of data collection were included, along with a youth club leader responsible for managing the club activities, a community leader who is influential and represents the community at the time of data collection, teachers who facilitate and coordinate school-based sexual and reproductive health programs, and those who could communicate in Amharic language.

4.4.2 Exclusion criteria

Youth club leaders who were not available at the time of data collection due to movement to other places were excluded from the study.

4.5. Study population

For this study, the population consisted of adolescents between the ages of 10-19 who reside in Shewarobit town and Kewet woreda and were attending selected primary and secondary schools. Additionally, parents, teachers, youth club leaders, community leaders, woreda-level health officials, and program administrators were also included in the study.

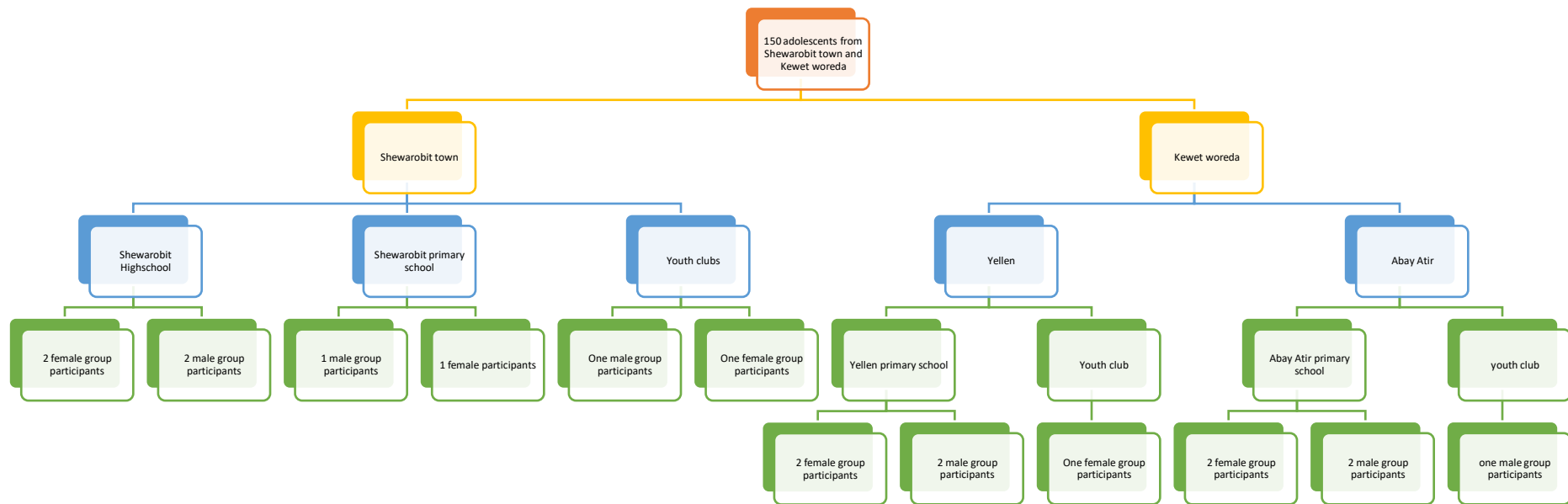


Figure 2. Allocation of study participants among Shewarobit town and Kewet woreda,

4.6 Data Collection tool and procedures

4.6.1 Interview guide

Data for this study was collected through focus group discussions to explore the barriers to adolescents' engagement aiming to draw from the complex personal experience, beliefs, perceptions, and attitudes of participants towards barriers to adolescent engagement and key informant interviews with adolescents and other stakeholders which was intended to gain deep insight on institutional level barriers and triangulate the data obtained from the FGD. Interview guides were used to collect the data from the focus groups and key informants. The focus group discussion guide was developed with questions that are specific to the research objectives of this study, through a review of various literature, and it lasted 1-2 hours. On the other hand, the key informant interview guides were designed to explore the levels of barriers that prevent adolescents from engaging in SRH. The interview guide (KII) was written in English and translated into Amharic, with the interview lasting between 30 minutes to one and a half hours. Before the actual data collection, a pretest was conducted on the first FGDs with adolescents and the first interviews with all stakeholders. Based on the lessons learned from the pretest, necessary adjustments were made to the audio recorder, the placing of the recorder, as well as the FGD and interview guide. The audio was adjusted to a closer distance from the study participants, which made them speak loudly. Moreover, the room and sitting positions of both the interviewee and interviewer were adjusted.

4.6.2 Data collection procedures

The focus group discussions (FDGs) were organized and coordinated by the researcher using a specific guide. Before the discussions, there was a conversation with the participants to determine the most convenient time and place to conduct the FDGs. The researcher also explained the objective of the study and obtained consent from the participants. The facilitators of the FDGs were provided with guiding questions and the discussions were conducted at the agreed-upon time and place in a private room at the school. The discussions were conducted in the Amharic language.

The FGD was conducted over five consecutive weeks with the same participants divided into 16 FGD groups. The first week was focused on building rapport with the participants and addressing the issue of SRH problems, SRH programs, and adolescents' engagement status in SRH programs in the area. The remaining four weeks were dedicated to discussing each level of barriers in depth, and due to time constraints, the discussions had to be spread out over multiple weeks. The FDGs were facilitated by a team of five people, including the principal investigator, four public health professionals, and one postdoctoral researcher who were all trained by the EASE project on qualitative data collection. The facilitators had prior experience working with adolescents, which helped to establish effective communication and encourage open discussion with the participants. The principal investigator provided a clear explanation of the objective and process of data collection to the other facilitators.

The facilitators created a friendly and relaxed environment for the focus group discussions (FGDs) by introducing themselves, giving participants time, and encouraging them to talk openly as if they were chatting with friends. The FGDs were flexible enough to allow participants to respond to questions freely, without being limited or interrupted to focus on specific issues linearly.

For the interviews, the principal investigator communicated with selected parents, teachers, youth club leaders, adolescents and youth health officers, community leaders, and program managers to agree on the time and place to conduct the interviews. All interviews were conducted by the principal investigator.

During the interviews, focus group discussion (FGD) participants were allowed to describe the barriers they faced in engaging with Sexual and Reproductive Health (SRH) programs, such as youth clubs, school clubs, and NGOs. Similarly, KII participants were allowed to discuss their challenges in engaging adolescents in the SRH program. To gather more evidence on the research questions, appropriate probing questions were used in both FGDs and interviews. Facilitators exchanged debrief notes after each FGD to ensure that all relevant information was captured. All interviews and FGDs were audio recorded, and notes were taken throughout the data collection process.

4.7 Operational definition

Meaningful Engagement- “An inclusive, intentional, mutually respectful partnership between adolescents, youth, and adults whereby power is shared, respective contributions are valued, and young people’s ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, and organizations that affect their lives and their communities, countries, and world.”(12)

Adolescents- period of specific health and developmental needs and rights when transition from childhood to adulthood occurs, from age 10–19-year-olds which is a critical age for life-altering decisions (1).

Sexual and reproductive health- a state of physical, mental, and social well-being about sexuality, which is not the absence of disease, dysfunction, or disability. Sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be achieved and sustained, the sexual rights of all people must be respected, protected, and fully exercised (12).

SRH Program- interventions or activities that are being undertaken to solve or prevent SRH problems.

In-school- adolescents attending school as a student.

Out-school- adolescents attending youth clubs as a member, but not necessarily students.

Rural- areas are places of high populations and high density, characterized by their built-up infrastructure.

Urban- having a low population and density whilst maintaining a lack of large infrastructure and their economy depends on agriculture and livestock.

Individual-level Barriers- biological and personal history factors that decrease the likelihood of being engaged in SRH Programs. Some of these factors are awareness, belief, behavior, and skill.

Inter-personal level Barriers- close relationships that may decrease the chance of being engaged in the SRH program. A person's closest social circle-peers, school teachers/mentors, and family influence their behavior and contribute to their range of experience.

Community level Barriers- explores the settings, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with decreasing engagement of adolescents in SRH Programs such as societal belief and awareness of the community in SRH.

Institutional level Barriers- looks at the broad school and program implementers factors that prevent adolescents' engagement in SRH Programs. This includes lack of organizational guidelines, inadequate recruitment, and place of engagement.

4.8 Data quality assurance (Trustworthiness)

To ensure the quality of the data, the principal investigator participated in all processes, including interview guide development, data collection, transcription and translation, and data analysis. As previously stated, a pretest was performed, notes were recorded, and a quality recorder was used throughout data collection. The records were critically verified and rechecked by advisors, and an easy environment was used for data collection.

To maintain the credibility of the finding the researcher first got familiarized with the study area as well as with study participants, formed closed communication, and was encouraged to feel free and talk and researcher's age was not too far which helped the FGD participants build rapport. In the first FGD, the FGD and interview guides were evaluated and updated to ensure that the questions were understandable by the participants and could provide enough information. Throughout the data collection fieldwork supervision was thereby qualitative experts (advisors) in the process of data collection and received comments to improve the quality of the data. There was also an audio-record for further need of checking the data which was checked and rechecked by the principal investigator as well as advisors. The FGD facilitators including the PI held regular meetings to discuss any key findings that emerged during the first data collection period which were tested in different settings, as well as any challenges encountered during the data collection process. The researcher spends at least two days per week in the field throughout the data collection, taking notes on each visit and having a reflexive diary to write the researcher's thoughts, feelings, and personal experiences separate from the description of the field findings.

In the process of maintaining dependability, the researcher read and cleaned all transcriptions by giving codes to the participants and read the transcriptions, again and again, to internalize and search for any disconfirming data. Notes taken during the data collection and transcription were used to ensure the consistency of the findings. The codes were checked and rechecked by qualitative experts (advisors) until a consensus was reached on the codebook and were discussed to clarify the findings.

To the process of safeguarding transferability, a diverse group of people with adequate information was chosen in sampling based on age, gender, schooling type, and adolescents' participation in reproductive health or anti-HIV/AIDs clubs or any other related clubs by the PI and other stakeholders. The FGD and interview guide were prepared in English first and then translated into Amharic. Another person translated it back into English to ensure consistency. A detailed description of the data was taken, including recording, verbatim transcripts, and detailed descriptive note-taking.

To ensure the confirmability of the findings; the key findings from each site were discussed and shared among the group, as well as being checked in different settings, age, and schooling types by different facilitators in each FGD. The data collectors compared their key findings to all other findings and cross-checked their findings for replication. FGD and key informant interviews were all used to collect data from various perspectives, and the same questions were asked in different ways, or reframing questions were added during the interview. Following data collection, the key findings were presented to the participants and other stakeholders in the workshop prepared by the EASE project in Dabre Brehan to ensure the data is their reflection feedback was received from different stakeholders which was used as one input and also shared to peer to give feedback of their own. Finally, all other efforts that were used for quality enhancement were documented and quotes that can reflect the real feeling/tone of the participants were included in the writing with interpretation.

4.9 Data analysis and management

Audio-recorded FGD and key informant interview data were transcribed into Amharic and translated into English by the principal investigator and facilitators. Field note has been taken by the data collectors to capture facial expression and non-verbal reactions. Data were coded abductively such that; inductively for those findings emerging from the data including Sociodemographic characteristics of study participants, SRH problem, SRH service, and engagement status, and deductively using the socio-ecological model to describe the barriers at each level. Framework analysis was used since it can be applied in both deductive (top-down) and inductive (bottom-up) ways which is the preferable approach for this study (56). A qualitative study with a framework analysis approach was

used to describe barriers. This approach based on what was explained by Nichol et.al (2013) argues that framework analysis is theoretically flexible for identifying, describing, and interpreting patterns (themes) within a data set in great detail (55).

The code book was developed based on the socio-ecological model and the transcribed and translated data (Annex-1). The Abductive approach was used in the deductive approach as the starting point which allowed analyzing data in relation to the themes that emerged through the review of the Socio-ecological model which was used as an analytical model. However, each of the relevant information emerging through the data was also considered in the process of analyzing the data inductively.

After coding all translated data categorization and thematization was done using the analytical framework and data charted in different groups across different cells to enable comparing and contrasting of the data, Atlas. ti version 09 software was used to facilitate the analysis. Quotes that best explained the participant's view both in terms of census and dis-agreement have been used to support the finding.

Table 2- Theme, categories, and codes to explore barriers at different levels for Adolescents' engagement in the SRH program, North Shoa zone, Amhara region, Ethiopia, 2023.

Theme	Category	Code
	Socio-demographic characteristics	Age, male, female, religion, grade, rural, urban, in school, early adolescent, late adolescent, out school, student, health officer, youth club leader, parents, teacher, program officer, parents' education, community leader,
	Engagement status	Youth club, school club, not engaged, leader, planning, implementation, monitoring, evaluation, meetings,
	SRH problem	Unwanted pregnancy, early marriage, teenage pregnancy, sexual violence, sexual harassment, FGM, unsafe abortion, early sexual debut, unprotected sexual intercourse, risky sexual behavior
	SRH service	Condom, post-pill, injectables, abortion care, information, youth-friendly, accessibility, affordability, availability, health service providers, sexual education, peer-to-peer education,
Individual level	Awareness on SRH	Adolescents, reproductive organs, pregnancy, HIV, sexually transmitted disease, contraception, SRH right
	Awareness of SRH problems	Unplanned pregnancy, unsafe abortion, early marriage, sexually transmitted disease, HIV, sexual violence, FGM, early sexual debut, sexual harassment, unprotected sexual intercourse, teenage pregnancy
	Awareness of SRH services	Affordability, accessibility, availability, health providers, when to use, content, benefit
	Awareness on engagement	Benefit, policy, where to engage, engagement, ways of engagement, engagement in planning, engagement in implementation, engagement in monitoring, engagement in evaluation, beneficiary, messenger
	Skill	Leadership, facilitation, advocacy, communication, problem-solving, managing emotions, decision making
	Belief	Young age, powerless, useless
	Behavior	Substance abuse, undisciplined, resistance, ignorant, commitment, sexual activity
Inter-personal level	Peer related barriers	Misinformation, negative attitude, peer pressure, lack of information, lack of support, substance abuse
	Family-related barriers	Fear, expectation from family, stigma, negative perception of clubs
	School teachers/ mentor	Knowledge, support, attitude
Community-level barriers	Societal beliefs	Value on age, religious belief, normative value, early marriage
	Awareness	Engagement, SRH, SRH problem, place of engagement
Institutional-level barriers	School	Resource, system, structure, place of engagement
	Program implementation	Resource, agenda/priority, knowledge, organizational culture, place of engagement, tokenism, report-based, political alliance

4.10 Ethical consideration

Ethical clearance has been obtained from the Research Ethics Committee of Addis Ababa University (AAU), College of Health Sciences, School of Public Health with approval number 001. Letter of support has been obtained from the school of public health for each study site and permission has been taken from the Woreda Health Bureau of Shewarobit and Kewet Woreda/Written informed consent was obtained from each adult study participant. Parent consent and assent were obtained for those aged from 11 to 18 years. All participants were informed about the study's objective and the benefits they would receive as such the awareness they would develop during the discussion. Furthermore, EASE project experts in qualitative research trained all data collectors, including the lead investigators, on the ethical implications of qualitative data. The participants talked and decided on the time and location to minimize the disruption to their time and education. Furthermore, participants were fully informed of their ability to withdraw from the study at any moment and that their participation was entirely voluntary. Perhaps all participants were chosen fairly in consultation with their school director and youth club leaders, taking into account the wide range of differences. All information collected from study participants was kept confidential throughout the process, and unique codes were assigned for each participant based on their preferences to ensure that their names were not included in the transcriptions, and data translated and stored in the collected data in a secure location.

4.11 Finding dissemination plan

After completion of the research, the final result will be submitted to Addis Ababa University, College of Health Sciences, School of Public Health. The results of the study will be presented during the thesis defense and after approval of the study; the final result document will be disseminated to different stakeholders that will contribute to improving adolescent health and related services. Finally, efforts will be made to present in various seminars, and workshops and for publication of the research in national or international reputable journals.

5. Finding

The study's findings were presented in five different themes, namely: (1) Individual level barriers, which included challenges related to awareness of SRH, SRH problems, SRH services, engagement, skills, beliefs, and behavior; (2) Inter-personal level barriers, which included peer-related, family-related, and school teachers/mentors; (3) Community level barriers, which involved societal beliefs and awareness on SRH; (4) Institutional level barriers, which encompassed school and program implementing organizations. To ensure the quality of the study, the researchers used specific phrases while writing the findings of the interview. For instance, used "most/major" for more than five responses, "some" for responses of 3-4 participants, and "few" for responses of 2. For FGD, use "almost all" for 5 and more adolescents, "all" for all, "some" for 3-5 adolescents, "only one" if only one agrees.

5.1 Socio-demographic characteristics

A total of 16 FGDs with adolescents, (24 at Yellen, 20 at Abay Atir, 44 at Shewarobit for eight consecutive days, and 4 FGDs at Shewarobit for two consecutive days), 27 KII with youth club leaders, parents, woreda health officers, youth and sports officers, community leaders and programmers were conducted and included in the analysis of this study.

5.1.1 Characteristics of FGD Participants

The socio-demographic characteristics of the adolescents who participated in the study are presented in Table 1. A total of 150 adolescents took part in the focus group discussion, with ages ranging from 10 to 19. Almost two-thirds of the participants were in the early stages of adolescence (10-14 years old), with a total of 87 individuals falling within this age range. Additionally, half of the participants were male (n=73), while the majority were enrolled in school, with 84 students in secondary school and 61 in elementary school. Only a few adolescents (n=5) were neither employed nor enrolled in education.

The study found that more than half of the adolescents resided in rural areas (n=80). The majority of adolescents identified as orthodox (n=110), followed by Muslim (n=32). Out of the 150 adolescents, one-fourth (n=37) were either out of school or were part of youth clubs.

Table 3. Socio-demographic characteristics of FGD participants in North Shoa zone, Ethiopia 2023

Socio-demographic characteristics	Number of participants
Age	
10-14	87
15-19	63
Sex	
Male	73
Female	77
Educational status	
Secondary	84
Primary	61
Not in education	5
Schooling status	
In-school	113
Out-school	37
Religion	
Orthodox	110
Muslim	32
Protestant	8
Place of residence	
Urban	70
Rural	80
<p>*In-school- adolescents who are in the school and aren't involved in the youth clubs outside the school. *Out-school- adolescents who are involved in the youth clubs outside the school but might be students in the school. * Urban- areas were labeled as a city with higher infrastructures (Shewarobit city). * Rural- area with less infrastructure and people mainly based on agriculture and livestock (Abay Atir and Yellen).</p>	

5.1.2 Characteristics of KI interview participants (N=27)

A total of 27 key informant interviews were conducted with various stakeholders who were assumed to have decision-making power regarding adolescent engagement in SRH programs. Out of these interviews, nine were conducted with parents, two with community leaders, two with programmers, six with teachers, two with Woreda health officers, two with youth and sports officers, and four with youth club leaders, where four of them were young.

Table 2 demonstrates the socio-demographic characteristics of the key informant interviews. The age of the study participants ranged from 23-65 years with a median age of 34 years. Almost one-third of the adult and young participants in the interview were female (n=10, 37.03%). Among the nine parents who participated, five of them were not formally educated. All teachers were facilitators and leaders of school clubs related to sexual and reproductive health. Half of them (n=3, 50%) worked with programmers from non-governmental organizations as facilitators of the programs that were implemented in the school.

Table 4. Socio-demographic characteristics of KII participants in North Shoa zone, Ethiopia 2023.

Participants code	Sex	Age	Education	Occupational status	Role in the community
P1	M	24	University	Student	Youth club leader
P2	M	23	Secondary	Student	Youth club leader
P3	M	19	Secondary	Student	Youth club leader
P4	F	18	Secondary	Student	Youth club leader
P5	M	45	No formal education (Can't read and write)	Farmer	Parent
P6	F	36	Elementary school	Housewife	Parent
P7	F	30	No formal education (Can't read and write)	Housewife	Parent
P8	F	29	No formal education (Can't read and write)	Housewife	Parent
P9	F	32	Elementary school	Merchant	Parent
P10	M	42	No formal education (But read and write)	Merchant	Parent
P11	F	31	Elementary school	Housewife	Parent
P12	M	59	No formal education (Can't read and write)	Farmer	Parent
P13	F	46	No formal education (Can't read and write)	Housewife	Parent
P14	F	34	BSc degree	Teacher	Teacher
P15	F	38	BSc degree	Teacher	Teacher
P16	M	28	BSc degree	Teacher	Teacher
P17	F	34	BSc degree	Teacher	Teacher
P18	M	31	BSc degree	Teacher	Teacher
P19	M	39	BSc degree	Teacher	Teacher
P20	M	34	BSc degree	Woreda health officer	Woreda health officer
P21	M	27	BSc degree	Youth & sport officer	Youth & sport officer
P22	M	36	BSc degree	Woreda health officer	Woreda health officer
P23	M	32	BSc degree	Youth health officer	Youth health officer
P24	M	34	Masters	Programmer	Programmer
P25	M	31	Masters	Programmer	Programmer
P26	M	50	No formal education (can't read and write)	Farmer	Community leader
P27	M	65	No formal education (can't read and write)	Farmer	Community leader

5.2 Engagement status of adolescents in SRH programs

It was discovered that adolescents were engaged in various roles from planning to monitoring and evaluation of SRH programs within their possible engagement areas, including youth clubs, school clubs, and programs implemented by NGOs in schools. Out of a total of 150 adolescents, 47 of them engaged in creating awareness of SRH problems in the community through drama, literature, and peer-to-peer education in youth clubs found outside the school. Eight of these late-age adolescents (15-19) were engaged in the planning, implementation, and evaluation of youth club activities, while the remaining 26 were engaged only in the implementation levels of the youth club, creating awareness through participating in dramas, poetry, and peer-to-peer education. Out of the eight, only three were engaged in leadership roles in the club. However, all of them were involved only in the implementation levels of the programs, which were implemented by adult programmers.

The results show that the majority of in-school adolescents have never been involved in the planning, implementation, monitoring, and evaluation of programs or any other possible engagement areas. Out of the remaining adolescents, only 18 of them were engaged in the implementation levels of programs in school clubs, which involved participating in dramas scripted by teachers. The rest were involved in implementation levels of programs in both school clubs and youth clubs outside the school. It is worth noting that none of the early-aged adolescents in the urban area were engaged in youth clubs or SRH programs outside the school (see Annex 1.)

Engagement in planning

Almost all in-school adolescents mentioned that they had never been part of the planning phase of an SRH program. This includes the formation of SRH clubs, planning of the club activities, developing scripts for dramas performed by the adolescents, identifying areas of SRH problems to work on, and participating in programs organized by NGOs. However, teachers mentioned that at the end of each year, adolescents participate in the planning phase for the following year's activities.

“..Even the name of our club is supplied by the teachers or they are the club's owner; we don't even know what the club's meaning or objective is, not even to take part in the planning of the club activities. ...” (14 years old female FGD participant)

Eight late-age adolescents (15-19) who are out of school mentioned that they are in the planning phase of their youth club activities. They stated that their activities do not involve non-governmental organization programs. They organize their youth club activities because they will not be able to participate in the planning stages of government programs involving them or non-governmental organizations. On the other hand, government officials stated that they have never invited adolescents in the planning stages of a program because it is an uncommon practice. Non-governmental programmers also mentioned that due to budget constraints, they only involve a few representatives.

“...We have never planned anything with Kebele before. True, we have done many things as a club up until now, but nothing has changed. Every January and February, there is a wedding; we have been reporting to the kebele since we heard about it in school. However, after they check their age, they will pass and marry, even if they are under the age of 18...” (19 years old female KII participant)

Engagement in Implementation

In-school adolescents, most of them, were involved in program implementation levels in school clubs, which included participation in dramas scripted by teachers. Most of them were female adolescents, as the school encouraged more females to join clubs for their empowerment. Additionally, six adolescents were involved in program implementation levels in both school clubs and youth clubs outside the school, performing dramas and peer-to-peer education in the youth clubs outside the school.

“.... We do not have a specific role, but if chosen, we will perform dramas, dances, and vocals. ...” (14 years old female FGD Participant)

“.....Most school clubs are founded based on female adolescents because most of them are formed to prevent problems from occurring to females, and females are usually the ones who are urged to participate in many's clubs in the school....” (13 years male FGD participant)

It was observed that there are no early-aged adolescents who participate in youth clubs outside of school. However, late-aged adolescents engage in various activities such as preparing dramas, and poetry with entertainment for community awareness, peer-to-peer education among members, and participating in various charitable activities. It was noticed that most of the adolescents who engage in the youth clubs are males, especially in rural areas. Supported by 18 years old male FGD participant:

“.... In this community, females are not typically encouraged to participate in SRH concerns, particularly in youth clubs....” (24 years old male KII participant)

Engagement in Monitoring and evaluation

All of the adolescents mentioned that they have not been involved in any monitoring or evaluation of school programs. However, out-of-school adolescents reported that they monitor and evaluate their youth club activities, but they have never been involved in the monitoring or evaluation of a program administered by the government or a non-governmental organization.

“.... No one participates in that activity, and we do not even know what the term means....the teachers are also in charge of that responsibility...” (13 years male FGD participant)

5.3 Existing Sexual and reproductive health problems in adolescents

Based on the information provided, it can be inferred that the majority of participants who participated in the focus group discussion and interviews came to a consensus that the primary concern among adolescents between the ages of 10 and 19 is related to sexual and reproductive health matters. In the focus group discussions at each research site, adolescents listed out and prioritized the sexual and reproductive health problems that exist in their area, such as early marriage, teenage pregnancy, unwanted pregnancy, risky behaviors (such as substance use, alcohol consumption, early sexual debut, unprotected sexual intercourse), gender-based violence or sexual harassment, female genital mutation, and unsafe abortion. During a focus group discussion, participants identified a range of problems including female genital mutilation and sexual harassment. However, some differences were observed and the parents, woreda health officers, community leaders, and teachers did not consider these issues as problems in their community.

Participants from rural areas reported that early marriage is a prevalent sexual and reproductive health problem in their community, unlike participants from urban areas. In rural areas, early marriage is considered a bigger problem as compared to urban areas, where only a few adolescents recognize it as a sexual and reproductive health problem. Early marriages are often the result of family pressure, fueled by a lack of awareness among parents about the serious consequences of such unions. Cultural norms also play a role, as does financial strain, as early marriage is sometimes seen as a way for families to earn money. In both scenarios, the reasons for early marriage mentioned by the adolescents were family pressures due to a lack of awareness of the consequences of early marriage, the cultural ground of the community, and early marriage used as a source of income for the girl's family. Over two-thirds of adolescents in rural and urban areas stated that adolescents got married early because their parents feared their daughter would lose her dignity once she entered adolescence. To protect their daughter's dignity and prevent unwanted pregnancy, parents marry off their children at an early age. In terms of stating SRH problems, no differences were seen among early-aged and late-aged adolescents as well as male and female adolescents. Which participants from FGDs explained it in this way:

“...In this case, it is often the children's families who force them to marry at a young age, rather than the children themselves. If her parents and the community said that she would not do anything with education, then she would stop learning and marry.... There are even parents who marry off their children for the sake of money...” (14 years old female FGD participant)

“To preserve her dignity, they will force her to marry when she is 15 years old; otherwise, they fear she will lose it while away from home.” (17 years old male FGD participant)

In the same way, more than two-thirds of adolescents reported that they are getting married with their own will at an early age without their family's consent because they are starting early relationships and as a means to escape the stigma of unexpected pregnancies.

“There was an early marriage at the time, which is still going on, so there were no romantic relationships or anything similar. Now, early romantic relationships are a major contributor to early marriages.....” (15 female FGD participants)

Although parents and adolescents share the same ideas about early marriage being the main sexual and reproductive health problem, more than two-thirds of parents only mention problems that arise as a result of the interest of adolescents in early marriage, arguing that it is due to family pressure. One parent expressed his argument:

“...Nowadays, if adolescents start a relationship, they simply say they love each other and move on; they do not even bother sending elders to obtain permission from a family. ...” (59 years old Male KII participant)

About the issue of teenage pregnancy or unplanned pregnancy, every participant consistently reported that risky behaviors—such as drug and alcohol abuse, early sexual debut associated with the use of sexually explicit materials, unprotected sexual intercourse, peer pressure, and ignorance—were the main causes of the problem. Concerning this, the majority of participants agreed that female students who come from rural areas and who live in rented houses are more victims of these problems. Regarding the problem, participants stated:

“...Being a girl is difficult nowadays because they (the girl and her boyfriend) may have sex at school and in mobile vehicles. No matter how good a student she is, today's women do not care if they get pregnant or sick; they will not even use contraception.....” (17 years old male FGD participant)

In other words, some participants explained migration as a burden of sexual and reproductive health problems that result in gender-based violence and harassment. They explained their concerns:

“.....They migrate to other countries, where they face sexual and reproductive health problems such as rape and harassment, which have physical and psychological consequences. ...” (31 years old Male KII participant)

As confirmed by two interviewees, female genital mutation is a problem that persists covertly in rural areas, while participants in urban areas reported that it has been resolved.

“...It happened quietly... I heard that two newborn female babies in our village were circumcised. ...” (13 years old female FGD participant)

5.4 Individual-level barriers

At the individual level (i.e., awareness, belief, skill, and behavior), these factors influence the engagement of adolescents in their sexual and reproductive health programs, Individual factors were discussed with high frequency by all participants. Individual factors were discussed at a frequency of 1386 (n = 1088 FGD, n = 298 interviews) by all participants.

Table 5. Individual level factor informed by socio-ecological model belief, awareness, skill, and behavior count, North Shoa zone, Amhara region, Ethiopia, 2023.

Individual-level barriers	FGD Gr=2221; GS=104	Interview Gr=1439; GS=27	Totals
1. Belief	118	37	155
2. Behavior	61	51	112
3. Awareness of SRH	210	26	236
4. Awareness of SRH problems	228	18	246
5. Awareness of SRH service	23	3	26
6. Awareness of engagement	430	83	513
7. Skill	18	80	98
Totals	1088	298	1386

Note. Frequency counts of factors within each category were reflected in the number of times participants indicated a factor within their response.

Awareness of sexual and reproductive health

The first factor at the individual level, focused on adolescents' awareness of sexual and reproductive health. More than half of adolescents who are in school don't have detailed information or know what sexual and reproductive health is. Out of this, most of them relate it to the size of the population, relationships among men and women, population health, and societal problems. According to their statement, they expressed their interest in learning about sexual and reproductive health, suggesting that they would be more inclined to engage with it if they had more awareness. They also mentioned that teaching about this topic in schools would be helpful. However, they acknowledged that they may not have given the topic their attention yet because they are not familiar with what sexual and reproductive health entails.

"..I have not studied reproduction, but I believe it is related to population size and the number of children born in that population..."(15 years old female FGD participant)

".....It is impossible to participate in the planning phase because, as she stated, we must first determine whether it is beneficial to students....."(17 years old male FGD participants)

On the other hand, a considerable number of adolescents have a different awareness of sexual and reproductive health. Approximately one third of out-of-school adolescents, half of early-age adolescents, and in-school adolescents state that sexual and reproductive health is associated with harmful traditional practices that are still prevalent in their community.

"...SRH refers to the harmful traditional practices, such as early marriage, that she encounters before becoming pregnant and childbirth. For example, it is against the law to give birth before the age of 18...."(18 years old female FGD participant)

This statement highlights that a majority of young adolescents believe that sexual and reproductive health programs are not useful because they only cover topics related to pregnancy, delivery, and spousal relationships. The study found that almost half of the participants shared this view.

"...I think it's the life of husband and wife..."(13 years old female FGD participant)

"...When men and women marry, they have sexual relations and then bring a child into the world..." (13 years old male FGD participant)

However, it has been found that some of late-age adolescents and out-of-school adolescents have gained extensive experience with various trainings and working on sexual and reproductive health. Furthermore, about half of the adolescents who are out-of-school have explained the meaning of sexual and reproductive health and have mentioned that their knowledge in this area has helped them to work beyond themselves and contribute to the community.

"When discussing SRH, I believe we are referring to pregnancy-related health issues, and there are numerous issues associated with pregnancy and others, such as HIV/AIDS, fistulas, and sexually transmitted infections. HIV/AIDS has no cure, but STIs can be treated if caught early..."(17 years old female FGD participant)

"...I will take what I have learned and apply it to help the community raise awareness about sexual and reproductive health..."(19 years old male FGD participant)

As per the youth club leaders, their limited knowledge and information about their sexual and reproductive health rights are acting as a barrier to their participation and discussion of their concerns, and they are unable to engage in various programs.

"...The first problem is that they do not know what their right is; for example, if someone told them that it is their right, they do not believe as it is their right..."(23 years old male KII participant)

Awareness on SRH problems

It has been observed that most adolescents, both in-school and out-of-school, lack awareness about sexual and reproductive health problems. Many adolescents, especially those at a younger age, claim to have limited awareness about sexually transmitted diseases., supported by focus group discussion;

"...I have never seen such disease in practice, but I have heard of it. They would say sexually transmitted disease, but it does not happen very often. We have heard of many early marriages, but we have never heard of sexually transmitted disease..." (14 years old female FGD Participant)

Teachers, programmers, and woreda health officers consistently mentioned that adolescents lack awareness of sexual and reproductive health problems. This lack of awareness leads them to engage in risky sexual behaviors, which can result in serious health problems. Additionally, dropping out of school due to these problems is a common occurrence. In this regard, a female teacher made an illustrative point, saying:

".....When we see their sexual and reproductive health engagement, most of the Childrens are around 13 and 14 years old, so this Childrens may not think about these problems at this age, and most of the time the Childrens drop out from school, not even to engage in clubs, because of unexpected pregnancy and that pregnancy occurs because of unsafe sex, and at that time disease may also be transmitted, so I do not think adolescents have the awareness about such things and the majority of such adolescents are those who travel from rural areas to attend school....." (35 years old female KII participant)

Awareness on Sexual and reproductive health service

Less than one-third of adolescents are aware of the sexual and reproductive health services available in the health centers of their community. Even the youth club leaders also claimed that they don't know about youth-friendly services that are currently available. According to more than half of the adolescents, the lack of awareness is hindering them from creating awareness about sexual and reproductive health services for other adolescents. A statement noted by a focus group discussant:

"..... for instance, it is said that there are birth control pills, but I haven't seen any. There is no organization that provides the contraception for free. I don't know how to use it beforehand; I don't know when I see it, and maybe I know when I hear its name but how can I teach others to use without the knowledge..." (19 years old male FGD participant)

".... Lack of understanding, not knowing the difference between using it and not using it...the others doesn't even know or have the awareness about the service and whether it is built for them..."(23 years old female KII participant)

Almost two-thirds of adolescents, including those in early age and in school, are unaware of the accessibility of health services. They have also stated that they have never had any reason to visit health centers to obtain these services which is supported by statement given by male FGD participant;

“.....Oh, I am not aware of the services provided by the health center....I also doubt that high school students are aware of and use it because they are outsiders....” (17 years old male FGD participant)

Some adolescents who were out of school reported that sexual health services such as contraceptives, condoms, injections, and tablets, as well as information and counseling services, can be found in health centers, private clinics, and pharmacies. In this regard a FGD participant said;

“.... they can get it from a pharmacy or a supermarket; for example, when we see health centers, they have something to be used, which is a condom, and the health centers have a large supply of condoms....” (18 years old female FGD participant)

More than two-thirds of adolescents in urban areas reported that they are afraid of being seen by their parents or community members because the youth-friendly service center is located in one health center in the area and provides services alongside other health services. Additionally, more than half of the participants who are not in school mentioned that the youth-friendly services are no longer available and stopped working due to less emphasis and follow-up from the implementer side in rural areas where the health center officials started to use the service room as a store. Contradicting the adolescent's idea, woreda health officers and programmers from the state claim that youth-friendly services are available in all areas and are provided by trained professionals.. These findings can be backed up by the statements of a 24-year-old male key informant interview participant and a 34-year-old male key informant interview participant.

“.....It was built initially, but now the service is no longer available to us; it has been completely discontinued... The service is no longer available for youth/adolescents, and it is not in a state where we can use it... other officials are using it as a store.....” (24 years old male KII participant)

“.....We have three health centers at the woreda level, and Amref Health Africa has built youth friendly services in two of them, so youths have their own playground, medical center, and beyond that it has been working to create a place for them to get cards alone for their medical service, so youth health care service is placed separately, and when they come to that health center they get service based on their age.....” (34 years old male KII participant)

Awareness on engagement

Almost all adolescents define engagement as actively participating through answering questions, identifying problems and giving solutions, raising ideas actively whenever there are discussions, and practicing what is being taught. On the other hand, adolescents who are from out-of-school define engagement as presenting or performing dramas and shows to create awareness as well as volunteering. Participants affirmed that lack of awareness on the ways of engagement in different sexual and reproductive health programs has been a barrier that prevents them from being engaged, which may be supported by statements made by an 18-year-old female KII participant and a 13-year-old female FGD participant;

"...One of the barriers preventing us from participating in sexual and reproductive health programs is a lack of understanding about how we should discuss our difficulties...." (18 years old female KII participant)

"... One of the barriers to participating in various sexual and reproductive health programs is not realizing that one's own involvement is required to solve the problem...." (13 years old female FGD participant)

According to programmers, adolescents have no understanding of how to participate in various sexual and reproductive health programs which can be better elicited by a statement given by a programmer as;

"...By the way, at first, they are unsure what engagement entails... I mean, for them, engagement was simply attending meetings and being present in those meetings not only for them, but also for the government, but they should make decisions on issues that concern them and their voices should be heard and counted...budget should also be allocated based on their requirements...." (31 years old male key informant interview participant)

Moreover, one-third of late adolescents from in-school reflected that their engagement status is affected by their lack of knowledge on which area to engage or not knowing programs that engage adolescents in school.;

".....in the school we don't know any program working on sexual and reproductive health..." (16 years old male FGD participant).

Belief

Less than half of early-aged adolescents believe they are adolescents who are capable of much more, while more than two-thirds believe they are too young to be involved in or engage in sexual and reproductive health programs about which they can't decide or engage because of their age or because they believe they are not mature. In addition to this, early-aged adolescents believe that since they are under family control, they can't make any decisions except those made by their families, including their involvement in sexual and reproductive health programs. This was supported by the statements of, from FGD:

"...I am still in elementary school, and I will get there when I enter high school, which means when I mature....and we do not have such power in the first place because at our age, the decision is made by the family because we live with our families, and if we are not with our families, we can not even get food and drink, so we can not decide on our own, so we need their decision...." (14 years old female FGD participant)

"...We are referred to as being under the age of 18 because our brains have not yet matured and we cannot think like adults. We are only concerned with our immediate problems, not with our future or the problems of others...." (12 years old female FGD participant)

The adolescent youth club leaders (n = 2) express their inability to make decisions on events outside of the youth club in the kebeles because they feel that adults are more capable and should take those decisions. In this regard, a KII participant states that:

"....It is simple to become the leader of a youth club, but it is more difficult to do so in a kebele. We can suggest a solution to a problem, but the real decision-makers should be older people because the tasks at hand are beyond our abilities. This is because the elderly are capable of devising novel solutions to problems...." (18 years old female KII participant)

Additionally, some late adolescents in school mentioned that their engagement in sexual and reproductive health programs has no importance or benefit for them, other than it being a waste of time. This can be substantiated by remarks made by FGD participant:

"...what... I am not going that far away for something which has no use, why I am wasting my time by going there..." while other female adolescent repeated this statement as; *".....what is the use whether I joined or not...example in women's club I joined because I believed it has something with honor but there is nothing important and I just don't want to go there and sit..."* (17 years old male FGD participant)

Behavior

Nearly all adolescents stated that drug addiction is common among male adolescents, with some even claiming it began as early as age 11 or 12. These adolescents would rather take drugs than visit or participate in youth groups or clubs. In a rural research site, adolescents who were not enrolled in school said that prior club members had even used the youth club as a venue to consume drugs. They also mentioned that this had damaged the youth club's reputation in the neighborhood. Furthermore, these adolescents sit by the roadside and tell other adolescents that they won't alter anything, which makes them feel embarrassed about engaging in sexual and reproductive health problems.

".....They are now all spending their time at Shisha House, which is located near Khat Tera. Early in the morning, everyone spends their time sleeping, and when they wake up, they start chewing Khat...They ate their breakfast and began chewing a chat again at 12 p.m. Then people go there for leftover khat, mostly children....."(18 years old male FGD participant)

In addition, the participants from the three study sites consistently mentioned that adolescents, particularly boys, prefer to go to other unsafe places like bars and places for chewing khat rather than attending youth clubs or becoming concerned about sexual and reproductive health problems. In addition, most KII participants explained that nowadays many adolescents are undisciplined, ignorant, and more engaged in sexual activities; they are also not committed, rendering them unfit for the roles assigned to them.

"..... Adolescents would rather go to other bad places than deal with such serious issues... because adolescents are now more involved in drug addiction than adults. They are in large numbers in our community...they act as if they want to do everything their friends do.... they also rarely get along with their families, which is simply unexplainable...." (23 years old Male KII participant)

"... Nowadays, adolescents do not have good manners; for example, if an adult says a command word to one adolescent, that adolescent does not remain silent; instead, he reflects back in a negative manner...." (29 years old female KII participant)

Skills

In almost two-thirds of early-aged adolescents, they expressed their lack of skills in decision-making, leadership, problem-solving, facilitation, or communication. Conversely, they stated that they can have the skill and work better if they are capacitated with different training. This finding can be backed up by a statement of a focused group discussant saying,

"There is a desire to create different things from childhood to adolescence; we may be interested in opposite-sex relationships. We mostly disagree with our families because they believe they are superior and in charge.." (17 years old male FGD participant)

The others mentioned that they can engage and perform better, but they are unable to do so because they lack the opportunity to showcase their potential. In this regard, three woreda health authorities noted that adolescents could not participate in decision-making processes, including communication and problem-solving, where the adolescents might engage as reporters when problems occur as well as awareness-makers in the community. Regarding adolescents' skills, a KII participant stated that:

"... because most of the time, adolescent age groups are primarily involved in causing problems, other people who are better than them (age) should be the ones to solve the problem, but adolescent age groups can ask older people if they are doing the right thing...." (34 years old male KII participant)

Two participants in the key informant interview agreed that adolescents cannot control their emotions, which prevents them from taking on leadership responsibilities and making decisions. This can be substantiated by the remarks made by KII participant;

"....They are "warm ones" who are controlled by their emotions; they believe that they can obtain anything they see at any time or in any situation... who want to do everything that someone else does...." (24 years old male KII participant)

5.5 Family and peer related barriers

Family related barriers

According to key informant participants, nearly two-thirds of parents of early-aged adolescents forbade their children from participating in sexual and reproductive health clubs. Conversely, some parents of late adolescents stated that they have faith in their children, and a few of them have even refused to allow their adolescents to participate in these kinds of programmes, particularly the girls. Parents with both high and low incomes were consistent in their children's engagement. Nevertheless, of the three formally educated parents interviewed, two parents of early-aged adolescents mentioned that they allow their children to engage since there is benefit for them. All formally uneducated parents (n = 6) refuse to allow their children to participate in sexual and reproductive health programs because they believe that adolescents should focus on their education and participating in such clubs would distract them from their education. In addition to that, two of them state that the children have to help them out in the housework, whereas if they engage in such kinds of activities, their time will be taken, and they will not help out in the household work. They also stated that their behavior will change in a negative way. The majority of parents believe that their children's participation in youth clubs has not produced any changes or results; consequently, they do not wish their children to spend their time in the club. In this regard, formally educated and formally uneducated parents mentioned as follows:

"... This cannot all happen at this age... His education will be impacted....and for clubs, maturity is required so that you can lead both at the same time... However, because they are a child, they will say okay and will attempt to undergo both...."
(29 years old female KII participant)

"....My children both get up early in the morning and do housework like washing dishes until they go to school so that when they get busy they do not think about or feel their adolescence, otherwise I do not want them to go anywhere else...." (45 years old KII participant)

Other parents also put their statement as;

".....There is no such thing as a club or anything like that near me.... I just want her to keep my name out of bad company and focus on her education; the boys may try to trick them with money or other means, but I have always told them they should stay away from such things because I can provide anything they want...."(45 years old female parent KII participant)

"...I would accept them if they at least tried to work on these kinds of problems and if you heard about their work in any way, but I have never heard of anything, and I do not see anything fruitful on them..."(31 years old female parent KII participant)

Although these parents state that they don't want the adolescents to engage in these clubs, most parents (n = 7) consistently mentioned that they might allow it if the programme is at school because there would be close follow-up from the teachers. In addition to that, one parent stated that they would grant permission for their child to participate if there was someone responsible who could inform them prior to the program. This can be substantiated by the remarks made by one parent:

".....I assumed the goal was educational... And if it is with someone like you, it is fine with me... However, I am opposed to going to clubs with other friends and talking... Otherwise, if it is in school, I am fine with it as long as she gains knowledge...." (34 years old female KII participant)

"....There should be someone who can take the responsibility to engage these adolescents by discussing with parents and coming to the parents, because if there is someone who can take the responsibility, you will not be worried to give your child to involve in such programs, otherwise I do not like the way of calling these adolescents as if there is any program in one place without pre information, parents should have a discussion with a responsible body who prepares such kinds of programs....." (45 years old male parent KII participant)

In support of this, over half of the adolescents claim that their parents are a barrier to their participation in sexual and reproductive health programs or forbid them from participating in youth clubs and other programs due to housework, fearing that they would go to dangerous places and hearing the phrase " *You should not waste your time going to pointless places.*," as well as the fact that adolescents work late hours in the clubs, which they stated is particularly problematic for girls. The other half of them asserted that their parents are not responsible for their lack of engagement, instead stating that it is because of their interests.

"...There is parental pressure because we have to meet for the club meeting at 9:00 p.m. on Saturday, and if we are late, they will scold us by asking who will do the chores when we get home..." (16 years old female FGD participant)

From nine parents interviewed, five parents of early-aged adolescents believe that their children are at an early age for sexual and reproductive health matters and don't want their children to engage in sexual and reproductive health programmes. Concerning this adolescent, the focus group discussion confirmed that:

".... She is too young for that, and she is not going to listen to them... The problem is particularly acute in 9th and 10th grades... Whereas these clubs may be useful at that age, but I want her to focus on her education because it is even more difficult when she focuses solely on this one because she is a child and will gravitate more toward that direction...." (32 years female parent KII participant)

Concerning this, more than half of the participants mentioned that their parents won't allow them to talk or engage in sexual and reproductive health issues or in programs where if they are seen talking, they would be taken as indecent or have bad behavior. Therefore, the adolescents mentioned that they wouldn't be involved in such activities because of the fear that they would be taken as indecent by their parents. A KII participant stated as follows:

"...the other is related to family/parents It was difficult to keep our members, and they were even told they should not come to our club... The words we used to discuss sexual and reproductive health were also considered shameful and indecent, and adolescents were warned that they would be indecent or rude if they went to the club... If they discuss sexual and reproductive health in front of their parents, they will be considered rude/indecent and may even be spanked...."
(19 years old male KII participant)

Participants also stated that adolescents don't participate in programmes promoting sexual and reproductive health if their parents are people of faith because the youth club also doubles as an art club. As a result, parents worry that their kids will go to the club to dance and perform, which is against their religion, as well as worry that they will follow what is discussed there. A KII participant said,

".....They started leaving recently because of religion, and their parents are concerned that they will misbehave; when we say reproductive, they believe it is a place to reproduce and become entangled with others, which is why they prevent them from going....." (23 years old male KII participant)

"...there is one place for youths to have fun (Abyssinia club), where the girls comb their hair and the boys turn up the music loud enough to be heard all the way to the farm, and together they would do something, and we would see the results when the girls got pregnant....." (36 years old female KII participant)

Five out of nine parents who were interviewed defined sexual and reproductive health as health related to pregnancy, childbirth, and contraceptive use, while the remaining four did not know what it meant. Due to their lack of awareness, the adolescents stated that their parents do not allow them to participate in sexual and reproductive health.

".....Sexual and reproductive health refers to the services provided to pregnant women from pre-pregnancy to post-pregnancy. We also see its benefit for mothers who give birth, in that they have follow-ups beginning with their pregnancy....."(42 years old male KII participant)

"...I just want them to live (laughing) so they can work and eat, and I am doing the same thing right now because I do not know what else to do..." (59 years old male KII participant)

Additionally, a number of parents (n = 4) are uncertain about the existence of youth clubs or a program that teaches adolescents about sexual and reproductive health.; two adolescents from the key informant interview mentioned it as one barrier to their engagement.

".....but I am not familiar with the clubs that are operating here... I never meet other people outside of my house... We have no idea what they do in or about the club; we only see them when they say they go to clubs...." (30 years old female KII participant)

Peer related barriers

One-third of early-aged adolescents state their peers would call them fools if they joined school or youth clubs. And will discourage them by claiming that they are attending the programs for their own benefit and that the program is ineffective. The rest stated that their peers are very supportive of their participation, whereas their friends encourage them to participate more actively. A FGD discussant said;

"...Our friends would say, as they give you biscuits to attract you, "What is the point of this? It is enough if you are attending your regular education..." and those who participate in these programs may be thought to be fools, wondering what they will gain or do by participating in these programs...." (13 years old male FGD participant)

School teachers/mentors

In this regard, a 17-year-old male FGD discussant expressed his concern as follows: "*As I previously stated, no one approaches us and requests our participation. Even when the club organizers came by once in a while, they simply stood at the class gate and asked if anyone was interested in joining the club without explaining its purpose or the benefit it provided to the community, so we were not interested in engaging.*" More than two-thirds of adolescents state that the teachers don't give enough attention to sexual and reproductive health problems, they consider it their secondary activity in school or the responsibilities of the non-governmental organisations, so they won't be motivated, which is making the adolescents not give any attention to the clubs. A remark made by female student-focused group discussants is illustrative of teachers not paying attention: "*I am not sure...but the majority of the club does not want to*

educate the students beyond celebrating holidays such as Children's Day and Women's Day; they focus on the holidays....". In a similar way, one teacher participant confirmed this as follows: "The other issue was that the teachers who attended the trainings were not equally committed, despite the fact that we attended the training and discussed also trained teachers shifting to other schools... I believe it is due to the organization that provides the training. I mean, this one would benefit from some direction from the organization. We do not have such initiatives because we just implemented their order."

From all six teachers interviewed, almost half defined sexual and reproductive health as related to mothers' health during pregnancy as well as during birth. The rest explain it as health related to reproductive organs and reproduction.

".... Sexual and reproductive health promotes a healthy way of life for mothers. When we say reproductive, we mean when mothers receive special care and give birth. However, even before they reach the stage of giving birth, they should be physically, mentally, and psychologically prepared to feel strong and achieve better results...." (31 years old male KII participant)

Most adolescents reflect that the teachers don't have the awareness on how to engage adolescents in sexual and reproductive health programs. In this regard, 18 years old female KII participant mentioned as;

"Teachers are one of the factors that influence student engagement, which means that when they first start the club, they will select students who will perform well or who they are friendly with, and then when they find the club has too many members, they will expel them by saying you did not meet the criteria. When the school blames them for not including all of the students, they will invite that student to join, which is detrimental to the student's morale and discourages them from joining...." (18 years old female KII participants)

5.6 Community level barriers

Societal belief

The two community leaders interviewed mentioned that adolescents are usually counted as non-productive age groups who only work for themselves rather than the community as a whole, and the community counts them as a part of the community that doesn't work or has a use. This can be substantiated by the remark made by the one male community leader:

".....If we go to the idea of knowledge, a lot can be learned at this age but usually in this community they will not look for knowledge and they have been facing a number of problems so starting from the foundation works should be done because once they reach the higher age they will not accept what is being told so if the adolescents can get the awareness..." (50 years old male KII participant)

In the controversy, two-thirds of adolescents stated that the community counts them as children and doesn't count what they do in serious terms. Even when adolescents prepare dramas, literature, and other programs, when they perform them to the community, most of the community doesn't take them seriously, which is discouraging for them. They also mentioned that usually, the community mocks them based on the character they play in the dramas, which they stated it is embarrassing for them. This finding can be backed up by a statement of a focused group discussant saying,

"Another thing that people say to me when I act like a mother on stage is, "You are young, what are you doing acting like a mother?" They even refer to my father as having no children as a result of this, so what I am trying to say is that society does not accept what we are doing, even though some people encourage me. As a result, both the family and the community are impediments to our participation....." (17 years old female FGD participant)

The majority of participants reflect that early marriage is one barrier to the engagement of female adolescents. Since early marriage is a culture in the community, the girls won't concentrate and engage in such programs. A teacher and youth club leader participant, respectively, mentioned their statements as follows:

"....So when we say what should be done in adolescents as school and when we engage them in some activities, when we hear that the girls are going to get married, we report to the woreda, kebele, or women's association, but these bodies can not even implement because they deal with these parents who force their child to marry, then they will divert the problem to us and say it is because he wants her for himself and such, so the community does not have the awareness..."
(39 years old male KII participant)

".....get married early before they even finish their program..." (23 years old female KII participant)

All community leaders and youth club leaders reflect that the community relies on the backgroundchange, so of the person in the community to accept (such as religious leaders and elders) and attend the programs that person prepared, or some sort of benefit should be there where that person can provide it so that they hear what they want to reflect, which causes adolescents who engage to give up on their engagement with the mindset that nothing will change, so they won't have the interest to engage in these clubs because of a lack of results.

"....The community is not yet alert; the community must still be aware of many things. I mean, ... If you go to the woreda or kebele, the community may not even know what the purpose of meetings is. For example, if you call the community for meetings, they may not come because they believe they will not benefit from it....."
(56 years old male community leader KII participant)

"....As I previously stated, in our community, you must build/demonstrate trust. It could be religious leaders, elders, or a teacher named Shamble, who has widespread acceptance, and I am confident that if he begins to provide sexual and reproductive health education, the entire community will change...." (24 years old male youth club leader KII participant)

In addition to these barriers, the finding also highlighted that more than half of teachers believed that migration is common in the community, where adolescents, especially girls, discontinue their education and migrate to make their lives better after observing others change through the same process, which disrupts the continuity of activities.

"... Most of the time, migration is common in this community, and it is also all set up for migration at this age, so they usually get pushed or excited to migrate because the migration is mainly for the purpose of money (this time aged adolescents/youths are money based) they usually think the shortest way to find money instead of thinking about finishing their education and finding a job so they usually migrate and end up dying, going to bad places, or failing, which is sad for their family. The person you observed performing or doing well may migrate the next day or marry before finishing their program." (38 years old male KII participant)

In the same way community leaders also stated their concern as *"...but the biggest problem in this community which drag our attentions from sexual and reproductive health as well as marriage also education...is migration where the adolescents migrate since the young age where at age of 15, 13 years old so migration is the biggest problem that is affecting our community...the adolescent/youth hope is now migration instead of thinking about how they can learn about sexual and reproductive health or marriage and how I can communicate with my community and grow they wont think about such things..."* (65 years old male KII participant)

Of the four youth club leaders three of them mentioned that they couldn't undertake their engagement activities because of the current instability which makes it difficult to engage adolescents as; *"... We do not go to clubs anymore because of the current situation, because of the war. They all want to work, they even come but when half the members come today the other half won't show up and when the other half shows up tomorrow this half might not come..."* (24 years old male KII participant)

Awareness

Almost all out-of-school adolescents from rural areas mentioned that the community counts them as rude or indecent because they teach and create awareness regarding sexual and reproductive health. In the community, talking about sexual and reproductive health in public is rude or indecent, and since they discuss sexual and reproductive health issues such as contraceptives in the club, the community doesn't have a good image of their club, which they stated makes it difficult to work in the community and mentioned that it is because the community has no adequate awareness. In support of this community leader, he mentioned that:

"...It is improving, but it was seen as a shameful/unacceptable thing where even children, especially girls, were misbehaved because they did not have a job they would do (workless) because they did not have the awareness..." (50 years old male KII participant)

".....When we say the community, in this case the adolescents, talks about this trainings, they usually tell the adolescents that if we teach them inappropriate/rude things, for example, for those who are older (above 7th grade) and we teach them about condom utilization to prevent sexual transmitted disease, HIV/AIDS, they assume that we teach them to make them use it, as we want them to directly engage in it..."(24 years old male KII participant)

5.7 Institutional level barriers

School related barriers

In the school, all teachers reflect that the school system doesn't provide adolescents engagement in the sexual and reproductive health programs (school clubs) at all levels (from planning to monitoring and evaluation) where the adolescents engage as beneficiaries to take training or to receive aid when it comes from non-governmental organizations or prepare dramas or literature to create awareness, in which they don't have any other engagement in the planning or evaluation of the program because what has been practiced is by the teachers where the students only engage in the implementation level.

"... In general, as a responsible person, the teacher will prepare the report as a leader by taking what the club has done (whether it is drama or awareness creation), which is the practice (common way of working)..."(28 years old male KII participant)

"... At the school level, there are clubs that are initially organized by the ministry of education and must be formed in the school, such as a women's club and an anti-AIDS club....the teachers are the ones who lead and control the club, so adolescents will not have a place in the club other than in the activities...." (19 years old male KII participant)

From a total of six teachers interviewed, six of them reflect that they don't have enough resources (budget or material) to engage adolescents, and adolescents leave the club when they don't find something they expected to get from the club. In this regard, one female 34-year-old teacher expressed her concern as ; *"...There should be a budget to meet their expectations by focusing on such issues because if appropriate attention is not given, students will abandon these clubs, so higher levels should pay attention and the club should work more effectively... Because it is not a comfortable place for adolescents to change their sanitary pads, they filed a complaint with the school, but the school was unable to resolve the issue...."*

Program implementation

Two of the programmers, all woreda health officers, and youth and sports officers interviewed described limited resources as a barrier to engagement focusing on adolescents' SRH problems. In contrast, out-of-school adolescents purported that there were adequate resources, but mismanagement resulted in limited resources for engagement purposes. The following quotes reflect their concerns:

"...For example, there could be a large stage for adolescents/youths, and to represent the youths of Shewarobit from here, there would be a lot of expenses for that person to be taken and participate in that stage, which would be a budget constraint..." (woreda health officer, KII)

"...The first is the administrators, and the second is a budget shortage. For example, the budget for football is larger, but the budget for clubs is much lower. If one club plans to prepare a program, a lot of materials and time will be needed, so I believe that is why..." (19 years old male FGD participant)

In addition, out-of-school adolescents reflect that due to financial constraints in the youth clubs, adolescents can't undertake their activities in the way they should or as they planned in the initial stage of their work, where they stated that government officials don't support them at all and the aid from non-governmental organizations are not sustainable or permanent, which doesn't allow them to go as planned. In the same way, the two programmers mentioned that their support can't be permanent or sustainable since they are working on a project with a limited budget.

"...In terms of representation or coverage, we can not address everything because time and budget are limited because it is a project...you know the work of a project it is about doing something and showing I mean it could not last forever like a regular program, so as I mentioned earlier, we try to reach some through plate forms like peer to peer education, campaign, advocacy, and advocacy workshops..." (31 years old male KII participant)

All Woreda health officers and youth and sports officers interviewed were often willing to allow young people to air their views and vote but did not accept young people taking up key decision-making positions. In one research site, adolescents were not even part of the committee that was formed to reduce what they call harmful traditional practices such as early marriage in their community. In the woreda council, the programmers state that they have a place to reflect their voice, but the woreda officials claimed that even though the adolescents have the role to give ideas, they can't engage in decision-making roles. In addition, the two programmers state that the adolescents who are usually invited to meetings and given roles are politically affiliated and don't reflect the voices of other adolescents but are cited as dolls to fulfill the positions. The following quotes are part of the responses from the participants:

"...There is no process in place to include adolescents in this committee, but in communities where these issues are prevalent, we include individuals who are believed to be capable of resolving community issues, such as religious leaders, but not youths/adolescents... they were not included in the committee because, despite their age range of 10 to 19, it was not believed that these adolescents could solve the community's problems..." (Woreda health officer, KII)

"...It is, as I previously stated, because it is not believed that they can go into the community and stop these harmful traditional practices... So when the TOR comes from a higher level, they are not included in the committee..." (Woreda health officer, KII)

In the same way, almost all out-of-school adolescents mentioned that the officials don't give them a time, an emphasis, or a place at which they usually want them to color their programs, as well as whenever they want to show that they are working with them; otherwise, they stated that they don't even attend when they invite them to their programs. Moreover, two out of four teachers reflect that the programmers don't follow the progress of their work once they implement and train, which makes the trainees leave the work after some time, and the adolescents don't engage in that case. The following quotes are from adolescents and teachers:

"...The kebele does not support us and is unaware of what we are doing at this time. They are aware that we have a meeting every Saturday, but they have never attended. ..." (18 years old female KII participant)

"...On the other hand, they appear to be concerned about the problems at the meeting. They made a fool of you. They promise to assist you in their meetings, but when you go out and ask, they tell you to get lost. They say we do not have this, we do not have that, they tell you to ask this person, ask that person, and when these issues arise, we usually end up insulting them and telling them off, but they do not even listen...." (19 years old male KII participant)

"...only to take pictures and videos, but did not take the situation seriously. Simply to take their salaries and budgets. In contrast, we were fighting for the community." (16 years old female FGD participant)

"...There are kebele officials, even at the woreda level, who work with us, but they want us to highlight the program or color or educate the community through entertainment; otherwise, they do not allow or give us the opportunity to speak out about our problems or engage in appropriate and wider ways...." (19 years old male FGD participant)

"...They do not care; they just want to take pictures, so I doubt they understand. I have given up on them; we do not even check them anymore, and we have stopped doing the work." (18 years old male FGD participant)

Two of the programmers interviewed for this study explained the engagement of adolescents as adolescents' engagement in areas that are especially important to them because other bodies are the ones who decide for them, especially at early adolescence age, but they mentioned that they must be the ones who decide in their own lives which concern them. On the contrary, woreda health officials and youth health officers define engagement as when adolescents can engage in clubs and perform dramas, literature, and other activities to create awareness in the community as well as reflect their ideas and problems, not in the case of decision-making, where three of them explained that they don't have any further information on how to engage adolescents in sexual and reproductive health programs.

"...woo in that case, they might provide the question, but since it is an institution, it has its own leader, so we will discuss it, then they might be right and ask us to lead some programs that have been prepared, then we will not allow them to decide on their own, but we will discuss with the concerned experts, then we might allow them or not...but there is no such thing that they can decide and implement on their own...." (36 years old male KII participant)

Woreda health officials and youth and sports officials in three sites asserted the lack of policy guidelines, laws, or regulations on embedding adolescents' representation in sexual and reproductive health programs where the structure or system of the government doesn't give any direction or allow to engage adolescents in planning, monitoring, and evaluation of a program in which the plans come from the higher level to the lower level; therefore, there is no method or way to engage the adolescents; this is the trend where they have worked so far.

'...As I previously stated, we plan any activity based on the number provided by BOFED, so we plan based on that number... So they did not participate in such activities in our sector as a partner, for example, for STI they are one risk group, and for teenage pregnancy they are one risk group, so there is convulsion which is given to us as a number from a certain population, and that is how we plan...' (32 years old male KII participant)

"....As I previously stated, when we plan it comes from the higher level, but the written approach is from lower to higher, which is not feasible. Instead, we use what comes from higher levels and plan accordingly, so when we say believing they are important, we are referring to the lower to upper approach...." (34 years old male KII participant)

"...(laugh...) first, the system does not allow you or provide direction.... When I say it is not common, I mean that there is no direction that tells you that you should involve adolescents/youths in your planning or evaluation. ..." (27 years old male KII participant)

In relation to these programmers and several other adolescents, it was mentioned that adolescents who engage in youth clubs as well as school clubs are selected based on age limit in the case of programmers as well as regardless of academic performance and grade in terms of being close to other adolescents who engage in the club activities or friends and relatives, which they reflect as not letting early age adolescents and other adolescents who have the interest to engage even though they don't have such connections or opportunities. The following quotes reflect the above statements from the participants:

"....As the rule of the NGO it should be greater than 15 to be a member but we also include children with age below 15 as a supporting member and when their age becomes 15, they will be registered as a member. However, they must be consistent and timely...." (19 years old male FGD participant)

"...no, I mean the project focuses on youths from 15 to 29 years old, and 24 years old is chosen based on her educational background; for example, if you take a 14-year-old child, that child will not be available whenever needed..." (34 years old male KII participant)

"...Even our club "Felagot" began in this manner because the chairperson's child is our friend, and she told us about the club and asked us if we wanted to join, so we did, and then we asked those who participated in the dramas, and that is how the club members were formed..." (14 years old male FGD participant)

All programmers interviewed, one youth and sports officer, and almost all of the participants from two research sites consistently mentioned place of engagement as a barrier to the engagement of adolescents in sexual and reproductive health programs. In one research site, the youth club where the adolescents engage (such as through peer-to-peer education) was found in a place where prostitutes work and different bars are found, a place that has a bad reputation in the community, and the adolescents mentioned that their parents won't allow them to go to such places because they can't engage in sexual and reproductive health programs even though they want to. In the same way, on the other side, the youth club is found far away from the village, and in addition, the place is known for young individuals having sexual activities in open houses built or given to youths by the government; therefore, they mentioned that their parents don't permit them to go that far away from home and to a place that has a bad name because they fear the community might see it and give it a bad name for their children.

"...There are numerous challenges in the adolescents/youths, beginning with finding a place/office to work. For example, if you see Dagim Tesfa working inside kebeles, it was difficult for them to find another office after it was destroyed. We also went to the city administrator in this case.... .." (31 years old male KII participant)

"...In terms of the location of the youth clubs, it may be far from the center of the community, which may be unsafe, and the materials for the youths may be inadequate, but they work as best they can..." (36 years old male KII participant)

"...our club is located on the main place, at 'kewet Ber' When we work there, parents fear pregnancy because, as I previously stated, they believe she is going there to misbehave, which is why we go to their families and explain..." (18 years old female FGD participant)

This confirmed by parents as; *"...The location is found in between the prostitutes' work places. If you leave the club, it appears that you are doing something else or want to have sex with boys, which is what we believe. Even if you go outside in the gate and stand, it appears that you are doing something else....."* (A 38 years old female KII participant)

The other barrier mentioned by one-third of participants from urban areas is the dual purpose of the club where the clubs have their objectives other than sexual and reproductive health activities which their parents count the club as useless and also because of the work time after school, where mentioning they would go to dance and sing therefor, they won't allow them to engage

In this regard a 17 years old male discussant stated;

"...Let me tell you, the club devotes nearly 80% of its time to art as a primary service; we usually do not bother with anything else, but the adolescents are welcome to join us in whatever we are doing..." especially in the case of protestant religion parents doesn't allow their Childrens to attend such kind of clubs, where the clubs are formed by culture and tourism department which the religion doesn't allow. One parent supports this statement as; *"...I will not refuse permission, but if there is one place for youths to have fun where the girls comb their hair and the boys turn up the music loud enough that it can be heard all the way to the farm and together they do something and when we see them there are no results or any change..."*. The factor of place of engagement as a barrier could be better elucidated by a statement given by a programmer as;

"...adolescents are more focused on (attracted to) their own objectives, which is why the club is formed. For example, there is a club called Circus Shewarobit, which focuses primarily on the circus and whose goal is formation rather than sexual and reproductive health..." (31 years old male KII participant)

6. Discussion

This study explores barriers to adolescents' engagement in SRH programs by illustrating the multidimensionality and interaction of the factors that limit adolescents' engagement in sexual and reproductive health programs. The barriers were intertwined and reinforce each other across different levels of the SEM (Figure 2).

In adolescents engagement status, the majority of adolescents were primarily involved in the implementation stages of sexual and reproductive health programs rather than being fully involved, which was similar to the operational study conducted in women of reproductive age (15-49); in-school and out-of-school youths by four young co-researchers and a principal researcher, who held 11 focus group discussions with 68 adolescents and 8 adults and 10 in-depth interviews with adolescents and 20 with adult staff. Youth are currently primarily involved in the implementation of ASK in Addis Abeba, Dessie, North Shoa, and Hawassa, as specified, as they mobilize peers and create awareness of SRHR-related issues. Adults' perception of adolescent involvement as having the most additional benefit in terms of mobilization and awareness suggests. This is most likely the case because adults see mobilization and awareness as the main added value of youth involvement (22,57).

As the individual level barrier, the majority of adolescents do not have detailed knowledge of what sexual and reproductive health is, and as a result, it affects their interest in being engaged. This is also reflected in a similar case study in Kenya involving youth 15-24, which stated that because of the lack of awareness adolescents have on SRH, their engagement in community health care units is low. Similar study conducted in Kenya to examine the factors affecting adolescents' participation in SRH, in order to discourage young people from contributing meaningfully to CHC discussions and activities that also involve in relation to skill low educational attainment, lack of skill or technical know-how, which all this rendering them unfit to perform their roles which are assigned or given to them (21,49).

Participants from the three study sites consistently mentioned that adolescents, especially boys, prefer to go to other bad places, such as bars and places for chewing khat, instead of engaging in SRH programs of the youth clubs and in school clubs. The results showed that adolescents, especially in urban areas and also in rural areas more recently engaged adolescents prefer to engage in risky behaviors such as drug abuse and other risky behaviors instead of being engaged in those programs, where evidenced by a report's findings the Yes I Do project was carried out in the North Shoa zone, a study area where it is said that adolescents lack discipline and are more likely to consume drugs (20).

According to this study, more than two-thirds of early-aged adolescents think they are too young to participate in or make decisions about sexual and reproductive health issues because of their age or because they believe they are young which the study also shows late age adolescents (15-19 years old) engage in decision making of the activities of the youth clubs. This is supported by research from a program in Western Kenya that is similar to it, the ASK program's operational study on "Exploring the Factors that Influence Meaningful Youth Involvement in the Health Care System Management." Which state, although young people were present on the decision-making boards, they felt helpless and were denied the right to vote and falls short of the MYP definitions' emphasis on equality and participation in decision-making. Assigned but informed is still one of the five "petals" of the participation flower, meaning it is regarded as a significant type of adolescent engagement, and the CHOICE model underlines that there is not always a hierarchy of forms of participation. It is a type of "low responsibility," though, and it falls short of what adolescents themselves want in terms of having more decision-making authority (35,49). The early adolescents population also feels that because they are under to family authority, they are unable to make any decisions other than those of their families, particularly those regarding their participation in sexual and reproductive health issues.

Gender variation was also seen in the finding from the interviews of the participants where teachers and programmers stated that females are the one who are more engaged in sexual and reproductive health programs because of girls empowerment and more opportunities are there in sides of programmers. This finding contrasts with that of a study conducted in Malawi on youth participation in policy practice and progress, where the difference is explained because of the area of focus which is policy and program level as well as difference in setting and program of focus (46).

At the interpersonal level barriers, in this study, all uneducated parents (n = 6) don't allow their children to engage in sexual and reproductive health programmes that their adolescents should focus on their education and that participating in such clubs would divert their attention from it. As a result, none of the study's participants' children were allowed to participate in sexual and reproductive health programs. Additionally, two of them claim that the adolescents must assist them with home chores because if they get involved in these activities, it will take up their time and they will not assist with the chores. Furthermore, they claim that they will change their behavior negatively. They also assert that their behavior will change negatively. Nearly all parents admit that they have never observed any changes in or outcomes as a result of their children's participation in youth clubs; as a result, they do not want their children to spend time there. Similar to a study done in 2021, which involved an environmental scan study of youth engagement networks and a review of various literatures, it found that one factor that might discourage adolescents from participating in programs for sexual and reproductive health was families' attitudes toward the program. Additionally, it was suggested that parents should have a positive outlook on the program and that "additional education and empathy are needed to help families feel comfortable with young people's involvement."(26). Furthermore, because families have a strong influence on adolescents' sexual and reproductive health decisions, their decision to participate in SRH would be influenced (44).

In relation to parents, although these parents indicate that they don't want the adolescents to engage in these clubs, most parents (n = 7) consistently mentioned that they might tolerate it if the program is at school since there would be close follow-up from the teachers. Additionally, one parent said that if there was an adult who could assume the duty and who could alert the parents ahead of the event, they would consent for their child to participate. Adolescents who do not attend school are more likely to be engaged than those who do, despite parental support for attending school. This variation is also explained by a study on youth involvement in HIV and sexual and reproductive health policies, programs, and decision-making conducted in the USA. According to perspectives from the field, being in an educational setting helps parents feel secure about their children and helps them trust adolescents (44). Additionally, there were differences between early- and late-adolescents in terms of age, with the majority of early-adolescents never participating in SRH programs as a result of family pressure.

Participants also noted that adolescents do not participate in sexual and reproductive health programs if their parents are protestants because the youth club doubles as an art club. As a result, parents worry that their children will attend the club to dance and perform, which is against their religion, and they may also believe that they will follow what the club members discuss. According to the findings of the youth engagement network's environmental scan, religious beliefs, the taboo against adolescents talking about SRH issues, are all deterring adolescents from participating in SRH initiatives (26).

At the community level barriers, according to the community leaders who were interviewed, adolescents are typically considered as non-productive age groups that only work for themselves rather than the community, and the community views them as an unproductive member of the community. Similar findings from the youth engagement networks environmental scan study indicated that adults do not value adolescents contributions and do not think they are capable of taking on leadership roles or possess the necessary abilities to successfully complete tasks (26).

The majority of participants agree that one barrier to adolescent girls' engagement is early marriage. The study conducted in Kenya and Pike's argument that young people's social position is closely linked to cultural views of marriage as the point of transition to adulthood reflect the fact that girls will not focus on and participate in such programs because early marriage is a culture in the community (58). Young people's transition to adulthood is delayed when the average age of marriage rises, placing them in an extended "waithood"(36). The prospects for MYP may be limited as a result, especially for young people beyond the age of 18, who are legally adults but are still viewed as children socially and culturally and are not expected to engage as adults. This is referred to as a position of "non-adults whose potential as social, civil, and sexual actors is under-recognized". Effective MYP, "requires a rights-based approach that views young people as active social agents" (59).

At the institutional level barriers, In a similar vein, almost all of the out-of-school youth mentioned that the officials do not give them a time, emphasis, or location at which they typically want them to color their programs, as well as whenever they want to show that they are working with them; otherwise, they stated that they even do not attend when they invite them to their programs. In addition, two out of four teachers report that programmers do not monitor the development of their work after implementation and training, which causes trainees to stop working on it after a while and prevents adolescents from participating: Lack of resources, political interference, and a lack of guidelines and structures on how to engage youth at different levels make it difficult to find youth who truly represent the diversity of racial, ethnic, and socioeconomic backgrounds, as shown in studies conducted in Kenya and in the report of an accountability survey of the global consensus statement on meaningful youth engagement (21,43).

The dual purpose of the club and the venue where the youth clubs are found were also a barrier for adolescents engagement in SRH programs in this study noted by one-third of participants in urban areas, which is explained by an accountability survey of the international global consensus of youth engagement studies as assessment were not done prior to selection of a place for youth advisory board office due to biased decision making and recruitment process, and this may be due to variations in how program sites are implemented.

The use of an explorative qualitative method, which is the best method for gathering adequate data on socio-cultural determinants, along with the application of a socio-ecological model, which allowed for the analysis of barriers at various levels, are the study's strengths. Additionally, the study used a variety of data collection methods, including triangulation, which allow the cross-validation of the data. Although the adolescent's participation in SRH incorporates policy, financial release, and other factors, this study mainly focused on program owing to time and resource constraints. The fact that it disregards the information provided by health professionals is another limitation of the study.

Summary

	Key Barriers
Individual level	Lack of Awareness on SRH, SRH Problems and Engagement, Value on age, Drug addiction, lack of skill
Inter-personal level	Family expectation, Fear of spoiled, Family Educational level, Lack of information, Place of engagement , SRH as a taboo, Religious belief, Fear of nick names, being discouraged, lack of attention
Community-level barriers	SRH as a Taboo, Background status matters in the community, Benefit based, value on age, early marriage
Institutional-level barriers	Lack of Budget / Mismanagement, Misrepresentations/ Politically affiliated ,Lack of information and trust , Tokenism/ Coloring of Programs, Structure/ system of working ,Age limit in case of youth clubs ,Lack of assessment of the place of engagements

7. Conclusion

Despite the different levels of barriers in adolescents' engagement in SRH programs illustrated in the results, the awareness of both adults and adolescent people towards SRH and meaningful engagement should be emphasized. The results demonstrated widely held negative perceptions of the importance of adolescents' participation in SRH programs. Furthermore, it is important to note that the research was undertaken at a middle stage in the program, with organizations and communities that were new to the concept of Meaningful adolescents' engagement (Power to youth). While it is important that both global- and community-level actors review the mismatches highlighted above, such points should not be underestimated. Each level has its own effect on adolescent engagement, where not only the individual or adolescents decide on their engagement, but also different levels found surrounding their environment, ranging from their family and peers to the institutional level, which includes the community in which adolescents live and grow. Families are the primary decision makers in adolescents SRH, with expectations from their children in terms of household tasks as well as educational achievements preventing adolescents from deciding on their own in their engagement to SRH. A factor at the institutional level that has been found to affect or be related to a factor at the individual level where a lack of adequate assessment of places of engagement for engaging adolescents affects their awareness in SRH in any way, which needs to be emphasized. In this regard, the system or lack of well-structured direction of engagement for responsible persons to engage adolescents was not available, as evidenced by the outcome. In addition to the persistent taboo of quantifying adolescents' engagement in SRH, the value assigned to the age of adolescents was discovered to be the primary community level factor influencing their engagement. As a result, while focusing on adolescents' engagement in the SRH program, inclusiveness and the interplay between diverse components should be considered.

8. Recommendation

Based on the study findings the following recommendations were put in place for specific stakeholder; -

Individual

- Develop comprehensive and age appropriate SRH education programs targeting adolescents, focusing on accurate information, consent, and gender equality.
- Conduct awareness campaigns to address and dispel myths, misconceptions, and harmful beliefs associated with SRH.
- Collaborate with community leaders, religious institutions, and parents to bridge cultural and religious gaps and encourage open dialogue about SRH.
- Advocate for inclusive SRH education policies that address the needs of diverse populations.

Interpersonal

- Promote family and peer involvement in SRH education, fostering supportive environments for dialogue and decision-making.
- Provide comprehensive training for parents, guardians, and mentors on effective communication and guidance related to SRH topics.

Community

- Engage community influencers, such as community leaders, teachers, and healthcare providers, as advocates for SRH education and support.
- Create platforms and opportunities for adolescents to connect with positive role models who prioritize SRH and reproductive rights.
- Advocate for the implementation of youth friendly SRH services in community settings, ensuring accessibility and inclusivity.

Institutional

✓ School

- Developing and implementation of a system that engages adolescents in their SRH areas.
- Creation of an appropriate environment and emphasis on adolescent engagement and related activities

- Empower, mentor, and motivate adolescents to actively participate and organize their own clubs, as well as give training and skilled teachers to enable their participation.
 - ✓ Federal Ministry of Health/FMOH/ Programmers at Government level
- Creating a health management system framework that includes adolescent’s engagement from the top down, with a clear indication of their roles, expectations, and rewards.
- Young individuals (adolescents) should be assigned a certain number of posts, and protocols should clearly outline their tasks, expectations, and performance metrics.
- Increasing the capacity of different levels of health authorities in SRH, adolescent engagement, and methods of adolescent engagement.
- Mechanisms for disseminating information on strategic objectives to various health professional leaders and officials.
- Acceptability could be strengthened by defining meaningful adolescent participation in the local context collaboratively (organizations, community, adults, and young people or adolescents).
 - ✓ Programs at NGO level
- Increase adolescent’s empowerment through mentorship, inspiration, and (refresher) training, as well as connecting young people or adolescents to financial options and developing their entrepreneurial talents.
- Organizations could improve adolescents’ motivation by providing financial and non-financial incentives such as stipends, reimbursement for transportation and lunch expenses, income-generating activities, and role performance certificates.
- On an organizational level, advocating for meaningful adolescents’ engagement can help adolescents integrate and participate in local health care management frameworks.
 - **For researchers**
 - Further studies considering health professionals and officials in ministry of health on implementation of the guidelines is needed and also other approaches could be applied using mixed study designs to further elaborate.

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Annex

Annex 1- Code Book

	Theme	Category	Code
Barriers to adolescents' engagement		Socio-demographic characteristics	Age, male, female, religion, grade, rural, urban, in school, early adolescent, late adolescent, out school, student, health officer, youth club leader, parents, teacher, program officer, parents' education, community leader,
		Engagement status	Youth club, school club, not engaged, leader, planning, implementation, monitoring, evaluation, meetings,
		SRH problem	Unwanted pregnancy, early marriage, teenage pregnancy, sexual violence, sexual harassment, FGM, unsafe abortion, early sexual debut, unprotected sexual intercourse, risky sexual behavior
		SRH service	Condom, post pill, injectables, abortion care, information, youth friendly, accessibility, affordability, availability, health service providers, sexual education, peer to peer education,
	Individual level	Awareness on SRH	Adolescents, reproductive organs, pregnancy, HIV, sexual transmitted disease, contraception, SRH right
		Awareness on SRH problems	Unplanned pregnancy, unsafe abortion, early marriage, sexual transmitted disease, HIV, sexual violence, FGM, early sexual debut, sexual harassment, unprotected sexual intercourse, teenage pregnancy
		Awareness on SRH services	Affordability, accessibility, availability, health providers, when to use, content, benefit
		Awareness on engagement	Benefit, policy, where to engage, engagement, ways of engagement, engagement in planning, engagement in implementation, engagement in monitoring, engagement in evaluation, beneficiary, messenger
		Skill	Leadership, facilitation, advocacy, communication, problem solving, managing emotions, decision making
		Belief	Young age, powerless, useless
		Behavior	Substance abuse, undisciplined, resistance, ignorant, commitment, sexual activity
	Inter-personal level	Peer related barriers	Misinformation, negative attitude, peer pressure, lack of information, lack of support, substance abuse
		Family related barriers	Fear, expectation from family, stigma, negative perception of clubs
		School teachers/ mentor	Knowledge, support, attitude

[Annex 2. engagement status and possible engagement areas for adolescents.](#)

	Engagement areas	Early adolescents (10-14)		Late adolescents (15-19)		Sex				Engagement level (own club programs not with programmers)					
						Male		Female		Planning		Implementation		Monitoring and evaluation	
		Freq	Perc (%)	Freq	Perc (%)	Freq	Perc (%)	Freq	Perc (%)	Freq	Perc (%)	Freq	Perc (%)	Freq	Perc (%)
Out-school	Filagot club	3	60	-	-	-	-	3	15	-	-	3	8.3	-	-
	Biruh tesfa cultural and SRH club	1	20	9	31	-	-	9	45	3	42	9	25	3	42
	Dagim Tesfa cultural and SRH club	-	-	8	27	4	23.5	4	20	-	-	8	22.2	-	-
	Abyssinia cultural and SRH club	1	20	7	24	8	47.05	-	-	3	42	7	19.4	3	42
	Fana Addis cultural and SRH club	-	-	9	31	5	29.4	4	20	1	14.2	9	25	1	-
	Shewarobit circus and SRH club	-	-	-	-	-	-	-	-	-	-	-	-	-	-
In-school	Women's club	11	33.3	2	50	3	30	-	-	-	-	13	35.1	-	-
	Anti-AIDs club	2	6.06	-	-	2	20	-	-	-	-	2	5.4	-	-
	Gender club	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Mahrebe club	18	54.5	2	50	5	50	13	86.6	-	-	20	54.05	-	-
	Sexual and reproductive health club	2	6.06	-	-	-	-	2	13.3	-	-	2	5.4	-	-
YFS	Youth friendly service			7	4.8	5	71.4	2	28.5	-	-	-	-	-	-

Annex 3. Study information sheet for FGD participants

My name isand I am a student at Addis Ababa University and I am conducting research on barriers for engagement of adolescents in sexual and reproductive health programs in different levels in here North Shoa specifically on two selected areas Shewarobit town and Kewet woreda for the partial fulfillment of a master's in general MPH at Addis Ababa University. The objective of the study is to explore the barriers that is preventing adolescents from engaging in sexual and reproductive health programs. Therefore, the study will contribute to engaging adolescents in sexual and health programs in different areas.

Study site and period; - the study will be conducted in Shewarobit town and kewet woreda of North Shoa zone, Amhara region, Ethiopia from October-May 2023 GC.

Benefit: - There will be no direct benefit to you, but the information you offer will be significant in conducting this research and the result will be useful to bring change in the engagement of adolescents in SRH programs.

Risk- There is no risk or harm for participating in the study. You will be asked about the barriers for engagement of adolescents in sexual and reproductive health where there is no right or wrong answer.

Procedures: You are selected by your age and knowledge on the area for this study and I kindly invite you to participate in this study. If you agree to participate, you will select your preferable time to discuss with other selected participants who are also around your age on barriers to adolescents engagement on SRH programs with some guided questions raised by one facilitator about the research. The discussion will take place for at least four times at least once per week which will last for 40min-1;30 hr. With your permission, I will audio-tape record the group discussion session so that the results are more accurate and better represent your actual words.

Participation: - You have the right to choose not to take part in this study and your participation is based on your willingness. If you choose not to take part, you have the right to stop the discussion at any time. If you are willing to participate or refuse or decide to withdraw later, you will not be subjected to any problems.

Confidentiality: - The information that you provide will be kept confidential. All participants will choose a pseudonym (make up name) for purposes of anonymity. Only the researcher will have your real name, and this will be kept private. While all participants in the group discussion will be asked to keep what is said in the group dialogue private, we cannot guarantee that others in the group will not share what is said. Your name and consent form will be kept separate from the discussion transcripts and data to ensure that you cannot be identified. If you consent to participate, all identifying information will be removed from the audio-tape transcripts so that your responses remain confidential. In other words, the transcripts will not include any identifying information and the audio tapes will be destroyed once they are transcribed. The information gathered, including audio-tapes and transcripts will be kept in a locked storage or password protected computer of the researcher. The researcher will be the only person who has the key for this locked storage or password for the computer. Some of your comments may be included in the reports written to summarize what has been learned from this study, however, the summary will not include any identifying information about you. Neither your name nor your identity will be used for any publication or publicity purposes.

Whom to Contact: - If you have any questions, you may contact the person stated below.

Biruktawit Taye- Tele: +251919404033

Email: Biruktawittaye256@gmail.com

Annex 4. Informed Consent for FGD participants

I confirmed that I understand the objectives and conditions of the study that I give my consent to be part of the study. I have been given the necessary information about the research; the risks and benefits have been explained to me. I understand that the information regarding my personal identity will be kept confidential. I agree to not disclose information that I hear from others in the group discussion and I have understood that it is my right to terminate participation in the discussion at any time. The purpose has been explained to me in the language I understand.

Informed consent Certified by:-

Participant

Signature _____ Date _____

Facilitator

Name _____ Signature _____

Annex 5. Parental or Guardian Permission Form for Research Involving a childrens under age of 18

Title of Research: Exploring barriers to meaningful engagement of adolescents in SRH programs. Researcher: Biruktawit Taye (BSc)

Your permission is being sought to have your child participate in this study. Please read the following information carefully before you decide whether or not to give your permission.

Purpose of the research: The purpose of this study I am conducting research on barriers for engagement of adolescents in sexual and reproductive health programs in different levels in here North Shoa specifically on two selected areas Shewarobit town and Kewet worda for the partial fulfillment of a master's in general MPH at Addis Ababa University. The objective of the study is to explore the barriers that is preventing adolescents from engaging in sexual and reproductive health programs. Therefore, the study will contribute to engaging adolescents in sexual and health programs in different areas.

Procedure to be followed: During research, your child will be given age-appropriate information, based on their level of comprehension and education in the form of verbal communication. Your child will be assigned to each group with consideration for their age group (i.e., 10-14-year-olds and 15-19-year-olds) and gender during the group discussion. Furthermore, if your child is selected, the selected participants are trained in how to take safe and ethical photographs of people and places (i.e. Photovoice) to help initiate further discussion on the topic.

Incentives/benefits for participation: Your child will benefit from participating in this study by developing self-confidence by participating in discussion and taking training on use of camera and ethics. The results of this study will increase knowledge of meaningful engagement of young people.

Confidentiality: All records are kept confidential and will be available only to professional researchers and staff. If the results of this study are published, the data will be presented in group form and individual children will not be identified.

Voluntary participation: Your child's participation is voluntary. If you feel your child has in any way been coerced into participation, please inform the researcher. We also ask that you read this letter to your child (if age-appropriate) and inform your child that participation is voluntary. At the time of the study, the researcher will once again remind your child of this.

Termination of participation: If at any point during the study you or your child wishes to terminate the session, we will do so.

Whom to Contact: - If you have any questions, you may contact the person stated below.

Biruktawit Taye- Tele: +251919404033

Email: Biruktawittaye256@gmail.com

I, the parent or guardian of _____, Child _____ years of age, voluntarily permit his/her participation in a program of research named above and being conducted by Biruktawit Taye (BSc)

Name of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____

Annex 6. Study information sheet for interview

My name isand I am a student at Addis Ababa University and I am conducting research on barriers for meaningful engagement of adolescents in sexual and reproductive health programs in different levels in here North Shoa specifically on two selected areas Shewarobit town and Kewet woreda for the partial fulfillment of a master's in general MPH at Addis Ababa University. The objective of the study is to explore the barriers that is preventing adolescents from engaging in sexual and reproductive health programs. Therefore, the study will contribute to engaging adolescents in sexual and health programs in different areas.

Study site and period; - the study will be conducted in Shewarobit town and kewet woreda of North Shoa zone, Amhara region, Ethiopia from November 2022-May 2023 GC.

Benefit: - There will be no direct benefit to you, but the information you offer will be significant in conducting this research and the result will be useful to bring change in the engagement of adolescents in SRH programs.

Risk- There is no risk or harm for participating in the study. You will be asked about the barriers for engagement of adolescents in sexual and reproductive health where there is no right or wrong answer.

Procedures: You are selected by your knowledge on the area for this study and believed that you are concerned about the issue on study and I kindly invite you to participate in this study. If you agree to participate, you will be interviewed on barriers to adolescent engagement on SRH programs with some guided questions raised about the research. The interview will last for 40min-1hr. With your permission, I will audio-tape record the interview so that the results are more accurate and better represent your actual words.

Participation: - You have the right to choose not to take part in this study and your participation is based on your willingness. If you choose not to take part, you have the right to stop the interview at any time. If you are willing to participate or refuse or decide to withdraw later, you will not be subjected to any problems.

Confidentiality: - The information that you provide will be kept confidential. Only the researcher will have your real name, and this will be kept private. Your name and consent

form will be kept separate from the discussion transcripts and data to ensure that you cannot be identified. If you consent to participate, all identifying information will be removed from the audio-tape transcripts so that your responses remain confidential. In other words, the transcripts will not include any identifying information and the audio tapes will be destroyed once they are transcribed. The information gathered, including audio-tapes and transcripts will be kept in a locked storage or password protected computer of the researcher. The researcher will be the only person who has the key for this locked storage or password for the computer. Some of your comments may be included in the reports written to summarize what has been learned from this study, however, the summary will not include any identifying information about you. Neither your name nor your identity will be used for any publication or publicity purposes.

Whom to Contact: - If you have any questions, you may contact the person stated below.

Biruktawit Taye- Tele: +251919404033

Email: [Biruktawittaye256@gmail.com](mailto:biruktawittaye256@gmail.com)

Annex 7. Informed Consent for Interview

I confirmed that I understand the objectives and conditions of the study that I give my consent to be part of the study. I have been given the necessary information about the research; the risks and benefits have been explained to me. I understand that the information regarding my personal identity will be kept confidential. I have understood that it is my right to terminate the interview at any time. The purpose has been explained to me in the language I understand.

Informed consent Certified by:-

Participant

Signature _____ Date _____

Facilitator

Name _____ Signature _____

Date of interview _____ Time started _____ Time completed _____

Annex 8. Focused group discussion and Interview Guide

Annex 8.1 Focused group discussion guide for adolescents

General information

Date:	
Place:	
Facilitator:	
No of participants (sex aggregated):	
Starting time:	
Ending time:	

1. What is meaningful engagement of adolescents for you?
2. What forms of engagements do you know in adolescents SRH programs?
3. How do you want to be engaged in SRH programs? (Planning, implementation, monitoring and evaluation, and knowledge dissemination cycle of sexual and reproductive health programming)
4. Can you tell us about your engagement in SRH programs, if you have?
5. What do you think are the factors preventing adolescents from engaging in SRH programs?
 - ➔ What if we start from you, what individual level factors are there that is preventing adolescents from engaging in SRH?
 - ➔ How do parents prevent the engagement of adolescents in SRH programs?
 - ➔ How do peers prevent engagement of adolescents in SRH programs?
 - ➔ What are the factors that prevent adolescents engagement in SRH programs in schools?
 - ➔ What are the factors that prevent adolescents engagement in SRH programs in health service facilities?

Annex 8.2 Interview guide for key informant interview
(Youth club leaders)

General information:

Date:	
Place:	
Interviewer:	
Interviewee name:	
Title/position:	
Starting time:	
Ending time:	

1. What is your understanding of meaningful adolescent's engagement?
2. What do you think about engaging adolescents in SRH programs?
3. How do adolescents are engaging in SRH programs in this area?
4. What factors can prevent their engagement in SRH programs?
 ➔ Probe based on their title and levels of engagement.

(Teachers, Parents, youth health officers, Community leaders and Program designers or directors)

General information:

Date:	
Place:	
Interviewer:	
Interviewee code:	
Title/position:	
Starting time:	
Ending time:	

1. What do you think about adolescent engagement in SRH programs?
(Please, tell us in your own words)
2. What has been your experience working with the young people in a program? (if there is any)
 - Was it difficult to work with young people How?
3. Tell us what has been happening with regard to engaging adolescents in SRH programs in this area?
4. What has been challenging in engaging adolescents in SRH programs?

Annex 9. Amharic Version of subject information sheet

የመረጃ መስጫ ሰነድ

ስሜይባላል።የአዲስ አበባ ዩንቨርስቲ ተማሪ ነኝ እና በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶችን በስነ-ተዋልዶ ጤና ላይ እንዳይሳተፉ የሚያደርጉዎቸው ነገሮች ላይ ጥናት እያካሄድኩ ነው በተለይ በሁለት በተመረጡ አካባቢዎች ሸዋ ሮቢት ከተማ እና ቀጭት ወረዳ ላይ። ይህ ጥናት ለመመረቂያ ጽሁፍነት ለአዲስ አበባ ዩንቨርስቲ እሚውል ይሆናል። የጥናቱ ዋና ዓላማ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይካፈሉ እንቅፋት የሚሆኑባቸውን ነገሮች ለይቶ ማወቅ ነው ። በመሆኑም ጥናቱ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በተለያዩ መስኮች በስነ-ተዋልዶ ጤና ፕሮግራሞች እንዲካፈሉ አስተዋጽኦ ያደርጋል።

ጥናት ቦታ እና ጊዜ፡- ጥናቱ በሰሜን ሸዋ ዞን፣ በአማራ ክልል፣ በኢትዮጵያ ከጥቅምት-ግንቦት 2015 በሸዋሮቢት ከተማ እና በከጭት ወረዳ ይካሄዳል።

ጠቀሜታ - ለእርስዎ ምንም ቀጥተኛ ጥቅም አይኖርም, ነገር ግን የምታቀርቡት መረጃ ይህን ምርምር በመርዳት ረገድ ትልቅ ትርጉም ይኖረዋል።

አደጋ- በጥናቱ መሳተፍ አደጋም ሆነ ጉዳት የለውም። ትክክል ወይም የተሳሳተ መልስ በማይኖርበት ሁኔታ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይሳተፉ የሚያደርጉዎቸው ነገሮች ላይ የሚያወቁትን ብቻ ይመልሱ። ።

ቅደምተከተል: እርሶ በዚህ ጥናት እንዲሳተፉ ከአካባቢው ላይ በአጋጣሚ/በእውቀት ተመርጧችኋል ፤ በጥናቱም እንዲሳተፉ በአክብሮት እጠይቃለሁ። ለመሳተፍ ከተስማሙ ከጥናቱ ጋር በተገናኘ የተወሰኑ ጥያቄዎችን ይጠየቃሉ። ቃለመጠይቁም ከ 40ደቂቃ-1 ሰአት ይወስዳል።

ተሳትፎ: የእርሶ ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ሲሆን ያለመሳተፍም መብት አልዎት። በቃለ መጠየቁ ወቅት ጥያቄዎችን መመለስም ሆነ የማይፈልጉትን ጥያቄ አለመመለስም ይችላሉ። ቃለ መጠየቁንም በማንኛውም ሰአት ማቋረጥም ሆነ ማስቆም ይችላሉ። በዚህም የሚደርስብዎት ምንም አይነት ጉዳት አይኖርም።

ምስጢራዊነት - የምታቀርባቸው መረጃዎች ምስጢራዊ ይሆናሉ። ከመርማሪው በስተቀር ማንም መረጃውን ማግኘት አይችልም። መረጃው ከዚህ ጥናት በስተቀር ለሌላ ዓላማ አይውልም።

ካልዎት እና ተጨማሪ ማብራሪያ ከፈለጉ ከስር በሚገኘው አድራሻ ላይ የተጠቀሰውን ሰው ማግኘት ይችላሉ።

- ብሩክታዊት ታዬ - +251919404033 - ሜል: Biruktawittaye256@gmail.com

Annex 10. Amharic version of Informed consent for interview

የፍቃደኝነት ማረጋገጫ ሰነድ

አላማ እና ስለጥናቱ የተደረገልኝን ገለጻ የተረዳሁ ሲሆን በጥናቱም ላይ ለመሳተፍ መስማማቴን እገልጻለሁ። ቃለመጠይቁንም በማንኛውም ሰዓት የማቋርጥ መብት እንዳለኝ ተረድቻለሁ። የጥናቱም ገለጻ በሚገባኝ ቋንቋ ተብራርቻልኛል። መስማማቴንም በፊርማዬ አረጋግጣለሁ።

የፍቃደኝነት ሰነዱን ያረጋገጡት

ተሳታፊው ስም:

ፊርማ _____ ቀን _____

ቃለመጠይቁ አቅራቢ:

ስም _____ ፊርማ _____

ቀን _____ የተጀመረበት ሰዓት _____ የተጠናቀቀበት ሰዓት _____

Annex 11. Amharic version of FDG and interview guide

የአፍላ ወጣቶች ትኩረት ያደረገ የቡድን ውይይት መምሪያ

አጠቃላይ መረጃ

ቀን:-	
ቦታ:-	
አወያይ:	
ተሳታፊዎች (በጾታ)	
የመጀመሪያ ሰዓት	
የማጠቃለያ ሰዓት	

1. የአፍላ ወጣቶች ንቁ ተሳትፎ ማለት ለእናንተ ምን ትርጉም አለው?
2. በስነ-ተዋልዶ ጤና ላይ ምን ዓይነት የንቁ ተሳትፎ አይነቶችን ታውቃላችሁ?
3. በስነ-ተዋልዶ ፕሮግራሞች ውስጥ መሳተፍ የምትፈልጉት እንዴት ነው? (የስነ-ተዋልዶ ጤና ፕሮግራም ማቀድ፣ መተግበር፣ ክትትልና ግምገማ እንዲሁም የእውቀት ማሰራጨት ዑደት)
4. በስነ-ተዋልዶ ፕሮግራሞች ውስጥ ስለተሳትፎችሁ ልትነግሩን ትችላላችሁ? (ካለዎት)
5. በአፍላ ወጣት ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይሳተፉ የሚከለክሉ ነገሮች ምንድን ናቸው ብላችሁ ታስባላችሁ?
 - ➔ በአፍላ ወጣት ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ላይ እንዳይካፈሉ የሚያግዳቸው ምን ዓይነት የግለሰብ ደረጃ ምክንያቶች አሉ?
 - ➔ ወላጆች በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይሳተፉ ተጽእኖ የሚያደርጉት እንዴት ነው? ጓደኞች በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይሳተፉ ተጽእኖ የሚያደርጉት እንዴት ነው?
 - ➔ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶችን ትምህርት ቤቶች በስነ-ተዋልዶ ጤና ፕሮግራሞች እንዳይሳተፉ ተጽእኖ የሚያደርጉት በምን መልኩ ነው?

→ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በጤና አገልግሎት መስጫ ተቋማት ውስጥ በስነ-ተዋልዶ ጤና ፕሮግራሞች ላይ እንዳይሳተፉ ተጽእኖ የሚያደርጉት ነገሮች ምንድን ናቸው?

ቃለ መጠይቅ

ቁልፍ መረጃ ሰጪ አካላት ቃለ መጠይቅ

(ወላጆች, የሃይማኖት መሪዎች, ተፅዕኖ መፍጠር የሚችሉ ሰዎች, የትምህርት ቤት መምህራን እና የጤና አገልግሎት አቅራቢዎች)

አጠቃላይ መረጃ

ቀን:-	
ቦታ:-	
የጠያቂ ስም-	
የተጠያቂ ስም:-	
ርዕስ/ክፍል:	
የመጀመሪያ ሰዓት	
የማጠቃለያ ሰዓት:	

1. በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች ስነ-ተዋልዶ ላይ ስለሚኖራቸው ተሳትፎ ያላችሁ ግንዛቤ ምንድን ነው?
2. በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ፕሮግራሞች ውስጥ መሳተፍን በተመለከተ ምን ያስባሉ?
3. በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በዚህ አካባቢ በስነ-ተዋልዶ ፕሮግራሞች ላይ እንዴት እየተሳተፉ ነው?
4. በስነ-ተዋልዶ ፕሮግራሞች ውስጥ እንዳይሳተፉ ተጽእኖ የሚያሳድሩባቸው ነገሮች ምንድን ናቸው?

→ ከመጡበትና እና ተሳትፎ ደረጃ ላይ ተመስርቶ ይመርመር.

(የወጣቶች ክበብ መሪዎች፣ የአፍላ ወጣቶች እና ወጣቶች ጤና ባለስልጣናት፣ የጤና ቢሮና ፕሮግራም ዲዛይነሮች ወይም ዳይሬክተሮች)

አጠቃላይ መረጃ

ቀን:-	
ቦታ:-	
የጠያቂ ስም-	
የተጠያቂ ስም:-	
ርዕስ/ክፍል:	
የመጀመሪያ ሰዓት:	
የማብቂያ ሰዓት:	

1. በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ፕሮግራሞች ላይ ስለሚኖራቸው ተሳትፎ ምን ያስባሉ? (እባክዎ፣ በራስዎ አባባል)
 2. ከአፍላ ወጣቶች ጋር በፕሮግራም ላይ ሲሰሩ ምን ተሞክሮ አጋጥሞዎታል? (ካለ)
 - ፈታኝ ነበር? እንዴት?
 3. በዚህ አካባቢ በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶች በስነ-ተዋልዶ ፕሮግራሞች ላይ መሳተፍን በተመለከተ ምን እየተከናወነ እንዳለ ቢነግሩን?
 4. በአፍላ ዕድሜ ላይ የሚገኙ ወጣቶችን በስነ-ተዋልዶ ፕሮግራሞች ላይ እንዳይሳተፉ ሊያደርጉዎቸው የሚችሉ ነገሮች ምን አሉ?
- በተለያዩ ደረጃ ላይ መመርመር በተለይ የወጣቶች ተሳታፊ መመሪያዎችን ወይም የተሰጡትን ስልቶች ተግባራዊ በማድረግ ረገድ ተፈታታኝ የሆነው ነገር ምንድን ነው?

