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Does Facility Based Sexual and Reproductive Health Services Meet the Needs of Young Persons? Views from Cross Section of Ghanaian Youth

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Abstract

The focus on facility based health setting to provide sexual and reproductive health to the youth has been tested in several settings and achieved varying results. This study examined whether facility based sexual and reproductive health services met the needs of Ghanaian youth. Adopting the descriptive cross sectional design, 170 youths between the ages of 10 and 24 were sampled. A three-stage stratified random sampling technique was adopted. The results of the study are presented using descriptive statistics. The study established that a total of 55.8% (95/170) of the youth had utilized at least one or more of a sexual and reproductive health service in life time. However, only 45.2% (43/95) of youth used or accessed sexual and reproductive health services from a facility based setting. Facility based sexual and reproductive health service provided specifically for the youth is very limited. This calls for the provision of out-of health facility services located within the communities and at strategic places while ensuring confidentiality to the youth. More rigorous research is recommended on a national scale to examine youth preference for the type of facility based and out-of-facility based sexual and reproductive health services to meet the needs of young people.

Keywords

Facility-Based, Sexual and Reproductive Health, Young Persons, Youth, Needs, Ghana

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1. Introduction

The sensitive nature of discussing sexual and reproductive health matters in Ghana especially among young people makes service utilization difficult. Notwithstanding the difficulty in having such public discourse, improving sexual and reproductive health service utilization among young persons is significant for both economic and public health benefit to a country [1]. The sexual and reproductive health challenges that the youth face range from early marriage and child bearing, STIs and HIV which derail a nation's socioeconomic development.

A variant of issues emerge when it comes to the utilization of sexual and reproductive health services by the youth in health facility settings. Key among such factors is the attitude of health care providers. Studies by Katz and Naré [2], Erulkar and colleagues [3] in Senegal, Kenya and Zimbabwe respectively have identified fear as a major barrier to seeking sexual and reproductive health care in facility settings among youth. To young persons, the fear of being seen to be accessing sexual and reproductive health service made them feel ashamed about their needs. This is coupled with the negative attitudes of service providers, lack of privacy and confidentiality, and age restrictions. Thus facility related factors continue to pose a challenge to achieve the objective for establishing such sexual and reproductive health service giving facility.

Many countries employ recreational facilities as tools for providing sexual and reproductive health education to young people [4]. This has been done through empowering young persons in making sexual decisions through new skill learning. Despite the global dimension of these interventions, the success stories are mixed, without any consensus in the body of literature on the effectiveness of these interventions [5] [6].

Cost and programme ineffectiveness are mostly cited as the challenges to facility based sexual and reproductive health interventions [6] [7] (Ross, 2010). There is often the question of limitedness in evaluation designs for interventions in the Sub-Saharan region. A few evaluations on sexual and reproductive health have reported ability of such interventions to reduce risky sexual behaviours and resulting HIV and STIs [8].

Youth friendly reproductive health services influences service utilization positively [8]. It is widely acknowledged among reproductive service health providers throughout the world that "Youth Friendly" services are needed if the youth are to be adequately provided with reproductive health care [5] [9]-[11]. The demand for youth friendly services is informed by its ability to effectively attract the youths, meet their needs comfortably and responsively, and succeed in retaining these young clients for continuing care. These services should however be characterized by specially trained providers, privacy, confidentiality and accessibility to the youths [12]. However, youth generally do not see health as an issue of need of services [13] and that may access sexual and reproductive health service only when a sexual action has the tendency of causing danger, harm or discomfort to the youth. Brindis and Davis [14] indicated that the needed health service delivery that would be friendly to the youth should include the features as sexual and reproductive health education and counseling, physical examinations, cervical cancer screening and the STD screening, counseling, and treatment, HIV testing and counseling and others. There is a need for services that emphasize meeting the needs of young people in a variety of places where they congregate which includes malls, bus parks, the streets, recreational centres and sporting events [15]. This means bringing health services to the door step of the youths.

In the study of Zabin & Clark [16] in the USA, young people notably, virgins or those within two months of having had their first intercourse were more likely to enroll in a clinic with special teens hours rather than those which offered equal care for all people and not only the youth. Similar findings were made in Jamaica where clinics with special teen hours or solely made for addressing the health needs of the youth received much attendance by the youth [17]. This reiterates the need for separate services provided to the youth, to overcome their resistance to access the traditional health care system [18]. Though youth only facility-based sexual and reproductive health service has been documented to receive youth participation and service utilization [16]-[18], the youth continue to request out-of-facility sexual and reproductive health services [19].

In Ghana there are situations where youth have shown interest in facility based sexual and reproductive health services and reported friendliness of service though separate services were not created for them. Evidences exist in Ghana where youth who have shown interest in service have a difficulty locating where sexual and reproductive health services are located [20].

There is a component of reproductive health services that are out of health-facility based. These types of services are offered in homes by family members, older peers in community, outreach youth reproductive health services delivery by health education promoters, church and mosque leaders at religious meetings. The pivot of the services rendered to the youth is one that is acceptable, appropriate and accessible. In-school sexual and reproductive health services are essential component of out-of health facility services. In-school interventions

benefit from a ready-made audience and there is reasonably strong evidence of the benefits of using curriculum-based participatory and life skills approaches to increase knowledge and awareness [19]. Significant increase in condom use, knowledge of STDs and reduction in sexually transmitted disease symptoms as a result of In-school interventions has been reported in Nigeria when active referral systems between schools and health facilities were evaluated using a Randomized Controlled Trial (RCT) [21]. Earlier evidence of a quasi-experimental evaluation of an out-of-facility based intervention using a matched control did not establish any significant impact on reproductive health service use [22]. The evidence of the study was weakened on the basis that the schools and clinics chosen were chosen in part due to their willingness to participate. In addition the "before and after" groups differed due to high drop-out. The study did not account for the drop out reasons with the logistic regression only controlling for chosen variables. Other factors that correlated with the outcomes of interest may therefore exist [22].

Such weakness limited the out-of-facility sexual and reproductive health interventions ability to improve service use among the youth. Michielsen *et al.* [23] have argued however that, school based sexual and reproductive health interventions decline in their effectiveness over time resulting from broader intervention, limitedness in methodologies and overemphasis on increasing knowledge which has been found cannot alone change sexual behavior of youth [24]-[26].

In Bangladesh, Kenya, Mexico and Senegal, applying quasi-experimental intervention design to test the effect of in-school education in addition to that of community mobilization activities and youth friendly health services, the study did not demonstrate a consistent pattern of improvement in sexual and reproductive health service through out-of-facility based interventions between the countries. No impact on service use was found in Mexico and Kenya [27], while in Bangladesh service use doubled in the intervention area without the school component, and increased ten-fold when it was included, but no significance testing was carried out. In Senegal a significant increase ($p < 0.05$) above the control was only found when the school intervention was included. The implication of this finding was that, where there was an observation of an increase in service utilization, it was due to the out-of-facility intervention [28] [29].

Youth sexual and reproductive health activities led by other organizations were going on in both control and intervention areas [30]-[33]. Evidence suggests however that, sessions of youth within the community struggled to maintain attendance over a period of time, with other commitments often getting in the way [23] [34]. This calls for an integrative service approach to increase service uptake.

The combined provision of services through the use of peer education, recreational activities and media yielded some results in three separate interventions as reported in Dushishoze [35], Pathfinder International in Gweru [36] and ABTEF youth centre in Togo [37]. In Rwanda, Zimbabwe and Togo clinic data which were reviewed over time did not have any control. No significant effect was found between youth centre visitation and reproductive health service utilization in Zimbabwe.

Hessburg *et al.* [1] posited that providing either out-of health facility sexual or reproduction health service in stand-alone to Ghanaian youth or whether to continue with facility base reproductive health services put service providers in between two fix areas amidst logistical and monetary constraints. Despite the existence of theoretical and empirical knowledge about sexual and reproductive health provided by health facilities, studies are inconsistent [38]. Family Health International and many assumptions remain unaddressed. Currently empirically based evidence to show how effective an investment into out-of-facility based sexual and reproductive health service will be is non-existent in Ghana. Whether the existing facility based sexual and reproductive health services centers are meeting the needs of young people constitutes the objective of this study.

2. Methods

2.1. Study Area

The study location was the Kwadaso Sub metro district of the Ashanti region of Ghana. It is found within the Kumasi metropolis. The Kumasi metropolis is located in the forest zone and council forms part of the nine administrative sub metro councils of the Kumasi metropolis. The total population of all persons in the Kwadaso sub metro district council is 220,798 [39] (GSS, 2010).

The Sub Metro has one Town Council that serves its nine electoral areas with 25 Councilors.

The Sub metro is home to key of Ashanti regions hospitals and health services centres which include the Seventh Day Adventist hospital (SDA), Siloam Hospital-Kwadaso, Maranatha Hospital, Dr. Amin Bonsu Hospital, Marie Stoppes International Center and Apatrapa Maternity Ward. The Sub Metro has fifty-nine (59) schools

including twenty (20) Junior High Schools, two secondary schools and five tertiary institutions.

2.2. Study Design and Sampling

This study employed a cross-sectional with multistage sampling design in selecting 170 youth aged 10 - 24. The sampling frame consists of a list of elements (units) of the population. The sample frame constituted all youth aged 10 - 24 in the study area. The sample frame was 84,083 [39] (GSS, 2010). In Stage 1, one administrative region, the Ashanti region was selected randomly from ten regions across Ghana which is differentiated by regional location. The stage 2 involved the selection of one district; Kumasi metropolis from the 30 districts in the Ashanti region. In the Stage 3, the Kwadaso Sub metro council was randomly selected from nine (9) sub metro councils. The cluster stratified sampling was used to categorize the youth into two main strata; out-of-school youth and in-school youth. The in-school youth were further clustered along three cohorts of junior high school youth, senior high school youth and tertiary students which were selected randomly basing on the closeness to the main hospital in the study area.

The study location was clustered into four areas (Sofoline, Market area, Agric Nzema and Asuoyeboa area) from within which 20 out-of school youth were sampled randomly selected from to conduct the study. After the stratified sampling had been adopted in grouping the students according to their classes in their school, random sampling was employed in collecting data from the youth from within each stratum. Out-of school youth were interviewed using structured questionnaires on one-on-one schedule. The focus of the questions was on socio-demographic characteristics and issues of facility based sexual and reproductive health service utilizetion. The Socio-demographic information consisted of, age, gender, occupation, education, religion and. Questions on utilization of facility based sexual and reproductive health services related to the type of services ever accessed, intention for subsequent visit or otherwise and the reasons for the decision to revisit service centres or not.

2.3. Data Collection

The study administered questionnaires to the in-school youth and structured interviews to collect information from out-of-school. The questionnaire were prepared in English and given out to the in-school youth. The questionnaire was pre-tested at a mixed sex secondary school; Elite College. The interviews were conducted in Asante Twi, the local language of majority of the residents. Out-of-school youth were interviewed using structured questionnaires on one-on-one schedule. The focus of the questions was on socio-demographic characteristics and issues of facility based sexual and reproductive health service utilization. The Socio-demographic information consisted of, age, gender, occupation, education, religion and. Questions on utilization of facility based sexual and reproductive health services related to the type of services ever accessed, intention for subsequent visit or otherwise and the reasons for the decision to revisit service centres or not. The response rate was 94.4%.

2.4. Data Analysis

The results were generated using descriptive statistics. The data analysis involved the estimation of percentage of the responses of the respondents. The distribution of factors pertaining to the utilization of facility based sexual and reproductive health service, type of service used, sexual experience of youth and reason for subsequent visit or not was estimated using percentages and frequency Thus, the univariate analysis (T2, T3, T4), comprise of a frequency distribution of selected variables which are pivotal to this study.

2.5. Ethical Consideration

Ethical Clearance was sought form the Department of Sociology and Social welfare. More to that, both written and verbal consent were sought from the school heads and participants whiles assuring them of the highest level of anonymity and confidentiality.

3. Results

The results of the study are presented on the 170 youth who were surveyed. This section presents results from the cross tabulation (**Table 1**) and univariate (**Tables 2-4**).

From **Table 1**, 25.3% (38/150) in-school youth had ever used sexual and reproductive health service (SRHS)

Table 1. In-school youth utilization of facility-based sexual reproductive health service before* level of education.

Variable		Level of education of youth			Total
		Tertiary	Secondary	Junior High School	
Whether youth has ever used facility-based reproductive health Service	**Yes**	15	16	7	**38 (25.3%)**
	No	32	32	36	**100 (66.7%)**
Total		**47**	**48**	**43**	**138 (92.0%)**

*Estimates not 100%, since not all in-school youth responded.

Table 2. Sexual experience and facility based sexual and reproductive health services.

Variable	N	%
Facility based sexual reproductive health services utilized by in-school youth in lifetime		
o Contraceptives	9	23.9
o Condoms	17	44.6
o Sexual and reproductive counselling	12	31.5
Total	**38**	100
Sexual experience among youth of all youth category		
o Yes	77	45.2
o No	93	54.8
Total	**170**	**100**
Utilisation of FBSRHS by youth (***All youth categories, N* = 170**)		
Yes		
– *In-school youth* (***N* = 150**)	38	25.3
– *Out of school youth* (***N* = 20**)	5	25
Total	**43**	25.2
No		
– *In-school youth*	100	66.7
– *Out-of school youth*	15	75
– *Not applicable responses*	12	8
Total	**126**	**74.2**
Total utilisation for all youth category	**43**	**25.2**
Reasons why in-school youth did not use facility-based sexual reproductive health service until after first sexual experience		
o Ignorance	8	23.5
o Lack of service	7	20.6
o Lack of motivation by others	7	20.6
o Fear of stigmatization from society	0	0
o Fear of parents	12	35.3
Total	**34**	**100.0**
Reproductive health service utilized by in-school youth during visit to the hospital/clinic in the last six months		
o *Treatment for STIs infection*	10	33.3
o *Family planning*	5	16.6
o *Counselling*	13	43.3
o *Abortion and pregnant*	2	6.6
Total	**30**	100

at the facility. Not all in-school youth expressed their opinion on their use of SRHS. 92% (138) of youth responded to the questions of ever using SRHS. Out of the remaining 12 (8%) young persons who declined to respond to the question of ever using facility-based SRHS, three (3), two (2) and seven were in tertiary, secondary and junior high school levels respectively. Majority 66.6% (100/150) of In-school youth have never used facility-based SRHS. 15 out of the 38 youths who had ever used SRHS were in the tertiary institution, 16 were in secondary schools while 7 were in the Junior High school. This implies that the youths in the secondary schools utilize reproductive health services more than the rest of the youth.

Table 3. Facility based sexual reproductive health service utilization related factors.

Factor	N	%
Whether in-school youth are aware of any facility-based youth friendly sexual reproductive health services offered to youth in the district		
o Yes	41	27.3
o No	109	72.7
Total	**150**	100
Whether youth (***all categories***) *will visit SRHS centre visited last time for Sexual reproductive health services.*		
o Yes	37	38.9
o No	58	68.1
Total	**95**	**100**

Table 4. Reason for youth non-visit or subsequent visit to access FBSRHS.

Reason for youth intention to revisit youth centre/hospital/counseling/sick bay	N	%
o Friendly, caring staff	13	35.1
o Short waiting time	6	16.2
o Youth corner	5	13.5
o Place to talk with peer counselors	3	8.1
o Convenience	4	10.8
o Had a nice experience	6	16.2
Total	**37**	**100**
Why youth will not return to health facility/hospital/peer counselor/sick bay visited last time for sexual reproductive health services again		
o Needs parent permission	29	50.0
o Needed partner's permission	13	22.4
o Unfriendly staff	6	10.4
o Staff does not welcome/approve of young people	10	17.2
Total	**58**	**100**

Table 2 summarizes the number of youths and how they utilized facility based sexual reproductive health services mentioned.

From the results in **Table 2**, 23.9% (9/38) of the in-school youth who had ever used FBSRHS utilized contraceptives, 44.6% (17/38) utilized condoms whiles 31.5% (12/38) utilized sexual and reproductive health counseling. The interview with the out-of school youth showed that only two in the unaffiliated category had gone to a clinic to access facility based sexual and reproductive health services on the specific problem of menstrual difficulty, while three in affiliated youth category had ever accessed service.

Out of the entire youth studied who had had sexual encounter in life time before, 58.8% (43/77) of them said they used FBSRHS after their first sexual experience. The services used under consideration were facility based sexual reproductive health services. The results show that out of 43 youth who utilized SRHS, a total of nine used sexual and reproductive service before first sexual experience (four In-school youth and five out-of-school youth). According to 35.3% (12/30) of the youth, they did not use facility based sexual and reproductive health service before first sexual intercourse.

The study found that, 23.5% of young persons utilized SRHS lately as a result of ignorance, 20.6% youth on the other hand accessed service later due to the unavailability of SRH services during the first sexual initiation and among 20.6% of young persons, the lack of motivation by others denied them the ability to use sexual reproductive health service before their first sexual intercourse. The majority 10 youth who used SRHS after their first sexual experience offered other varied reasons why they did not use SRHS prior to first sexual experience. The reasons included not being interested, no specific reason and not grown up by the time of first sexual intercourse.

Table 2 show that, majority (43.3%) went for counseling as the sexual and reproductive health services uti-

lized during visit to the hospital or clinic during the last six months. To them the counseling services were friendly. The youth who sought treatment for STIs were 33.3% family planning was also given by 16.6% of the youth studied. Furthermore 6.6% of the subjects indicated they were at the hospital or clinic for abortion and pregnancy related issues.

Table 3 presents the responses from youth on whether they are aware of any youth friendly reproductive health service rendered to them in the area. The percentage of in-school youth who were not aware of such services in the area was high 72.7% (109/150).

The percentage of in-school youth who were aware of YFRHS rendered to them in the area was very minimal 27.3% (41/150) constituting less than a third of the in-school youth. 80% representing Sixteen (16) out of the twenty out-of-school youth interviewed corroborated the point of view of the in-school youth that they do not know of any youth friendly sexual reproductive health service facility in the area. Only four were in the known of the availability of such services in the study area. Additionally, the youth were made to assess whether they will go to the particular sexual reproductive health service provider again.

The study found that out of the total number of 95 youth who had used at least one or more sexual reproductive health in lifetime, majority 61.10% would not revisit where they accessed services whereas 38.9% would visit their reproductive health service provider again whether in facility or out-of-facility. The results show that whiles only 45.2% (43/95) both in-school and out-of school had used facility based (Clinics, hospitals, youth centers etc.) reproductive health services before, the total number of youth who had used both facility based and non-facility based sexual reproductive health services was more than half of the study population 55.8.% (95/170). The youth who use non-facility based sexual and reproductive health services were relatively higher (30.5%, 52) than those who use facility based sexual reproductive health service (25.2%, 43).

The results presented in **Table 4** accounts for the reasons for young person's intention to revisit service providers or not to revisit.

The youth gave reasons such as caring staff (35.1%), waiting time and having had a nice experience (16.2%) as the reasons for revisit. Additionally, a percentage of 13.5 each said they would visit the same facility again because of the youth corner whiles to 8.1% of young persons the facility offers a place to talk with peer counselor. The studied found out that other factors such as waiting time (16.2%) and convenience as reasons for revisit.

Among the 58 youth who were not in the position to revisit the service centre accessed in their previous time, (50%) would need their parents' permission, 22.2% needed their partner's permission. According to 17.2% of the youth, the staff do not welcome or approve of young people accessing services and as such would not revisit the service centre again.

Others opined that unfriendly nature of the staff at the facility (10.4%) accounted for their decision not to visit the centre subsequently.

4. Discussion

This study examines young person's perspectives on utilizing sexual and reproductive health services at facility level. We used cross-sectional survey design with multistage sampling to elicit information from affiliated and unaffiliated youth aged between 10 and 24. The study identified sexual and reproductive health service at the facility level was very minimal.

The study showed that a greater number of the youth who met their peer counsellor indicated that their peer counsellors were friendly. Some even went the extra mile to stipulate that their counsellors were very friendly. Family Health International [38] accords to the essence of peer counselling; holding that it is the most effective component of providing youth friendly reproductive health services. Population Council [40] reports that though greater number of the youth in the study accessed counselling; the benefits accrued to the educators themselves and not to the youths; thus, counselling in itself is not of any vital importance to the youths. This runs contrary to the view shared by the Family Health International [38]. In the present study, though contraceptive has mostly been used by In-school youth in their life time, sexual and reproductive health counselling was identified as the single most frequent accessed facility based sexual and reproductive health service among the youth during the last six months preceding the conduct of the study.

Despite the Pathfinder International [36] [37] recognizing youth friendly reproductive health services as appropriate and effective strategy for addressing the sexual and reproductive Health needs of the youth, majority of the youth sampled in this study have not visited either hospital or clinic for reproductive health services for the last six months. This shows the need to access youth friendly reproductive health services at hospitals or clinic

has not been recognised by most youth in the present study area. The reason for the lower turn-in for accessing health services could be in line with Senderowitz and others [34] finding that the essence of accessing reproductive health services are because of specific biological and psychological needs of the youth, the high risks of STIs, HIV, and pregnancy, disproportionately high risk of sexual abuse, importance of behaviour related risks which are all subjectively related to every youth. In this study, parental and partners permission have been found to be determinants in youth subsequent visit to health centre.

Among the few who visited the health facilities; they indicated counselling as the major reason for the visit; followed by treatment for STIs infection, family planning and abortion and pregnancy respectively. Most of these youth spoke to doctors instead of Nurses, Health Assistant or counsellor about their sexual and reproductive health services and were very satisfied with the attitude of the staff and the nature of the services they received [5] [9]. The youth however indicated parental permission as the major reason why they are not likely to return to the health facility to accessed reproductive health services. This could be as a result of parental fear which influence the youths not to access reproductive health services in successive manner [13].

The issue of youth drop out and subsequent service use is common even among areas where interventions have been set up [22]. The study found that about a third of the youth (61.05%) were not in the position to revisit where they accessed sexual and reproductive health service during their last visit.

The drop out in service utilization is consistent with Magnani [22] study, though he did not account for the reason for the youth intention not to revisit, this study found several interrelated factors to be responsible youth intention not to revisit. Corroborating Godia [41] study, the absence of a proper appreciation for the importance of sexual health care especially among parents could prevent youth from utilizing reproductive health service in consecutive manner. Additionally, the reproductive health challenge that accounted for youth visit to the service centre might have been addressed for which might have influenced youth decision not to revisit.

The youth indicated greater satisfaction for services they received from the health providers. In contrast and was inconsistent with earlier works by Pathfinder [42], that the attitude of service providers could be bad; however results in this study indicate otherwise. This finding confirms similar studies by Liu and others [11] study in China. However, despite youth satisfaction with service providers, only a quarter of the youth who had ever used sexual and reproductive health service had intention to revisit service point as against close to one third of them who decline willingness to visit subsequently.

Knowledge of the existence of facility base sexual and reproductive health service has been identified to be very low in this study. Only 25% of all youth had ever accessed facility based sexual and reproductive health service in the study area out of the 58.2% of the youth who had ever utilized SRHS, with the majority 30.5%, accessing service out-of health facility and not at facility level?

Whiles evidence by some scholars like Senderowitz, Michielsen and his colleagues [23] [34], suggest that youth attendance to out-of-facility based sexual reproductive may decline over a period of time, due to young person's commitments to other activities, the present study found contrary as the most preferred sources of sexual and reproductive health service utilization was mainly out-of-facility-based.

5. Conclusions

The study has established that despite the satisfaction of young persons with the sexual and reproductive services offered in the Kwadaso Sub metro council, service utilization was generally poor. This was partly attributable to the fact that majority of the youth did not know the existence of facility based sexual and reproductive health service despite their existence in the study area. The greater proportion of the youth had accessed services out of health facility.

Intention to revisit point of service delivery was generally on the low side. There is a need for services that integrate both out-of-facility and facility based sexual and reproductive health services. Additional sensitization campaigns are to be vigorously pursued to help young person's locate where facility based sexual and reproductive health service centres are located. In respect of policy interventions, the study finding offers an empirical base for training non health workers in the delivery of sexual and reproductive health services so that medical conditions could be referred to health facilities.

6. Limitation of the Study

The major limitation of this study was the issue of recall biases. The nature of the study required youth to give

answers to events that had taken place in the past years. This could have potential effect on the accuracy of the information being given. However, this threat was minimized to its barest minimum by asking study participants to recall mostly in either the last one year or the last six months. The other limitation has to do with the tendency of respondents offering socially desirable responses. The use of filters in the questionnaire aided in checking any inconsistencies. Additionally, through the use of strict confidentiality and anonymity the participants freely agreed to provide accurate responses.

Author's Contribution

The paper conceptualization, design, results interpretation and manuscript writing was done by Appiah S. C. Y and Dapaah J. M. The design, manuscript review and final approval were done by Badu E. and Obeng B. All collaborated in interpretation of the data and preparing the manuscript. All authors have read and approved the final manuscript

Conflict of Interest

The authors' declare no conflict of interest.

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Abbreviations

SRHS: sexual and reproductive health services;
FBSRHS: facility-based sexual and reproductive health service;
YFSRHS: youth friendly sexual and reproductive health services.